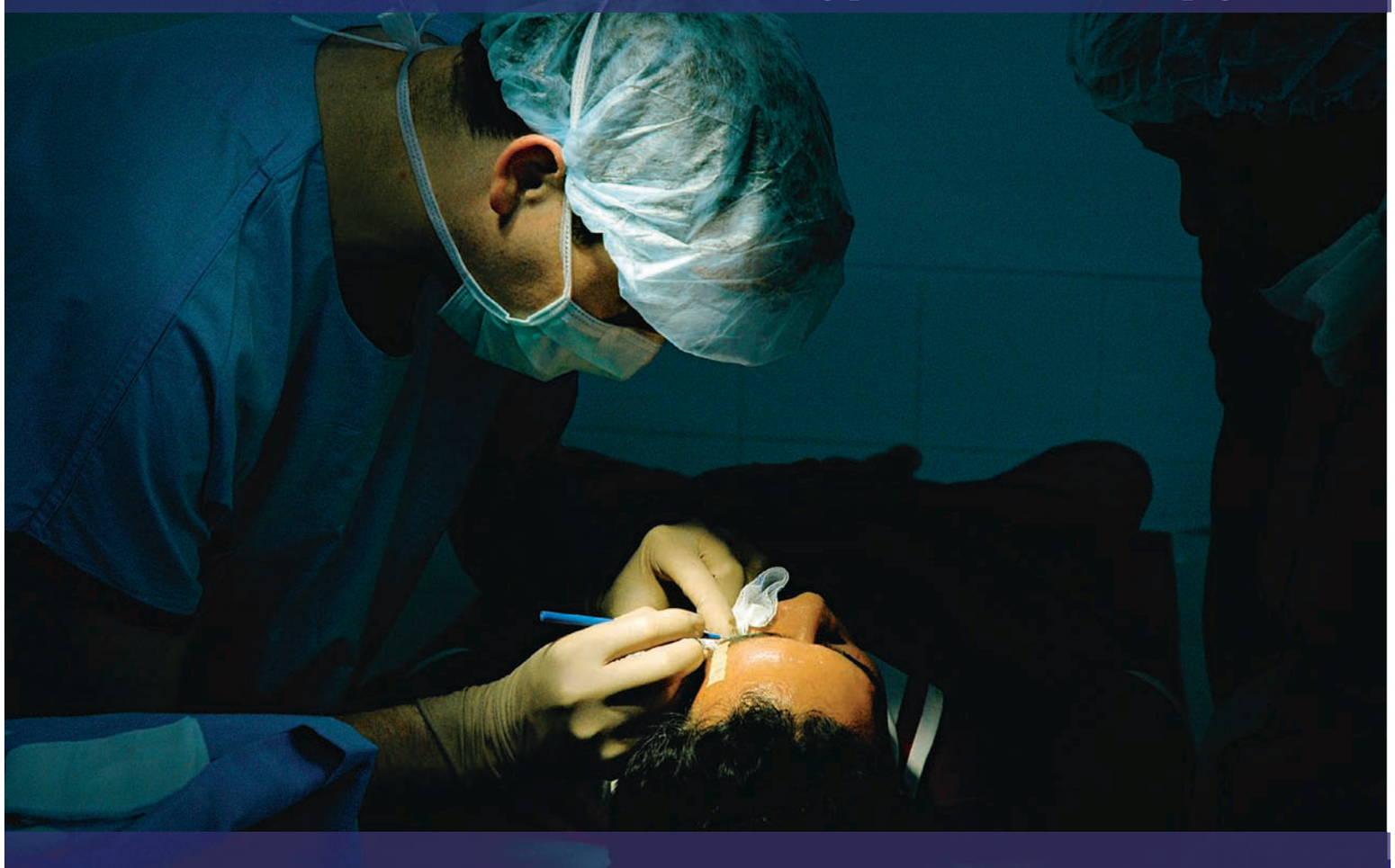
THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL NEWS

Vol:9 No:10 November-December 2008

November-December Highlights:

Curing preventable blindness, page 28



The College of Surgeons of Australia and New Zealand

Merry Christmas and a Happy New Year

PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

PROVISIONAL DATES

In 2009 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives.

NEW! MAKING MEETINGS MORE EFFECTIVE

27 June, Melbourne
21 August, Sydney

Want to learn how to have more productive meetings? This whole day workshop is a 'must' for anyone who sits on a committee or a board. It explores the ten principles for effective meetings and the role and responsibilities of the chair and committee members. You can improve your chairing skills and develop strategies for conflict resolution and gaining consensus.

NEW! LEADERSHIP IN A CLIMATE OF CHANGE

19 – 22 June 2009, Sydney

Presented by University of New England (UNE), this workshop can help you to understand what it takes to be an effective leader. It uses the DISC model to examine the nature and practice of organisational leadership through the exploration of issues such as organisational communication, influence and power and styles of leadership. You will also learn more about working as a team and gaining team commitment. These issues will be discussed in the context of organisational change and management. For a more comprehensive business focus, consider attending this workshop and 'Providing Strategic Direction' (below).

NEW! PROVIDING STRATEGIC DIRECTION

13 – 15 November 2009, Melbourne

Want a solid understanding of the strategic planning process? This workshop presented by the University of New England (UNE) will focus on how to establish a strategic direction through an effective planning process. You can learn how to implement an organisational strategy and conduct an organisational/market analysis to sustain competitive advantage and develop strategic measurement systems.

NEW! ADVANCED DIPLOMA IN BUSINESS MANAGEMENT

May 2009 – October 2010

Do you want to upgrade your skills by obtaining a recognised business qualification? This course can hone your management skills and help you to become a better leader.

The University of New England (UNE) Partnerships is proud to offer this exciting, new learning opportunity tailored to the needs of surgeons who have three years (minimum) relevant workplace experience in the public or private sector.

This 18-month course combines distance learning modules with online interaction and three face-to-face workshops. It earns three credits towards a Masters, Business Administration (MBA) if desired. Practical workplace focused training shows how to effectively manage the strategic direction of a business through leadership, comprehensive business operations and financial management.

Each of the nine units has a set of action learning activities and practical work-based assessments. Distance learning is complemented by two face to face workshops in 2009 (see above) and another in 2010 'Sustaining Your Business'. The last workshop focuses on financial management.

FOR MORE COURSE INFORMATION Visit http://www.unepartnerships.edu.au

2009 DATES
JANUARY - JULY

ACT

18 July	Supervisors and Trainers (SAT SET), Canberra
30 July- 1 August	Surgical Teachers Course, Canberra

NSW

7 February	Supervisors and Trainers (SAT SET) (Facilitator training), Sydney
26 February	Polishing Presentation Skills, Sydney
1 April	Interviewer Training, Sydney (videoconference)
28 April	Supervisors and Trainers (SAT SET), Sydney
4 June	Mastering Difficult Clinical Interactions, Sydney
29 July	Mastering Intercultural Interactions, Sydney

QLD

11 March	Supervisors and Trainers (SAT SET) (Urology), Gold Coast
19-21 March	Surgical Teachers Course, Brisbane
25 March	Interviewer Training, Brisbane (videoconference)
2-4 May	Younger Fellows Forum, Brisbane (pre ASC)
5 May	Supervisors and Trainers (SAT SET), Brisbane (ASC)
5 May	Writing Reports for Court, Brisbane (pre ASC)

SA

4 March	Beating Burnout, Adelaide
16 June	Supervisors and Trainers (SAT SET), Adelaide

NT

27 June	Supervisors and Trainers (SAT SET), Darwin

WA

4 February	Supervisors and Trainers (SAT SET), Perth
29 May	Risk Management: Mastering Consent, Perth

VIC

6-7 March	From the Flight Deck, Melbourne
14 March	Communication Skills for Cancer Clinicians, Melbourne
2 April	Mastering Intercultural Interactions, Melbourne
29 April	Interviewer Training, Melbourne (videoconference)
26 May	Supervisors and Trainers (SAT SET), Melbourne
19 June	Winding Down from Surgical Practice, Melbourne
27 June	Making Meetings More Effective, Melbourne
4 July	Supervisors and Trainers (SAT SET), Ballarat

TAS

7 March	Supervisors and Trainers (SAT SET), Launceston

NZ

21 February	Supervisors and Trainers (SAT SET), Auckland
26 May	Supervisors and Trainers (SAT SET), Christchurch
26 June	Practice Made Perfect: Successful Principles for Practice Management, Auckland

FURTHER INFORMATION Contact the Professional Development Department on +61 3 9249 1106 or by email PDactivities@surgeons.org

President's Perspective

Ian Gough, President

Navigating in turbulent times

It is a time to reflect on some of the significant events that have occurred over the year internationally and nationally

External Turbulence

Next to the Great Depression in the 1930s, the last year will be regarded as one of the most economically turbulent of all time. Experienced financial advisors have no memory of similar volatility and asset devaluation. Throughout this, the College has been actively involved with managing our own assets in the sense of equities and buildings.

Whilst all efforts have been expended to minimise any impact, we are now all living in a world of credit uncertainty and financial turbulence. Fortunately the position of our College is sounder than many. The funding for our core activities is not dependent on investment income. Consequently we can continue our training and fellowship support activities without having to resort to substantial increases of fees or reduction in activities. However, at a personal level there will be many Fellows wondering how and when this period of unprecedented volatility will stabilise- hopefully relatively soon.

Ongoing Reviews

The health sector and the College have been besieged by reviews over the past few years. This year with a new Australian Government we saw the National Health and Hospital Reform Commission produce its initial paper of "Beyond the Blame Game". Substantial submissions and consultation have followed.

However, while we await the outcome of this review, which could be either incremental or transformational in its outcome, the health related crises continue on a daily basis. Barely a day goes by where access block, emergency bypass and waiting list issues are not mentioned in the press of Australia and New Zealand. There are many solutions that are offered from broad brush structural reform, different funding models and alternative models of delivery of healthcare including diversification of the healthcare workforce. In discussions with healthcare planners there is some acceptance that rationing does exist and must be addressed despite continuing political denial. One thing that does appear as a constant is that when there are consequences of inadequate government funding and planning, the health professionals and in particular the medical profession will be blamed by the governments.

National Registration and Accreditation

This issue has been highlighted in *Surgical News* for three years from the earliest days of the review by the Productivity Commission. Commencing with government legislation in Queensland and then following in other jurisdictions it is anticipated that the changes to achieve nationally based registration and accreditation will occur in the coming months. The way this has been proposed has resulted in all of the ten health professions that will be covered by this legislation now being in open rebellion against the Federal (Australian) Government.

The national registration concept is broadly acceptable but the establishment of standards and accreditation of the professions should never be accountable to a political process. These proposals are not consistent with International Convention and remain incredibly concerning. If this is not appropriately changed then any reciprocity between the educational standards of Australia, New Zealand and the rest of the world may be called into doubt.

When we are busily committed to the day to day activities of surgical practice it is hard to recognise the significance of these issues. However, they are profound and the College is very much involved in trying to achieve sensible and acceptable solutions that ensure the safety and quality of patient care.

Unifying force for surgery

The College is now firmly committed to being the College of Surgical Specialties. Importantly all surgical training is now undertaken by the appropriate specialist society with General Surgeons Australia (GSA) being responsible, with the New Zealand Association of General Surgery (NZAGS), for conducting the training in general surgery. The College is clearly defining its role as an "umbrella organisation" and our new strategic plan emphasises this. The purpose of the College is to be the unifying force for surgery in Australia and New Zealand, with Fellow of the Royal Australasian College of Surgeons (FRACS) standing for excellence in surgical care. True to the purposes for which the College was founded in 1927 we can now more effectively address the issues that are confronting surgical practice in 2008 to 2015. The strategic plan has just been released and I encourage you to read it.

Surgical Education and Training

All Trainees and Fellows would be aware of the changes in the educational program that were agreed last year and commenced in 2008. The Australian Medical Council (AMC) reviewed these changes in 2007 and again in 2008 to ensure our implementation was thorough and comprehensive. In a program of complexity involving so many parties, there will always be issues to address and improve. However, the AMC remains confident in our program, our ability to deliver and to communicate effectively with all our stakeholders.

Sustainability of Training

One of the most important issues that we are now addressing is the ongoing sustainability of our training program. As outlined by Birks and Palermo[1], the role of the supervisor is now much broader, more comprehensive and demanding than it was in the past. →

"The national registration concept is broadly acceptable but the establishment of standards and accreditation of the professions should never be accountable to a political process."

Maintaining the competence of our supervisors is critical and the College is committed to the ongoing development of the faculty of surgical educators. The College is currently undertaking a survey of all Fellows who are actively involved in our educational endeavours to delineate the key issues to address. We will be focusing on issues of recruitment, retention, training and development to ensure that the Fellows who are committed to providing the surgical workforce of the future are able to sustain their enthusiasm and their commitment.

Training in the private sector is recognised as necessary to cover the complete curricular requirements of most specialty programs and to provide training opportunities unable to be delivered in the public sector. There are now more than 60 accredited training posts in private across most specialties, some of these funded with the assistance recent federal government grants. Major private hospital groups are enthusiastic about taking specialist Trainees. Informing patients and obtaining their consent to the involvement of a Trainee in their care is, of course, an obligation. There is now legal recognition of the capacity of a surgeon to charge the usual private fee, and claim a medicare rebate, for a procedure done in private where a Trainee in a college program performs the procedure under direct supervision. The provisions are clearly explained in Group T8.2 pages 234 and 235 of the Medicare Benefits Schedule (November 2008). See: http://www.health.gov.au/internet/mbsonline/publishing.nsf/content/Medicare-Benefits-Schedule-mbs-downloads.

Seasons Greetings

I wish to sincerely thank the many Fellows and Trainees who are so committed to the College and the Specialty Societies. As I go around our countries attending the various College and Specialty activities, I am continually impressed by your enthusiasm for excellence.

I wish you and your families all the best for Christmas and for a peaceful and prosperous new year. We may anticipate that 2009 will be another exciting, challenging and rewarding year.

1. Birks, D. and C. Palermo, *Surgical education and training: maintaining the competence of supervisors*. ANZ J Surg, 2008. 78(9): p. 737-8.

The College Strategic Plan is available now

Cover photograph courtesy of Ellen Smith

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Work-life balance: The importance of planning

Ian Dickinson, Vice-President

Balancing work and non-work activities can be one of the most challenging elements of any occupation that requires high levels of responsibility. As we head into the Christmas/New Year period, in this final edition of *Surgical News* for 2008 it is timely to discuss this issue.

Many of you will be taking a well-earned break from your surgical duties and seeking to spend time with family and friends and to unwind as much as possible from the constant demands of your surgical work. Perhaps some of you will be also taking this time to reflect on the high demands of your work. For those of you who are finding the juggling of your work with family and non-work activities difficult, perhaps this article will give you some things to consider as the bulk of it is based on the views of other surgeons. This article also complements past editions of *Surgical News* which have addressed this area.

What is work-life balance?

The term work-life balance is one of the new buzz-terms. Other terms that converge with this include burnout, stress, exhaustion and so forth, as these often indicate that work is taking up most of a surgeon's time. Essentially, work-life balance refers to how someone allocates their time between work and non-work activities.

In highly demanding professions there is little time for personal reflection. Too often it is easier to draw up to-do lists and to allocate whatever time is left to sleep and family. However, a balanced life has more dimensions than this. One person's approach to a balanced life is that of Milton Bradley who developed the Wheel of Life (refer figure 1).

The Wheel of Life can be developed to suit each person's needs. There are only a few requirements when formulating your own Wheel of Life, namely to ensure that no one item dominates.

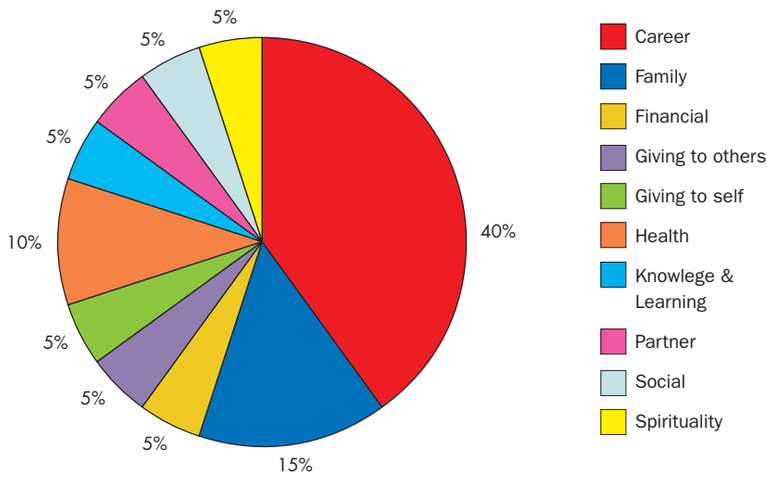


Figure 1: The Wheel of Life – One person's allocation of their time

Ironically, when we think of adding more balance in our life we tend to only take into consideration work and family. The truth is that we function best when we allocate our time across a spectrum of activities.

Figure 2 illustrates an alternative allocation of time for a qualified surgeon with a young family.

The art to creating your own Wheel of Life for each stage of your life requires you to be honest with yourself about what is important. Below are some work-life balance choices made by surgeons.

Re-shaping of a surgical career (Patrick J. D. Dawes, Clinical Senior Lecturer Otolaryngology - Head and Neck Surgery (ORL-HNS), University of Otago, New Zealand): Asking a surgeon to write about work-life balance is something of a non-sequitur. By definition we are all "type A"; driven, egocentric workaholics, everything else, families included, is a diversion from the true path to fame and success! Work-life balance is all about increasing relaxation time (operating more) and reducing stress time (fewer management meetings).

But seriously, perhaps the question we should each ask ourselves is how do we, our partners and families manage as individuals and as units? What are our hobbies? How hard do we question ourselves? Do we want to answer those questions, and, if so, how do we do that? Is work a hobby? How much am I paid? What is my management style? Am I a delegator, a starter but not a finisher, or a solo player? All these things go into making us individuals, and each individual has different needs to achieve a satisfactory work-life balance. But why ask these questions when the answers may be unpalatable?

My move to New Zealand was to take up a full-time position in ORL surgery, with the expectation of university sessions to follow. This is when work-life balance was just about right. What was the ideal balance? Getting home at a reasonable time made an enormous difference. Bringing less work home was pretty good too. →

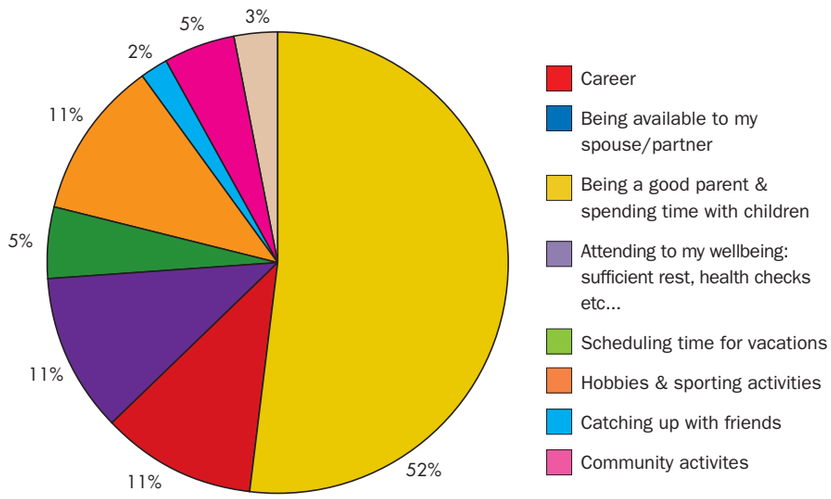


Figure 2: An Alternative Allocation of Time

Taking the children to school, coaching a soccer team, living five minutes from town, 15 minutes from the beach and having scenic Central Otago a drive away were all bonuses. Slowly building up a private practice (to supplement a relatively poor hospital salary) and having evening time for a run and relaxation with the family were too. In addition to all that, there was engaging in research, teaching Trainees and writing and collaborating over medical publications. It sounds idyllic.

I am sure that moving to New Zealand has been a great bonus for our family. Living here has allowed me to work in a post that combines clinical and academic responsibility, to maintain a reasonable income and to have plenty of family time – something I doubt would have been achieved in the UK.

Juggling children and general surgery (Juliette Murray, SpR General Surgery, West of Scotland): In order to accompany my husband (who is also a surgeon) on his fellowship to Grenoble in France, I took some unpaid leave. The French had a superb work-life balance and all members of the department were expected and encouraged to take afternoons off to ski or spend time with their families.

The French experience changed my view of the way I wanted to live and work. By the time we returned to Scotland, I was pregnant with my second son. Again, I worked normally throughout but this time took annual leave before the baby was due and took nearly a year off after the birth. This was great but it was daunting to go back after having been on leave for so long. I realised that there are no refresher courses or any means of being gradually reintroduced to surgery. I decided to work four days from 8am to 6pm and my on-call, which works out to between 12 and 16 hours per week, giving me an average of 54 hours at work per week. This is technically full-time but allows me to spend one full day with the children each week. I do all my admin at the end of the day and make sure that I am up to date and always pull my weight. I have not had any negative reaction from either trainee colleagues or bosses, all of whom have been very supportive.

My husband was appointed as a consultant surgeon not long after I returned to work. After much discussion, he opted to do a 10 session job and spend one day looking after the children. I found this enormously helpful. We never work the same weekend so the children are with at least one of us four days out of seven. It has been really interesting to see the reaction of some of his colleagues to a man working flexibly; there has been a few raised eyebrows. It is surprising that many surgeons are quite happy to accept a colleague working privately one day per week, but spending the same amount of time with their own children is considered controversial.

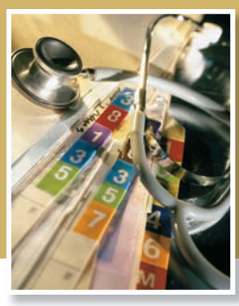
As many female surgeons are married to medics, I think mine is an option worth considering as undoubtedly it is much easier to work for four days than three. In conclusion, I think that it is possible to combine having a family with working as a surgeon but it requires flexibility, organisation and careful planning from both partners.

Moving Towards Balance

As 2008 draws to a close, give some time to your work-life balance. Do you spend enough time with your family? Do you have social activities and planned vacations that allow you to return to work feeling refreshed? Do you pay enough attention to your well-being? These and other questions about how you allocate your time are not only at the core of living a more balanced life, they are also important in determining how to be a well-rounded individual who can attend to their surgical work from a centre of peace rather than a centre of exhaustion and frustration. In looking at your New Year's resolutions, work life balance could be given some serious re-consideration

I wish you all a very happy Christmas and New Year.

To further explore work/life balance, why not attend a Beating Burnout workshop in 2009? See page 2 for more information.



Rights to inventions of employees

Ownership of intellectual property derived from research conducted on the employers behalf needs be clarified at the start of employment

Craig Subocz,
Senior Associate, Russell Kennedy Solicitors

A recent court case examines a university's claim to ownership of inventions developed in the course of a former employee's employment. These are issues for many surgeons.

The crux of the issue faced by colleges is that only where an employee of a non-commercial entity is bound by a clear and unequivocal "duty to invent" will the rights in such inventions belong to the employer institution.

Accordingly, universities and other employers should consider adopting the following strategy when dealing with the rights in inventions developed by employees and members:

1 Review the terms of current and future agreements with employees and members engaged in research to address the ownership of intellectual property;
2 Consider the validity of any regulations or by-laws made that purport to automatically assign the employee or member's intellectual property in the college;
3 Explore the benefits of entering into commercialisation arrangements to exploit the intellectual property subsisting in their inventions.

In April 2008, the Federal Court of Australia challenged the assumption that non-commercial institutions, such as universities, are automatically entitled through the employment relationship to the rights of inventions developed by their employees during the course of their research activities.

This update summarises *University of Western Australia v Gray (No. 20)* and discusses the implications of the court's decision.

Background

The University of Western Australia (UWA) employed Dr Gray to "teach" and to "undertake research". His employment was subject to the *University of Western Australia Act 1911* (WA) (UWA Act) and relevant regulations made under the *UWA Act*.

UWA declined an opportunity to commercialise Gray's research into liver cancer treatment, so Gray established a company to commercialise the research and assigned the intellectual property rights in his inventions to the company. Various applications were made by Gray and the company to secure patents for Gray's inventions.

Pursuant to the university regulations, UWA purported to own all intellectual property created by an employee in the course of his/her employment, except for copyright other than in computer programs, and purported to require the employee to execute all documents to prove UWA's title to the rights.

The court's decision

UWA claimed that Gray's employment contract contained an implied term which provided that UWA gained title to the intellectual property developed by Gray during the course of his employment. The Court found that the nature of Gray's employment did not give rise to such a term. It found that Gray's duty to engage in research was separate and distinct from a "duty to invent".

Gray was not bound by a "duty to invent" because:

1 Gray, not UWA, chose what areas of medicine to research. UWA imposed no obligation upon Gray to follow particular research avenues that might be more likely to lead to inventions;
2 Gray was free to publish the results of his research, notwithstanding that such publication would render the inventions incapable of patent protection;
3 Gray was not employed in any commercial role at UWA. His duties were to "undertake research" and to "teach";
4 UWA expected that Gray would secure funding for his research from sources external to UWA (such as CSIRO); and
5 Gray needed to engage in collaborative activities with other research institutions to support his research activities.

Thus, absent of any agreement to the contrary, the rights in academics' inventions developed in the course of their research belong to the academics, not their employer. This is so even when it is likely that an academic's research will result in inventions.

Further, it was clear from the circumstances that UWA, although a "trading corporation" for the purposes of the *Workplace Relations Act 1996* (Cth), was not engaging in commercial activities when obliging Gray to undertake teaching and research activities on UWA's behalf. Gray was not obliged to advance a commercial purpose of UWA when selecting the research activity to pursue.

The Court therefore rejected UWA's argument that Gray had breached the fiduciary duties he owed to UWA as a senior employee because UWA's claim was founded on the assumption that Gray was dealing with rights belonging to UWA. Since UWA could not establish that it had any rights in any of Gray's inventions, it could not establish that Gray had dealt with property belonging to UWA for his own benefit.

The Court also held that the regulations made by UWA in relation to intellectual property owned by its employees were invalid, because the *UWA Act* only permits UWA to make regulations dealing with property it already owns.

Continued on page 8

Master of Minimally Invasive Surgery – Why and for whom?

James Edwards, Chair SA Regional Committee & Guy Maddern, Chair, Professional Development & Standards Board

Although we are a small section of the College, in South Australia we like to think that, we make contributions in a variety of ways. We've furnished several Presidents of the College, most recently Andrew Sutherland, and we make a strong contribution in military surgery, such as Lieutenant Colonel Justin Bessell, Capitan Craig Jurisevic and Lieutenant Colonel Susan Neuhaus, as described in the August 2007 edition of *Surgical News*.

We also make a contribution to surgical innovation and teaching. Professor Guy Maddern among others has been working hard to formalise surgical teaching in minimally invasive surgery and to achieve academic recognition. We think this is an important project and would like to introduce it.

With the ongoing challenge to become subspecialised following one's Fellowship of the College, the need for appropriate placements at a post-Fellowship level is continuing to grow. This is being further complicated by the increasing difficulty of our Fellows to obtain employment, particularly in the United Kingdom as a result of the more restrictive access offered to Australians when compared with the members of the European community. As a result of the increasing demand and the need to have appropriately structured Fellowship opportunities, the University of Adelaide has set out to create a one-year Masters program in minimally invasive surgery. This is an initiative that can be taken up by any surgeon working in a Fellow-type role within any of the specialties of the College as well as those pursuing gynaecological surgery.

The program aims to provide a 12-month course linked to an appropriate clinical attachment at a hospital within South Australia. The content of the work involves appropriate practical minimally invasive surgical exposure under the supervision of a unit practising sufficient volume of such surgery to enable competency to be obtained over the 12-month period. In addition to this, a didactic series of lectures will be offered one day a week to participants to cover a broad range of important issues common to all minimally invasive surgery. The intent is that candidates from a range of specialties would come together to discuss not only the technologies and problems they experience within their own specialty but, in so doing, provide insights and solutions across the specialties. Unfortunately, the trend in recent years has been to see silos formed where ear, nose and throat surgeons have no opportunity to talk to gynaecological surgeons who, in turn, rarely have discussions with renal transplant surgeons. In this environment it would be hoped that information about approaches, equipment, devices and technologies could be shared. This may well lead to a better range of options and understandings of the potential solutions available to the minimally invasive surgeon as this area of surgery continues to progress.

There will also be a research component to this initiative that will be developed over the 12-month period. It is also intended that each candidate produce an instructional DVD which will be placed in a web-based library to create an enduring resource.

Assessment is an important part of all such educational initiatives. This has often been lacking in Fellowship opportunities and it is hoped that by providing not only an ongoing assessment of performance within the tutorial group but also formal examination at the end of the course it will be possible to ensure that an appropriate standard is reached by all candidates.

This is a new area for the University of Adelaide in terms of providing postgraduate surgical education that is intended to be delivered after the completion of the Fellowship exam. It is envisaged that if this is successful and the program is taken up sufficiently it may be able to be delivered online to other institutions around Australia. This would be possible provided an adequate practical logbook was generated and an appropriate assessment made by the supervisors. The lecture program and the research program could all be delivered and submitted on line and the examination could also be managed in a similar format.

These sorts of educational opportunities are important and will become increasingly so as we need to ensure that the correct curriculum and learning objectives are delivered to individuals pursuing post-Fellowship training and opportunities. The College itself has been looking at this area and will also, over the next few years, almost certainly develop similar initiatives or enter partnerships with universities elsewhere in the country.

Any enquiries regarding this initiative can be emailed to guy.maddern@adelaide.edu.au

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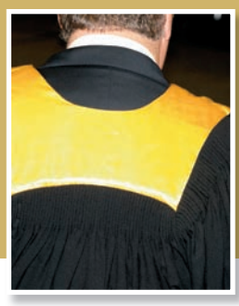
continued from page 7

Implications

Although UWA has appealed the court's decision, for the moment, it remains the most recent exposition of the law relating to ownership of rights in inventions developed by employees of non-commercial institutions. Should a university engage employees or members to undertake research on the it's behalf, without an express agreement they may not necessarily control the rights in any inventions derived from the research efforts of the employee or member. It would be prudent to take steps to ensure that its position on the ownership of intellectual property derived from research conducted on its behalf is clarified.

New to Council



What is special about Queensland and the College?

I.M.A Newfellow

A few months I wrote about the College in New Zealand as the New Zealanders felt left out. Now the Queenslanders are at me as they say they have a larger population than New Zealand and warrant special mention. I was going to ignore them but as the President and Vice-President are both Queenslanders I could only ignore them at my peril.

What is special about Queensland and the College? Well first of all they are having a large sum of money spent on their new building – $7.5 million (excl GST) to be precise. Do they warrant this expenditure? Yes, say the northerners, and the conservative southerners remain quiet. The building at Water Street does have some structural and occupational safety issues that would require a very extensive repair. As is often the case, a knock down and rebuild is cheaper and more effective.

It is a good location. The Queensland regional committee under the watch of Chris Perry spent a lot of time looking for an alternative but could find none as good. The ANZ College of Anaesthetists were co-owners but the College made them "an offer too good to refuse". (In reality it was fair market price.) So now the College owns the entire building. The development is well planned – the site is such that Stage 1 can be built and the old building still occupied, saving on rent for another site. Stage 2 will then go up after demolition of the old building and occupation of Stage 1.

Queensland has a well-spread population. Healthcare is difficult in the state as it has a large population in a large area, several quite large regional centres that need specialist services and many indigenous persons with special health problems. It has also had more than its fair share of problem doctors and administrators; not many states can lay claim to a previous minister of health facing criminal charges.

The Queenslanders boast of "sunny Queensland" but their claim is not entirely accurate. If you look at the Bureau of Meteorology website (www.bom.gov.au) you will see that of all the capital cities in Australia, Brisbane is not the sunniest city; it is Perth that has more sunshine, less wet days and more clear days.

One thing that we must acknowledge is the rapid expansion of the Queensland population. The Australian Bureau of Statistics (www.abs.gov.au) tells us that by 2056 Queensland will have a population of 8.7 million, having exceeded Victoria's population in 2050. If that proves correct, Victoria will no longer be the centre of surgery in Australia (as the Melbournians would have us believe). So is the new building a preparation for the new order? Have we already seen a portent of the new order with two of the last three Presidents being Queenslanders?

With such a swelling population, a referendum on a name change may well succeed. May I predict that by 2050 the Royal Australasian College of Surgeons will have had another referendum on a name change and will have become the Queensland and Australasian College of Surgeons. Now that will produce an interesting acronym: QACS.

International Committee

College aid programmes

Our international aid commitment is the largest of any medical college in Australia or New Zealand, which is a credit to the Fellows

After more than a decade of providing life-saving surgical services across the Pacific region, the College is now in the process of transforming its aid programs to allow for greater national autonomy of the services provided and for an enhanced focus on the education and training of the local health workforce.

Since 1995, the College has co-ordinated three phases of the AusAid-funded Pacific Islands Project, designed primarily to provide visiting teams of specialist surgeons to treat those patients in need of surgical care unavailable in their home countries. But now, with successful university programs in place for the training of surgeons from the Pacific, particularly in Papua New Guinea and Fiji, the College must to refine its programs to concentrate more on capacity building than case-load management.

In particular, the changes will affect the College's Pacific Islands Project to reflect changes that have already been successfully introduced to the PNG Tertiary Health Services Project and the Australia-East Timor Specialist Service Project.

According to the Chair of the Colleges' International Committee, Professor David Watters, no funds will be cut from the programs but future specialist surgical visits will be more specifically designed around teaching and training rather than operating.

"Initially these projects were all designed to deliver vital surgical services that were unavailable in many developing countries and island nations throughout the Pacific. That was the need at the outset which the College and its Fellows admirably met," Professor Watters said.

"However, with the number of specialist surgeons now graduating from the Fiji School of Medicine and the University of Papua New Guinea our focus needs to change. Now the most useful contribution we can make is to become much more involved in capacity building and skills transfer.

Top: A workshop during the Pacific Islands Surgeons meeting in Suva, Above: Training in Tonga

"We have always tried to provide training and develop skills but such activities were not so specifically written into the design of the three phases of the Pacific Islands Project."

Professor Watters said that one of the specific changes to be made as part of the overhaul of the programs would be the establishment of management boards from the various countries.

He said the boards would be responsible for setting their own agendas outlining the timing and type of specialist surgical team visits and the local training needs while the College would act as a partner in meeting those aspirations.

"National specialists now provide most of the tertiary services in Papua New Guinea and the proportion is also increasing in Fiji. Their skills can be supplemented and supported by visiting teams but the national specialists can perform a wide range of complex procedures in different fields and increasingly their expertise is being sought even by neighbouring Pacific Island countries," Professor Watters said.

"As these capabilities have developed, the Pacific Island specialists are becoming the real experts in providing specialist care in their own region. These changes are being made in recognition of that expertise and with the desire to support and enhance their skills."

The AusAid-funded programs were initially designed to streamline the flow of aid to the region by building on the commitment made by a number of different surgeons and specialties to visit those countries in need including ophthalmology (ASPECT), orthopaedics (Orthopaedic Outreach), plastic surgery (Interplast) and cardiac surgery (Operation Open Heart).

By the end of 2008, more than 70,000 consultations and more than 20,000 operations had been provided as part of the Pacific Island Projects and the Papua New Guinea programme.

Two-thirds of the cases treated were in the Pacific Islands including Samoa, Tonga, Cook Islands, Vanuatu, Solomon Islands, Tuvalu, Kiribati, the Federated States of Micronesia and Nauru and one-third were in PNG.

Professor Watters said the structure of the programs needed to become more flexible because the surgical needs within the region differed so greatly.

He said while PNG and Fiji were becoming self-sufficient, some island nations had such small populations they would never be able to support the full range of local surgical specialists.

Therefore, he said, tailoring the programs

Primary Trauma Care (PTC) course in Tonga, June 2008, under the Pacific Islands Project

to meet the needs as outlined by the local health workers themselves was crucial.

"The Pacific region is challenging because of the variety of national circumstances. Nauru has such a tiny population (12,000) that it has only two national doctors while the Solomon Islands, with a population of 400,000, is moving slowly towards training its own national subspecialist surgeons," he said.

"While two Solomon Islands surgeons have received Rowan Nicks Scholarships to fund their training in Australia, many small island nations simply don't have the resources to spend on tertiary surgical training. That means that while we will still send teams there, we believe training and education is paramount.

"The key with every visit in the future will be that when Australian and New Zealand surgeons leave, local health workers can do more than they could before the visit. The education and training may be directed towards general medical officers and nurses rather than doctors aspiring to be specialists."

Professor Watters said that while there would always be some tension between case load management and skills transfer, now was the time for the College to adapt to different regional realities.

"When these programs first began, consulting and operating were the most crucial needs. But now there is the infrastructure and manpower to allow for capacity building not just for surgeons, either, but for all health workers, GPs and nurses," he said.

"There are also benefits to be gained for the local population by the local health system setting the agenda because they are the people who know their own needs. They will have a greater sense of ownership in the assistance we provide and we will have less risk that we send an orthopaedic team, for example, when they desperately need a urology visit. There will also be more buy-in to the educational opportunities of a visit, particularly by locally-designated trainees.

"Although we have been partners in the delivery and development of services to the Pacific ever since the College teams started to travel to the Pacific, the future Pacific Islands Specialists Program, yet to be named, will ensure partnership on our part, local leadership and greater local responsibility and engagement."

The College will be holding an International Symposium on August 27 next year in Melbourne to inform Fellows of the changes and to facilitate the rollout of the redesigned programs.

Titled "Partners in Capacity Building through-out the Asia/Pacific Region", the conference will present speakers from various countries in the region outlining their needs and aspirations for the future provision of specialist surgical visits. Representatives of other specialist medical colleges will also attend.

"The College has the biggest international aid commitment of any of the medical colleges in Australia and New Zealand, which is a credit to the Fellows and their enthusiasm for helping our neighbours," Professor Watters said.

"Over the years some of our frequent flyers, as I call those surgeons who have an ongoing involvement in aid work, have almost become like members of staff in various countries.

"Their knowledge and relationships with local health workers have been crucial in the success of our programs and I would encourage them to attend this symposium to help us refine and define the way froward.

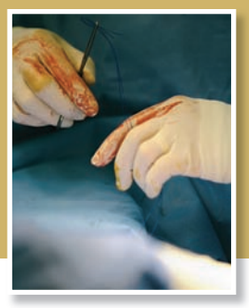
"Since 1995, these programs have been based on an evolving approach and we have known for the past few years that capacity building was the best contribution the College could make now and into the future."

Professor Watters encouraged those surgeons who planned to participate in aid programs to the region to attend the symposium.

"One of the great advantages we have to bring to this new model is that most Fellows in Australia and New Zealand already train junior surgeons so those skills in education, in transferring information and skills are already highly developed. Those Fellows wanting to participate then will still have the opportunity to do vital surgical work, even outside various capital cities, but with the additional focus of maintaining the skills of the local specialists, transferring skills where needed and acting as mentors," he said.

"In the future our role may change even further to provide aid that funds national surgeons to do what they have to do while we help provide the means and support to allow them to do it."

Sexual Harassment



The misuse of power

Sexual harassment at work can take various forms, all of which need to be recognised as unacceptable

Miriam Hechtman

"I just want them to stop" is often the resounding complaint made by victims of sexual harassment. Victims find it difficult to feel that they have some power because this sort of experience is disempowering. They feel that they can't speak up and that if they do they will be seen as a victim and hopeless or they will be penalised. Sexual harassment needs to be put in context, say the experts, as it is about power and the misuse of power. Often people who bully don't realise they are bullies and may think their behaviour is a way to establish a relationship with someone. It's not. If someone wants to have a loving relationship they need to understand that you can't use your power to win someone's heart.

According to Sex Discrimination Commissioner Elizabeth Broderick, sexual harassment is defined as unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances. Sexual harassment is not sexual interaction, flirtation, attraction or friendship that is invited, mutual, consensual or reciprocated. In the workplace, sexual harassment can take various forms. It can involve unwelcome touching, hugging or kissing; suggestive comments or jokes; unwanted invitations to go out on dates or requests for sex; unwelcome intrusive questions about an employee's private life or body; or sexually explicit emails or SMS messages.

The silence surrounding sexual harassment and bullying was one of the major findings from the survey, "Sexual Harassment and Australian Registered Nurses". In her research 10 years ago, Associate Professor, Jeanne Madison found sexual harassment was widespread and did not conform to conventional assumptions. "There was harassment from managers, there was harassment from doctors, but it wasn't exclusively one or the other – it was as much from peers and from within nursing as it was from other disciplines."

Healthcare facilities are particularly high-stress, time-poor workplaces, says Madison. "You have highly educated people who are going to be working hard, maybe forgetting themselves from time to time and not practicing good workplace respectful behaviour." This, however, needs to be guarded against, she says, and people need to be willing to speak up. "Most importantly, when individual situations arise people need to be willing to say 'Hey, that's not okay' and move on."

How organisations respond to sexual harassment in the workplace is fundamental to not only dealing with harassment cases but also in preventing occurrences. Dr Paula McDonald, senior lecturer at Queensland University of Technology, says many organisational responses to sexual harassment are ineffective and are often hostile to the target or victim who makes the complaint. Her recent study *Reporting Sexual Harassment: Claims and Remedies** explored 632 cases of sexual harassment reported to a community advocacy organisation in Queensland. Findings showed that inappropriate behaviour is often excused as being unintended or responded to with comments such as "He's just a product of his generation."

"There's a lot of dismissal associated with sexual harassment and that might mean that the victim is positioned as a problem to the organisation because there's a legalistic element to this and organisations see a complaint of sexual harassment as being a risk to them," says McDonald. The victim may consequently lose his/her job as a result or feel so alienated that they have no choice but to resign.

Data also showed that targets are reluctant to complain about harassment and few do. McDonald says factors that impact this reticence to complain include lack of knowledge about support systems available, fear of being seen as too sensitive and a lack of confidence in the organisation's volition to do anything about the harassment. The research also suggests that people employed in more precarious ways, such as short-term contracts and casual roles, which are common in the health care sector, are more vulnerable to sexual harassment.

Jessica**, a manager in critical care, says that although her hospital may have the right policies about bullying in place the gap is in

Recognising the problem

- The Health and Community Services sector had the highest incidence of sexual harassment of any sector, at 14 per cent of respondents
- Twenty-two per cent of women and 5 per cent of men have experienced sexual harassment in the workplace at some time

Source: The 2008 National Sexual Harassment Telephone Survey, 'Sexual Harassment: Serious Business', released by the Australian Human Rights Commission

how many people take it up, and that depends on their circumstances. "I don't think people are paying much credence to that if they're the person on the floor who is only one year out of training and doesn't want to make a big noise." Having a good manager who will listen to you and is approachable is imperative, she says. "It's more the individual investigation of claims that's the problem, and the person that's making the complaint – how far they want to go."

Though organisations with better policies tend to have less episodes of harassment, policy is only one aspect of a range of appropriate responses, says McDonald. "What is certainly needed is a better and more supportive approach to targets or victims when they do complain about the problem, and that it should be investigated promptly, which it's often not."

Education plays a significant role in preventing harassment in the workplace and it should be clearly defined and communicated to everyone in induction trainee programs, for example, and through regular training sessions for existing employees. Confidentiality is paramount, so providing trainees with mentors and opportunities to speak with a GP or external confidant outside the organisation will also be beneficial. Often protocol is only about how to make a complaint after the fact so promoting education across all levels of industry will prevent harassment and empower people who are potential victims to feel they can stop things before they start. It will also teach the people who are potential perpetrators about what the lines are and what you don't cross.

* Reporting Sexual Harassment: Claims and Remedies *by Paula McDonald and Sandra Backstrom, Queensland University of Technology, and Kerriann Dear, Queensland Working Women's Service*

** *Jessica is not her real name*

ASC 2009
Brisbane

The Brisbane 2009 ASC

Six new research prizes and a program of engaging sessions are features of the upcoming congress

Mark Smithers, Congress Convener & Andrew Stevenson, Scientific Convener

The Brisbane 2009 Annual Scientific Congress (ASC) is shaping to be the best surgical congress ever convened by the College. With an international and national faculty of 37 College and industry-sponsored Visitors and numerous speakers from Australia and New Zealand, this promises to be an excellent program. With the new four-day format (Wednesday 6 May to Saturday 9 May) plus Tuesday 5 devoted to symposia and workshops, there is much to appeal to all Fellows and Trainees. By now you will have received your copy of the Provisional Program. If not, then please contact jennifer.hannan@surgeons.org and a copy can be posted to you, or you can see the program online at the Congress website (see below). We encourage you to sit back with your copy of the Program and your favourite libation and review what is on offer – science, research, fellowship, non-surgical lectures, Associates and Trainees programs, take your pick.

Website

The Annual Scientific Congress website is now the best way to register for the meeting, submit abstracts and review updates on the program

With the new website you can register to receive updates on the program. The new online registration program works perfectly and is the easiest way to book. The address is asc.surgeons.org or you can access it via the College website (www.surgeons.org) by clicking the "Annual Scientific Congress" button on the left.

Research prizes

The College promotes surgical research and the ASC has been an important forum for the presentation of research papers and electronic posters. Abstracts accepted into the program, whether papers or posters, are published in the supplement to the *ANZ Journal of Surgery* and are available from the Virtual Congress. Three prizes have been presented at the meeting over several years, namely: Colorectal Prize (Mark Killingback Prize), Endocrine Prize (Tom Reeve Prize) and Surgical Education Prize

However, in 2009 there will be six new research prizes for Trainees in the following categories:

- General surgery – Bard Prize: best research presentation on hernia management
- General surgery – RACS Prize: best research paper in general surgery program
- HPB/Upper GI surgery – RACS Prize
- Plastic & reconstructive surgery – RACS Prize
- Trauma surgery – RACS Prize
- Vascular surgery – RACS/Atrium Prize

With the exception of the Vascular and the Bard Prizes, winners will recieve $500 and a certificate. Full details and updates are available on the Congress website.

Sessions of interest for all surgeons

The Congress scientific program is divided into two major sections; Sessions of interest for all surgeons and Craft group sessions

In the former are sessions with extensive cross-discipline appeal. The programs include the plenary sessions addressing College-wide topics, which utilise the talents of visiting surgical leaders from across the globe. Surgery, like finance, is an international undertaking and issues confronting one surgical College are often confronting others. If we fail to learn from them we, separately, may make the same errors. Programs such as the plenaries, medicolegal, military and trauma surgery, surgical education and others address important matters with which all surgeons are concerned.

General surgery program

The general surgery program is being convened by Michael Donovan who has compiled an excellent cross-disciplinary program. This is centred on the RACS Visitor, Mr Timothy John from the North Hampshire Hospital, Basingstoke, UK. He brings a broad experience of general surgery with special interests in upper GI/ HPB surgery and advanced laparoscopic surgery. Tim is a highly sought after speaker in Europe and has a vast array of high quality surgical videos.

Mr Mervyn McCallum (Newcastle, Australia) is the 2009 Bard Visitor in hernia management. He will present on a number of hernia-related topics including participating in a masterclass with Tim John on inguinal hernia repair. Bard has also kindly sponsored the Trainee Prize for the best research paper on hernia management (see above).

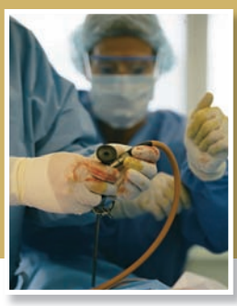
Neurosurgery program

Martin Wood is convening the neurosurgery program complemented by the pain medicine program convened by Leigh Atkinson.

The theme of the neurosurgery program is the "Essence of neurosurgery – the management of challenging pathology within unforgiving structures".

The program commences on Tuesday (the workshop day) with our RACS Neurosurgery Visitor from Sao Paulo, Professor Guilherme Ribas' symposium on complex 3D microsurgical anatomy and safe approaches to critical structures. The session is ideal for all practising neurosurgeons and Trainees. Professor Ribas is a highly regarded neurosurgeon and a neuroanatomist of note.

The scientific sessions come under the themes risk minimisation in difficult brain surgery, approaches and operative nuances, and minimally invasive neurosurgery: advantages and challenges. The joint sessions with the pain medicine section will address craniofacial pain syndromes, peripheral nerve injuries and controversies in surgery for back pain. Trainees and Fellows are encouraged to submit abstracts for the research paper sessions.



College license agreement on patient education pamphlets

The College is pleased to announce that it has reached agreements with Mi-Tec Medical Publishing and Specialist Management Services (SMS) in thier ongoing production of information patient education materials.

Fellows have the challenge of explaining complex surgical procedures in ways comprehensible to patients. Patient information pamphlets assist surgeons inform patients considering surgery. Under the licensing agreements, Mi-tec and SMS have been committed to rigorous development and peer review in the production of their pamphlets.

Commenting on the agreement Mi-tec Director Calvin Miller said: "The Mi-tec team and I are extremely pleased that the College and Mi-tec are continuing to build on our long and successful relationship. We look forward to producing more of the highest quality patient education for the College and all its members."

Mi-tec Medical Publishing produces high-quality and extensively reviewed patient education publications for 20 colleges, societies and associations in Australia and New Zealand. If you would like further information regarding Mi-tec documents you can contact Mi-tec on +61 3 9888 6262 or visit their website at www.mitec.com.au


ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ENDOSCOPY OF THE COLON OR UPPER GASTROINTESTINAL TRACT

A guide for patients

Endoscopes in gastroscopy and colonoscopy

GS07 Appendicectomy

What is appendicitis?

Are there any alternatives to surgery?

What will happen if I decide not to have the operation?

What does the operation involve?

Copyright 2008

Page 1 of 4

An example of a brochure from Mi-tec and SMS

Specialist Management Services (SMS) is the principal supplier of patient information documents to the Western Australia Department of Health and one of Victoria's largest public health networks, Southern Health. If you would like further information regarding SMS documents you can contact Specialist Management Services on +61 400 090 436 or visit their web site at www.smservices.net.au

SMS Business Development Manager Brendon Tudor said: "The College's endorsement is extremely important to Specialist Management Services. It acknowledges the rigour of the development and peer review processes that ensure the reliability of our patient information material. We are confident that all Australian surgeons can trust these sheets to help them build efficient, effective and safe therapeutic relationships with their patients."

Travelling Fellowships

Plastic surgeons from developing countries discussed the challenges they face at the inaugural ASPS Congress

Shankar Man Rai and Kiran Nakarmi from Nepal, Khin Maung Lwin from Burma (Myanmar), Thushan Beneragama from Sri Lanka, Interplast president Donald Marshall, John Maihua from PNG, Dulip Perera from Sri Lanka and Teddy Prasetyono from Indonesia

Top: Ian Carlise and Nyoman Riasa from Indonesia
Above: Keith Mutimer, Donald Marshall and Howard Webster, President of ASPS

The Australian Society of Plastic Surgeons (ASPS) held its inaugural Congress on the Gold Coast in October 2008, and Interplast used the occasion to hold a Queensland celebration of its 25th anniversary. The Congress included a spectrum of surgery from reconstructive to aesthetic with five international keynote speakers from the USA, Canada and the UK. In addition, Interplast provided travelling fellowships to nine plastic and reconstructive surgeons from five countries where programes are conducted. Dr Dulip Perera and Dr Thushan Beneragama from Sri Lanka, Prof Khin Maung Lwin from Burma, Dr Kiran Nakarmi and Dr Shankar Man Rai from Nepal, Dr Teddy Prasetyono and Dr Nyoman Riasa from Indonesia, and Dr George Gende and Dr John Maihua from Papua New Guinea attended the reconstructive sessions.

Interplast has been working with these international delegates for several years and has watched each of them grow in skill and talent and become trainers in their own countries. In addition to them attending the Congress, each was invited to give a presentation on the state of plastic and reconstructive surgery in their country, how it has grown during Interplast's programs and what is required in the future.

The session by the sponsored Interplast delegates was well attended. Each speaker presented a fascinating overview of the difficulties and growth of surgery and, in particular, reconstructive surgery in countries at varying levels of development.

For example, Indonesia is made up of approximately 30,000 islands. With 220 million people an estimated 3,000 to 6,000 cleft lip and cleft palate patients are born every year.

Burma, with a population of 56 million people, has only three plastic and reconstructive surgeons. Visiting teams are now allowed into the country to assist medical development but there is still no plastic and reconstructive postgraduate course. Interplast is assisting in the development of Burma's postgraduate training program in plastic surgery.

Similarly, Sri Lanka has a population of nearly 20 million people, and only nine plastic and reconstructive surgeons. Compare this to Australia which has a similar population but over 250 qualified plastic and reconstructive surgeons.

It was interesting to hear the different views expressed by Professor Lwin from Burma and Dr Shankar Man Rai from Nepal regarding the pitfalls and benefits of in-country training compared with sponsored training in the Western world. It is clear we must not ignore the everpresent problems of surgeons who come to Australia or any other developed country for training who, for various reasons, be they political, financial or the seeking of a better life for their family, do not return home.

Two units are better than one

True or False

Join the debate at www.theTransfusionquestion.com.au

Blood Watch, a Program of the NSW Clinical Excellence Commission.

YOUNGER FELLOWS FORUM 2009
Sunshine Coast, Queensland May 2-4 2009

Generation Younger Fellow - *Challenges in the new millennium*

How will emerging technologies, globalisation and Generation Y change the surgical landscape in the next ten years?

This year's **Younger Fellows Forum** is a fantastic opportunity for all Younger Fellows to explore what the fast changing environment of surgical practice will look like in ten years.

The Forums challenging program will explore emerging technologies in healthcare and training, managing Generation Y surgeons and the future approaches to credentialing. Led by key futurist speakers, Younger fellows will be encouraged to develop their leadership skills and help shape the future of the College.

Set at the idyllic Twin Waters Resort on the Sunshine Coast, Younger Fellows will have the opportunity to meet with peers, engage in robust discussion and fight it out in the 'Survivor Surgeon' outdoor program.

We invite you to have your say, relax and enjoy a weekend of stimulating discussion.

WHO? All Younger Fellows of the College (within ten years of gaining Fellowship) are eligible to attend.

HOW? Please complete the nomination form and return by fax or mail to the College Younger Fellows Secretariat.

COST? Free* This is a College sponsored event, delegates are required to meet their travel expenses.

Applications close Friday 12 December 2008.

For more information visit the College website www.surgeons.org
You can also contact the Younger Fellows Secretariat on +61 3 9249 1122 or glenda.webb@surgeons.org

Nomination Form 2009 Younger Fellows Forum

2-4 May 2009, Sunshine Coast QLD *(Prior to the College ASC 2009)*

Name: . . . . . .

Sex: ❑ M ❑ F

Year of Fellowship: . . . . . .

Contact Address: . . . . . .

. . . . . .

. . . . . .

State . . . . . Post Code . . . . . .

Home Phone: . . . . . .

Bus Phone: . . . . . .

Mobile Phone: . . . . . .

Facsimile: . . . . . .

Email Address: . . . . . .

Specialty: . . . . . .

Proportion of clinical practice time: ___% Public ___% Private

Have you previously attended a Younger Fellows Forum? ❑ Y ❑ N

Please attach a short professional biography for inclusion in the Forum program (maximum 150 words)

STATEMENT (please tick):

❑ I am a Younger Fellow of the Royal Australasian College of Surgeons (within ten years of gaining Fellowship).

Signature: . . . . . .

Date: ..... / ..... / .....

Submit your nomination to the attention of the Younger Fellows Secretariat by ***Friday 12 December 2008:***

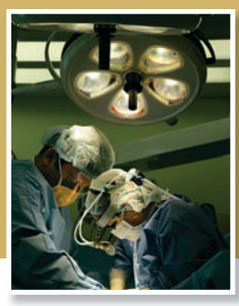
Post: Royal Australian College of Surgeons
Spring Street
College of Surgeons Gardens
MELBOURNE VIC 3000

Telephone: +61 3 9249 1122
Facsimile: +61 3 9276 7432
Email: glenda.webb@surgeons.org

Thank you for your nomination to attend the 2009 Younger Fellows Forum.

Please note:

- Selection is finalised in January 2009. If your circumstances change and you wish to withdraw your nomination, please contact the Younger Fellows Secretariat.
- Delegates will be required to pay for the cost of their transport to Queensland. Accommodation, meals, transfers and activities during the Forum will be covered by the College.
- The Forum is a delegate only activity. It is the general consensus of previous Younger Fellows Forum delegates that participants attend the Forum without their families (this condition also applies to Forum accommodation).
- Accommodation for delegates may be twin-share
- More information is available on the College website: http://www.surgeons.org/YoungerFellows



Sham Peer Review

Hospitals in-house assessments of vocal staff need to be opened up to the light of day

John Wright

Peer review of scientific publications and credentials for jobs and grants had probably been well considered in 17th century Britain and had become standard procedure by the early 20th century.[1] Anonymity and ensuring the credentials of "peers" or "experts" were fundamental aspects of these academic processes.

Initially, criticism of medical performance was inhibited by risks of defamation when doctors were encouraged to report other doctors' work for the sake of the "public good"– ostensibly a most worthy motivation. There, the notion of immunity or "privilege" for accusers was invoked, qualified only by the need to show their integrity, objectivity, proof of peer status and fairness.[2]

Public awareness, well-intentioned medical groups and the advent of medical insurers have led hospitals to seek reliable protection against charges of their own incompetence when whistle-blowing suggested it. They soon discovered that almost total immunity was achieved by conducting purely internal inquisition of their critics while unfettered by any conventional legal constraints. Why courts and governments have been reluctant to interfere with such procedures, even if improperly conceived, is unknown.[3,4,5]

Employers were able to impose the onus of proof on a "disruptive" critic who was given no legal protection while a hospital had complete immunity from defamation charges. Colleges and licensing authorities were bypassed to effectively end a medical career without fairness or right of appeal.[6] The technique is said to have reached plague proportions in the US. In one area, 23 per cent of emergency staff were threatened with dismissal if they complained of dangerous hospital practices.

In considering the evidence for malicious reviews of doctors in 2007, the American Medical Association identified only three cases where an impartial government body had found *"improperly motivated peer review"*.[7] A much different situation was suggested when a major US internet medical publisher was recently asked for a definition of "disruptive physician", a standard precursor of peer review done in bad faith. Within a few months there had been 1600 responses by doctors who were aware of and/or had been damaged by such procedures.[8] Lawyers' seminars on "s*trategies and tactics for medical staff peer review disputes"* are openly directed at US hospital administrations. One such legal firm acts for 500 hospitals – 30 of them with permanent retainers**.** Inevitably, the procedures are completely stereotyped and are equally apparent in other countries.[9]

> "Some reports suggest that only 20 per cent of victims of "sham" review ever return to their usual work."

A typical format [with a completely predictable outcome] is this: a doctor ["he"] reports, either internally or externally, a breach of safety standards; he is accused of "disruption" and/or incompetence and invited to resign or be suspended; his report is not investigated; the hospital selects referees with predetermined opinions and inappropriate or misrepresented credentials; an enquiry lacks all legal constraints; if an independent expert expresses views adverse to the hospital, his report is disregarded; the victim loses job, reputation and security while his registration is untouched.[10] Some reports suggest that only 20 per cent of victims of "sham" review ever return to their usual work.

In 2003, Dr Drummond Rennie, an editor of the Journal of the American Medical Association, supported by an editor of The Lancet, wrote of the profound pitfalls in "academic" peer review: "*There seems to be no study too fragmented, no hypothesis too trivial, no literature too biased or too egotistical, no design too warped, no methodology too bungled, no presentation of results too inaccurate, too obscure, and too contradictory, no analysis too self-serving, no argument too circular, no conclusions too trifling or too unjustified, and no grammar and syntax too offensive for a paper to end up in print.*"[11]

Similar flaws clearly apply to "clinical" reviews where hospitals and their enlisted doctors may criticise other doctors with dire penalties to reputable and valuable practitioners. It is high time that the professionally lethal technique of hospitals conducting "peer review" in private with a complete lack of legal constraints, such as due process, and employing selected "peers" who are not peers but have unlimited immunity, is corrected by legislation.[12,13]

Disclaimer – this article does not refer to any recent or ongoing review and represents the views of the author.

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Pictured: Guy Maddern

Happy 10th anniversary ASERNIP-S!

The Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) is the only health technology assessment group in the world that focuses on surgical procedures. During the 10 years since its inception, this group has developed a strong international profile through the production of over 60 reports on evidence-based surgery, surgical technologies and audit. In addition, ASERNIP-S pioneered the introduction of national audits into the surgical community. The ASERNIP-S project has grown from a small staff of two in 1998 to a Division of Research, Audit and Academic Surgery with close to 50 employees.

In the beginning

In 1998, the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) was established under the auspices of the College. The aim was to use evidence-based methodologies to evaluate and document the safety and efficacy of new surgical technologies and techniques as they were introduced and preferably before they were widely accepted into the Australian healthcare system. Funding was provided by the Federal Government for the program, which ran initially as a pilot.

Systematic reviews

During the first year, ASERNIP-S undertook to produce systematic reviews of 10 new surgical procedures. Systematic reviews are the most appropriate and best validated tool of health technology assessment organisations. They provide critical summaries through a thorough assessment of relevant articles in the world literature. The best systematic reviews are produced when the results of a number of good quality randomised controlled trials (RCTs) are available. The process of meta-analysis enables the results of several comparable studies to be combined to produce an overall estimate of the combined result.

> "ASERNIP-S aims to review procedures before they are widely accepted into the community"

Typically, however, few RCTs are performed in the area of surgery, for a number of reasons. For example, due to individual circumstances and needs a patient may not be a suitable candidate to undergo a comparative treatment. Also, ASERNIP-S aims to review procedures before they are widely accepted into the community to identify any potential risks early, when little high level evidence (such as RCTs) on the procedure may be available in the published literature.

Considerable effort was put into establishing appropriate methodologies, processes and infrastructure to conduct the first assessments of surgical techniques and technologies. The organisation is based in Adelaide, but draws on the experience of surgeons throughout Australia and New Zealand. Fellows of the College are invited to be involved with the review process in an advisory capacity.

Horizon scanning

In 2000, to inform surgeons and policy makers of new techniques about to impact on the Australian healthcare system, ASERNIP-S developed a horizon scanning process for the detection of new and emerging technologies (NETS). This was extremely successful and has since undergone many changes. We have become a member of the Australian and New Zealand Horizon Scanning network (ANZHSN), which is an initiative of the Medical Services Advisory Committee (MSAC).

Audits

Since the inception of ASERNIP-S, auditing has been an integral component of the program. The National Breast Cancer Audit (NBCA) was started by the Breast Section of the College, but later came under the management of ASERNIP-S. This audit was different to research audits resulting from inconclusive reviews. Its aim was to improve surgical care of women with early breast cancer through the review of audit data and the establishment of quality standards of treatment. The NBCA is an example of a clinical audit, and has reached its 10-year milestone.

The College is using this expertise to establish the bi-national audits of surgical mortality and the Trainee logbooks program within the (now named) Research, Audit and Academic Surgery Division in Adelaide. It is hoped that the logbooks program will form the basis for a full practice audit for Fellows.

Reporting

Wide dissemination of information from ASERNIP-S assessments, both locally and internationally, is needed to achieve quality improvements in surgical care. A website was created and information posted as it became available; a study of web hits showed increasing interest each year.

An executive summary was introduced and sent to hospital accreditation boards and committees. The research community was informed of proposed, current and completed projects through the database of the International Network of Agencies for Health Technology Assessment.

In addition, we write articles on each systematic review for publication in the peer-reviewed literature to inform the wider surgical community, both in Australia and overseas, as well as in newsletters for surgeons and consumers.

Since its inception 10 years ago, ASERNIP-S has grown from having two staff to a team of almost 50

Consumer information

While ASERNIP-S has always produced patient summaries of its systematic reviews with the help of a consumer representative, in 2003 the organisation set up consumer information groups, comprised of researchers, surgeons and two consumer representatives, to prepare consumer information. The format was redesigned into an attractive three-page document which can be read more quickly on the internet. Similar documents were created to be targeted at busy healthcare workers who do not have time to read the full systematic review.

The consumer representatives on the ASERNIP-S Advisory Committee have guided our progress and helped to establish important links with a range of consumer organisations, such as the Consumers' Health Forum. We also work on patient participation with international organisations, such as Health Technology Assessment International.

Previous staff and advisory committee members.

In October 1997, Professor Maddern was appointed the Foundation Surgical Director of ASERNIP-S and was instrumental in setting up the processes required to assess new interventional procedures and technologies as they apply to the practice of surgery.

During the last 10 years ASERNIP-S has been privileged to work with and employ a wide range of people. We would particularly like to remember the late Professor Chris Silagy, the Foundation Director of the Australasian Cochrane Centre, who provided invaluable input as an inaugural member of the committee.

Few staff members join ASERNIP-S with prior experience in the specialised area of evidence-based surgery but all have brought significant experience from a wide range of backgrounds. With in-house training these staff members have used their previous experience to positively add to the ASERNIP-S program. We are grateful for the contribution of current and previous staff.

Funding

As with any not-for-profit, non-government project dependent on external financial support, funding has been a concern for ASERNIP-S. During the early years the Department of Health and Ageing supported the whole project, enabling systematic reviews, auditing and horizon scanning to be undertaken. Later, separate funding was obtained for some auditing activities. Similarly, the funding has been provided separately for the different types of reviews. MSAC directly funds their reviews and additional funding was obtained for the horizon scanning project. ASERNIP-S retains some flexibility in choice of reviews with separate government funding.

Significant work has also been commissioned through other sources. In 2002 a number of (rapid) reviews were undertaken for the National Institute of Clinical Excellence in the United Kingdom. The Australian National Institute of Clinical Studies and the National Breast Cancer Centre have also commissioned work.

ASERNIP-S needs to secure ongoing, long-term funding so that it can continue to play an integral role in the improvement of quality of care both in Australia and internationally. We look forward with optimism to the next 10 years.

For a copy of the full article, please see ASERNIP-S: International Trend Setting, ANZ Journal of Surgery*, Volume 78, Issue 10, October 2008, Pages: 853-858, by Guy Maddern, Margaret Boult, Eleanor Ahern and Wendy Babidge*

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Successful Scholar

Lumley Travel Scholarship

A year abroad gave this winning surgeon the opportunity to amass research from a vascular surgery hotspot

Vascular surgeon Dr Raffi Qasabian used the $60,000 Lumley Travel Scholarship to conduct research and gain clinical experience at one of the world's leading international centres in endovascular thoracic stent grafting. The vascular surgical group at St Thomas' Hospital in London has performed over 250 such procedures, one of the largest single-site series of such operations available for study anywhere in the world. The group also performs almost 100 infrarenal AAA stent grafts each year.

Dr Qasabian spent 2007 in London researching the data to help make the information more clinically accessible by investigating the mid- to long-term results of thoracic endografting.

"This scholarship allowed me to access an amazing amount of research data. While the surgeons in the St Thomas' unit have done more than 250 cases in three or four years, a major teaching hospital in Australia would be lucky to conduct 70 such procedures in 10 years," he said.

"Thoracic endograft placement for the treatment of proximal aortic pathology is challenging, due to the curvature of the arch and the technological limitations of the currently available thoracic endografts.

"So one of my research projects involved looking at the data collected at St Thomas' to see how well the wall of thoracic endografts conform to curved aortic segments and how well the leading edge conforms to the inner curve attachment zone of the arch. Then I investigated if there was any correlation between these factors and complications following thoracic endografting."

Dr Qasabian conducted his research under the supervision of Mr Peter Taylor, the head of the unit and President-elect of the Vascular Society of England.

While in the UK, he attended European Vascular and Radiology conferences and gave three oral presentations, one of which is being prepared as a scientific paper to be submitted to the *British Journal of Surgery*.

Henry and Sheena Lumley with Raffi

Raffi with Peter and Kok-Tee Taylor

"While I was there I was operating full-time as well as doing clinical research so it was an intense but hugely rewarding experience. I presented papers at a Vascular Society meeting in Manchester and at the Inaugural British Society of Endovascular Therapy," he said.

"St Thomas' also has an age-old tradition whereby old boys and girls and current staff members present research papers to a group known as the Cheselden Club. Being part of that was fun, very English, and I won the Jenny Ackroyd Prize for Best Presentation on my presentation about the medium- to long-term results of thoracic endografting."

Now back home and working at the Royal Prince Alfred Hospital in Sydney, Dr Qasabian said that one of the most rewarding aspects of his trip was the ability to forge relationships with some of the best and most experienced surgeons in the field.

"I made some amazing friends in London, both professionally and socially, that I hope will last a lifetime. I even met the son of the gentleman who originally bequeathed the scholarship to the College and spent a great afternoon at his beautiful country house," he said.

Dr Qasabian said he was grateful for the support of the College.

"It was a great experience to work out of one of the busiest and best vascular units in the world and feel able to make a contribution. At heart I am a surgeon and I love my clinical work but in modern times I think it's crucial to try and marry both clinical practice and research," he said.

"I think we have a responsibility to analyse the data as we collect it, not only for the welfare of patients but to pass on information to colleagues around the world, which was the central aim of this scholarship trip. The work I did there, then, means not only that I improved my research skills but that I had the opportunity to do that in a way that benefits both colleagues and patients."

Dr Qasabian wants to continue conducting clinical research as part of his role as a vascular surgeon in a major teaching hospital in Sydney. He is currently looking at recurrent thoracic aneurysms following stent-grafting, and has a particular interest in aortic dissections.

Science, golf and fire: The GSA Annual Scientific Meeting

What do you get when you cross 230 general surgeons, Trainees and partners with a beautiful location, an outstanding educational program and fire-eating dancers? The third General Surgeons of Australia (GSA) Annual Scientific Meeting, held at the Hyatt Regency Coolum Queensland from 26-28 September.

The overall themes of the meeting were acute care and oncology for the general surgeon. The scientific program included contributions from speakers including Professor Bob Thomas, Mr Jonathan Koea, Professor Michael Cox, Associate Professor Owen Ung, Dr Damien Petersen, Professor Bruce Mann, Mr Phil Truskett, Dr Susan Neuhaus, Ms Meron Pitcher, Mr Andrew Barbour, Professor Stephen Ackland, Associate Professor Fran Boyle, Associate Professor Sandro Porceddu, and Dr Jane Turner.

The scientific program concluded with a Trainees' Forum coordinated by Dr Matthew Peters and Dr Joanne Dale, including free papers and a "complications and catastrophes" session, with College President Professor Ian Gough, Mr Tom Wilson, Mr Graeme Campbell and Professor Michael Cox all under the spotlight!

The meeting wound up with the inaugural GSA Golf Championship – Trainees Vs Fellows, with the Fellows victorious in 2008. Thank you to all the delegates, speakers, and sponsors who helped GSA to make the meeting such a success.

In 2009, the GSA Annual Scientific Meeting will be held in conjunction with International Surgical Week 2009, at the Adelaide Convention Centre from 6-10 September. Details are available on the website www.isw2009.org

Al Saunder & Bruce Waxman

Dancing the night away at the gala dinner

College Scholarships

Helen O'Connell, Chair, Board of Surgical Research

The 2009 scholarship and grant recipients

The Board of Surgical Research thanks all applicants and congratulates the following successful recipients

John Mitchell Crouch Fellowship
Professor Stephen O'Leary
Fellowship Value - $75,000

Professor Stephen O'Leary is the William Gibson Chair of Otolaryngology at the University of Melbourne and the Chair of the Senior Medical Staff at the Royal Victorian Eye and Ear Hospital. His major achievements include: the development and commercialisation of a virtual reality simulator for ear surgery; the discovery that cochlear implantation increases the risk of pneumococcal meningitis and that this risk is ameliorated by immunisation; the development of a method for improving the neural representation of complex stimuli such as speech, through electrical stimulation of nerves which has led to a provisional patent; and the discovery that hearing can be protected during inner ear surgery by the application of glucocorticosteroids. The John Mitchell Crouch Fellowship will assist Professor O'Leary to continue his important research in these areas.

Research Scholarship and Fellowship Recipients

Where indicated * scholarship recipients must procure 25 per cent of their scholarship from either their research department or by external award or donation. The College wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding many of the following scholarships and grants.

Surgeon Scientist Scholarship
Dr Tarik Sammour
Scholarship Value - $70,000
Topic: Humidification in Laparoscopic Colonic Surgery: A double blinded, randomised controlled trial.
Supervisor: A/Professor Andrew Hill

Sir Roy McCaughey Surgical Research Fellowship*
Dr Sam Adie
Scholarship Value – $60,000
Topic: The association between quality and effect estimation in surgical research.
Supervisor: Professor Ian Harris

Sir Roy McCaughey Surgical Research Fellowship*
Mr David Chang
Fellowship Value - $60,000
Topic: Biomarkers of phenotype, prognosis and response to therapy in pancreatic cancer.
Supervisor: A/Professor Andrew Biankin

Foundation for Surgery John Loewenthal Research Fellowship*
Dr Tamara Bonney
Scholarship Value - $60,000
Topic: The role of androgen in testicular descent.
Supervisor: Professor John Hutson

Francis & Phyllis Thornell Shore Memorial Scholarship*
Dr Michael Wu
Scholarship Value - $60,000
Topic: Assessment of the mechanisms involved and severity of arterial disease in insulin resistant states including diabetes.
Supervisor: Dr Sophia Zoungas

Eric Bishop Scholarship*
Dr Sidney Levy
Scholarship Value - $60,000
Topic: Analysis of lymphangiogenesis and angiogenesis inhibitors in cancer.
Supervisor: A/Professor Marc Achen

Foundation for Surgery Research Scholarship*
Dr Tinte Itinteang
Scholarship Value - $60,000
Topic: Haemangioma: An understanding of the biology.
Supervisor: Dr Darren Day

Foundation for Surgery ANZ Journal of Surgery Scholarship*
Dr Kieran Rowe
Scholarship Value - $60,000
Topic: Development of novel methods for adipose tissue engineering.
Supervisor: Dr Keren Abberton

Foundation for Surgery Catherine Marie Enright Kelly Scholarship*
Dr Yi Chen
Scholarship Value - $60,000
Topic: Cardiopulmonary bypass and acute release of Activin A in inflammation.
Supervisor: Professor Julian Smith

Foundation for Surgery Louis Waller Medico-Legal Scholarship*
Dr Joseph Smith
Scholarship Value - $60,000
Topic: The litigation threat to surgical practice: Legal reform and risk management.
Supervisor: Professor Guy Maddern

Travel Scholarship, Fellowship and Grant Recipients

Foundation for Surgery Research Scholarship*
Dr Arul Bala
Scholarship Value - $60,000
Topic: Function of the human zona incerta and potential as a target in deep brain stimulation surgery.
Supervisor: Mr Christopher Lind

Raelene Boyle Scholarship – Sponsored by Sporting Chance Cancer Foundation*
Dr Benjamin Namdarian
Scholarship Value - $60,000
Topic: Evaluation of circulating endothelial cells in prostate cancer detection, prognosis and treatment response.
Supervisor: Dr Christopher Hovens

CONROD-RACS Trauma Fellowship
A/Professor Philip Walker
Fellowship Value - $50,000
Topic: Establishment of a statewide trauma registry for the endovascular management of thoracic aortic trauma (TEVAR for TAT Registry).

Foundation for Surgery New Zealand Research Fellowship*
Mr Martin Hunn
Scholarship Value - $60,000
Topic: Dendritic cell therapy for high grade glioma.
Supervisor: Dr Ian Hermans

Foundation for Surgery Research Scholarship*
Dr Adam Fowler
Scholarship Value - $60,000
Topic: The role of IqGAP1 in human high-grade glioma and its regulation by miR-124a.
Supervisor: Dr Kerrie McDonald

Sir Roy McCaughey Surgical Research Fellowship*
Dr Alasdair Watson
Fellowship Value - $60,000
Topic: Development of a universal preservation strategy for cadaveric heart, lungs, liver and kidneys during orthotopic transplantation.
Supervisor: Professor Peter Macdonald

Foundation for Surgery Research Scholarship*
Dr Zoe Wainer
Scholarship Value - $60,000
Topic: Identification of genetic markers to predict metastasis in patients with resected Non Small Cell Lung Cancer.
Supervisor: Mr Gavin Wright

Foundation for Surgery Reg Worcester Research Fellowship*
Dr Richard Tee
Fellowship Value - $60,000
Topic: Optimising vascularisation of tissue engineering chamber for construction of robust tissue.
Supervisor: Dr Fan Jiang

Margorie Hooper Scholarship
Dr Eng Hooi Ooi
Scholarship Value - $65,000

Lumley Exchange Research Fellowship
Dr Patrick Schweder
Scholarship Value - $60,000

Stuart Morson Scholarship in Neurosurgery
Dr Amal Abou-Hamden
Scholarship Value - $30,000

Murray and Unity Pheils \Travel Fellowship
Dr Adele Burgess
Fellowship Value -$10,000

Morgan Travelling Scholarship
Dr Nathan Lawrentschuk
Scholarship Value - $10,000

Ramsay Fellowships for Provincial Surgeons - 2008
Mr David Birks
Fellowship Value - $12,500

Dr Michael Borschmann -
Fellowship Value - $12,500

Dr Jacob Jacob
Fellowship Value - $12,500

Dr David Ardern
Fellowship Value - $6,250

Mr Stephen Jancewicz -
Fellowship Value - $6,250

Hugh Johnston Travel Grants
Dr Raymond Goh - Grant Value - $10,000

Mr Anand Ramakrishnan - Grant Value - $10,000

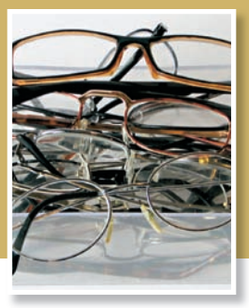
Dr Sandrine Roman - Grant Value - $10,000

Dr Benjamin Teague - Grant Value - $10,000

Other Scholarships
The following lists external awards that Fellows and Trainees of the College have been successful in attracting from external organisations.

Edwards Travelling Scholarship - 2009
Dr Dominic Parry - Cardiothoracic Trainee
Award - sponsored attendance of a major American meeting (AATS or STS), return business class flights, tour of the Edwards manufacturing facility in Irvine, California and two days placement at a major teaching hospital such as the Cleveland Clinic.

Preliminary Notice: Applications for 2010 scholarships will close one month earlier next year, that is, at the end of April 2009.

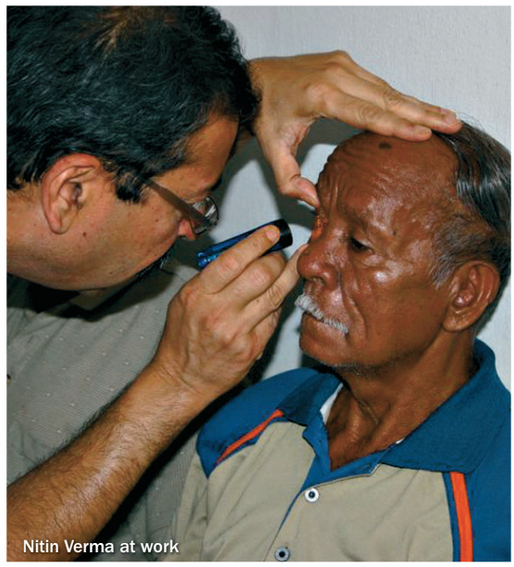


The East Timor Eye Program

After many succesful trips, this exceptional undertaking is now looking to pass on infrastructure and knowledge

PHOTOGRAPH COURTESY OF ELLEN SMITH

Happy to see again



Nitin Verma at work

The East Timor Eye Program (ETEP) provides outreach services by ophthalmologists and optometrists to the developing nation and is currently setting up eye treatment centres in its national hospital and the five district hospitals. Established in 2000, the ETEP was set up with the twin goals of ensuring that East Timor becomes self-sufficient in the provision of eye care and eradicates preventable blindness.

The ETEP works with the Australia Timor Leste Program of Assistance for Specialist Services (ATLASS). The ATLASS Program is funded by the Australian Government through AusAID and is managed by the College. Volunteer surgeons and nurses funded by the College and the ProVision Optometry Team have so far treated more than 30,000 vision-impaired East Timorese with 2,200 surgical procedures done and 23,000 pairs of spectacles dispensed. The achievements so far are remarkable given that there was not one eye surgeon left to treat the population after the violence following the vote for independence in 1999.

Now, the ETEP is in the process of refining the eye clinic in Dili and setting up new clinics in the regional centres of Baucau, Suai and Oecussi, with operating theatres being upgraded to allow for cataract surgery. Further services are now also being provided in Maliana and Moubisse, both of which are located in rugged highland areas.

Six visits are made each year through ETEP with optometrists travelling ahead of surgical teams to assess patients. Spectacles are made and dispensed by local NGO Fo Naroman (Vision) Timor Leste and provided at the cost of only $2 or free if patients cannot afford this.

Approximately 100-150 patients are treated on each visit. The program is funded by the College through the ATLASS Program as well as by ProVision Optometry, Rotary and a large number of private and corporate donations.

Tasmanian ophthalmologist Dr Nitin Verma, who set up the program at the request of the World Health Organisation, said he was proud of its success and the continued enthusiastic involvement of Australian surgeons through the College of Surgeons.

"There is no other specialist surgical programme of visiting teams to East Timor that goes to all six district hospitals and I think that is an impressive achievement," said Dr Verma. "We are just a bunch of volunteers, most of us very close friends now, who saw a need and chose to do something about it because it seemed the right thing to do."

Dr Verma said the strength of the program lay in its co-operative structure between Australian team members and local East Timorese.

"The ETEP is based in a three-tier structure. There are local eye care nurses who dispense eye glasses and treat infections, we have our optometrists and then the surgeons" he said.

"Since the beginning of the program we have also brought into the country 90 per

cent of the necessary ophthalmic equipment including lasers and microscopes. Yet while the East Timorese are still dependent on these visiting teams, we are now supporting a Chinese ophthalmologist working out of Dili while an East Timorese ophthalmology trainee should be fully qualified by the end of the year, which is extremely pleasing."

The major causes of preventable blindness and visual impairment in East Timor are cataracts, uncorrected refractive error, Vitamin A deficiency and tropical infections. Many local people with visual impairments suffer enormously in the economically struggling country

utes later was in theatre," said Dr Verma.

"The following day, Senor Faustino was one of the first to have his eye patch removed and soon had started speaking out in a loud voice. All the locals, including our interpreter were looking at him and listening intently and it was clear that whatever he was saying had everybody in the room captivated.

"I asked what it was and the translator replied: 'This man has just told us that this is the first time he has seen for 20 years and that it is the first time he has seen his granddaughter's face.'

ies and the conditions that they will be working in and we are now in the process of going through a shortlist of candidates," he said.

"Of course we are always looking for donations in the hope that while we may in the future not be so hands on, we do not stop supporting this crucial health need."

One of the surgeons described by Dr Verma as a "star" of the program, Brisbane ophthalmologist Kevin Vandeleur, made his last visit to Oecussi in August. He said the optometrists tended to 400 patients while the surgeons operated on 70, mainly for the treatment of cataracts. With his Australian practice


A local nurse scrubs Kevin Vandeleur while a prepped patient waits


Patients waiting patiently for their operations

Nitin Verma and Kevin Vandeleur operating

given the effect of blindness on financial survival – not only impacting on the person affected but family members forced to give up time to care for them. Some older people, through the lack of simple cataract surgery, are forced to live solitary lives while family members work outdoors.

Yet lives are changed through every visit. Dr Verma related a story of the treatment of an elderly man during a trip in 2007, the first such visit by a surgical team to the regional centre of Maliana. After a quick assessment of those waiting in the clinic, team members noticed the clearly blind man who had been led by the hand to the end of the queue by his granddaughter.

"The nurse brought him to the front of the line and Dr Ellis examined him. He had an old trauma with significant corneal scarring to his right eye with no pupil reaction. The left eye had a dense white cataract with a beautiful pupil reaction. He was offered surgery to remove the left cataract and 30 min-

"It was the kind of moment that makes all of us volunteers keep going back.

"There are no pensions in East Timor and while the elderly are treated with great respect compared to Australia, unfortunately the care of the blind often takes someone away from productive work with the obvious economic consequences.

"Everyone in the room realised that this was a turning point in his life, that he could regain some independence and hopefully greater happiness."

After seven years, the ETEP is now working to provide the infrastructure – both in terms of equipment and the construction of the centres – and then gradually move out. Dr Verma said that while one surgeon for one million people was clearly not enough, the ETEP was in the process of raising funds to cover the income of another ophthalmologist.

"This will be an international appointment. We are looking for surgeons from South East Asia who are used to large through-put surger-

based out of the Royal Brisbane and Princess Alexandra Hospitals, Mr Vandeleur has been involved in the ETEP for five years. He said he enjoyed the challenge and the opportunity to see parts of the country not readily accessible.

"I like operating there, it's challenging to do good surgery in such places but it can be done, it just takes skill and a great deal of preparation. And much of that is done by the wonderful nurses who achieve so much behind the scenes not only in assessing the needs of patients but getting them to the hospitals at the right time," he said.

"We have people in this program who go into the mountains to assess the local people and explain what can be done for them. Some of the old guys walk for hours, sometimes days, to get to the clinic.

"They're as tough as teak, the people of East Timor, and it is a pleasure to help them."

For more information on the East Timor Eye Program please visit www.etep.org.au

Surgical care in Afghanistan

Treating Australian soldiers in the NATO field hospital in Tarin Kowt

Melbourne orthopaedic trauma surgeon Annette Holian was writing up reports in the North Atlantic Treaty Organisation (NATO) field hospital behind the razor wire and bomb-proof walls in Afghanistan in early September when the phone and internet lines were suddenly disconnected.

This, for the Dutch and Australian military personnel running the hospital, could only mean one of two things; either an important official was visiting Tarin Kowt or there had been a major incident in their zone of operations. As we all know now, it was the latter. Nine Australian special-forces soldiers had been wounded by the gunfire of Taliban fighters.

In the following hours, the injured men were airlifted to the hospital compound by US Black Hawk medivac helicopters. Dr Holian, a Royal Australian Airforce (RAAF) Wing Commander in the High Readiness Specialist Reserve and Clinical Director of the Kamp Holland Role 2 Hospital at the time, immediately activated the Mass Casualty Plan.

"Australia was providing surgical and Intensive Care Unit (ICU) support at the NATO field hospital in Tarin Kowt where our Special Forces and Reconstruction units are based. As such the commander of the hospital told us there had been a significant incident involving Australian personnel but we didn't initially know how many were involved or whether they would all come to us," she said.

"As it played out, two of the soldiers were treated at the US hospital for the first night. We went straight to the Mass Casualty Plan in the Kamp Holland hospital because we normally work with only two Trauma Resuscitation bays.

"Many of us in the team had been to Holland in April where we had practiced implementing the plan which made an enormous difference because we all knew our roles, where the equipment was located and the system we would use for patient assessment.

"The soldiers were assessed as either Priority One or Priority Two. As the field triage and primary care had been excellent, the most seriously injured had been airlifted first so it was quite orderly. We then set up extra trauma beds and operated into the night."

Now back in Australia and back at work at the Alfred Hospital in Melbourne, Dr Holian said most of the soldiers had emergency surgery that night for chest and abdominal wounds and bullet injuries to limbs with the most severely wounded then sent on to Landstuhl in Germany.

"Because these were high-velocity bullet wounds, the injuries were complex and almost all of the soldiers had daily visits to surgery to keep the wounds clean while they were still with us. Those who didn't go to Germany first were flown back to Australia on the C17 Medivac aircraft," she said.

"This was the first time that aircraft was deployed to bring an Australian home."

Dr Holian said all the men had survived their injuries.

"We were certainly pleased with the initial care the team was able to provide but even more I think we were proud of Australia's ability to get the soldiers out of danger and into care quickly and then on to other medical centres with the expertise to do follow up surgery."

Dr Holian, whose deployment in Afghanistan lasted for six weeks from late July to mid September, is familiar with danger zones having completed two tours in East Timor as well as being flown in to treat the desperately wounded in the immediate aftermath of the New Guinea and Indonesian tsunamis.

She said while the gun battle with the Taliban had caused the most casualties in one incident during her deployment, many injuries treated by the hospital staff of 35 were caused by Improvised Explosive Devices (IEDs).

"These are bombs hidden in the road and triggered probably by pressure or electronic devices," she said.

"There were two major incidents involving Dutch personnel that I assisted with, one soldier having been seriously injured with severe torso, leg and head injuries. We operated on him for ten hours before he was stable enough to be flown home to Holland where he required several more trips to the operating theatre.

"There was also another IED incident involving three Australian soldiers so in all, throughout this deployment, we activated the Mass Casualty Plan three times."

Despite the circumstances and the danger that did not allow for any travel outside the razor-wire of the NATO compound, Dr Holian said she had enjoyed the experience.

"It was a fantastic experience to be able to go there and treat these Australian soldiers, not only because they deserve the best care Australia can provide but also because we don't see such injuries here so it is extremely professionally, and personally, satisfying work," she said.

"The NATO hospital was incredibly well set up and while I haven't worked with the Dutch before we found that we worked extremely well together. They found us, as specialists, very co-operative and open and prepared to share the duties, even including the cleaning."

Dr Holian said her team deployment, which also included Squadron Leader Sharon Cooper from Townsville, was only the second international military surgical deployment made since the response to the Nias earthquake in Western Sumatra in April 2005.

She said an earlier surgical team had been sent to Afghanistan in March.

"It was a fascinating experience," she said.

"The Dutch have good English so

that wasn't a problem and there were interpreters there translating from Pashto, the local language, into both Dutch and English. I felt quite safe within the compound, which has rocket proof shelters and is protected by an outer wall and a razor wire wall, and had no desire to go driving around.

"However, I visited the nearby US hospital in the first week to see their facilities and to work out methods of co-operation if that was needed. Occasionally we borrowed their equipment and I assisted their orthopaedic surgeon on two occasions and on one occasion we asked for their help because one of their surgeons had more vascular experience and we needed his assistance to stop the bleeding of one of the soldiers we were treating."

Dr Holian said that as well as the military work, the medical staff at the Kamp Holland Hospital also treated local people with gunshot or bomb injuries as well as specific orthopaedic injuries at a twice-weekly out-patients clinic.

"That was our only interaction with the local people, those that presented with injuries or medical emergencies that could not be handled at the local hospital. In one case the team saved a 14-year-old boy who had shot himself in the leg but only after they had been able to convince his family the limb would need to be amputated," she said.

"There were a few cultural issues such as this one. That incident was tense but the boy is doing well now. The other issue I noticed was that no women of childbearing age presented at the clinic," Dr Holain said.

"I found that worrying but the interpreter said that such women spent most of their time indoors and so out of danger. I hope that was the case."

Dr Holian will be back on call as part of her role in the High Readiness Specialist Reserve in December.

Pictured from top: Trauma centre preparing for mass casualties, the team at Kandahar, and Annette Holian and a patient who had an open tibial fracture, at 2 weeks post op

Green Fellows

Taking up the clean energy mantle

An orthopaedic surgeon's campaign in support of local initiatives to combat climate change

Regional orthopaedic surgeon and newly-evolved environmental campaigner Mr Matthew Nott is leading a grass-roots renewable energy movement that could transform the nation's approach to tackling climate change. Instead of waiting on federal or state politicians to come up with answers based on economic modelling, Mr Nott has galvanised the community in the southeast NSW region of Bega to take up the climate change gauntlet themselves.

Through his organisation, Clean Energy for Eternity (CEFE), Mr Nott is now in the process of raising funds for the development of both a solar and wind farm in the region as well as working to have solar power installed in all Surf Lifesaving clubs around Australia.

With a slogan of 50/50 by 2020, the organisation has also won a commitment from five local shires to aim for a 50 per cent increase in the use of renewable energy and a 50 per cent decrease in overall energy consumption by 2020. The local movement has also attracted considerable interest given that it is taking place in the political bell-weather seat of Eden Monaro.

A surfer but no "tree-hugger", Mr Nott said he began the movement after spending a particularly torrid afternoon on surf patrol at Tathra beach on a 42-degree day in late 2006.

"I was in the process of reading Tim Flannery's book *The Weather Makers* and that turned out to be a particularly bad day to be reading a book on climate change. I immediately wanted to do something but my wife wisely suggested that I read more than one book before I launched into action so I spent the following five months reading everything about climate change that I could get my hands on; scientific papers, the views of the sceptics, political reports," he said.

"From that I came to the very firm conclusion that climate change is real and does pose a terrible threat to the future. I have three sons and I thought that if the worst predictions came true they could be fighting for their lives by the time they reached my age and that was an appalling thought.

"Then not long after, I had to travel to Whistler in Canada for an orthopaedic conference and while there I saw various organisations building snow-making equipment because they were worried that there may be insufficient snow to host the 2010 Winter Olympics.

"I found that seriously distressing, that people were willing to spend so much time and money to overcome the effects of climate change while doing nothing to prevent it."

And thus was born Clean Energy for Eternity which has since grown from the Bega region all the way through to Sydney with representatives of the group in Mosman and Manly.

Mr Nott said the main aims of the organisation were to raise awareness of the science behind climate change and thereby change attitudes and bring the community together to develop local solutions.

As a start, he organised a human sign on Tathra Beach and was staggered when more than 3000 people across all age groups and demographics turned up to participate. The people formed the words "clean energy for eternity" an event that has since been replicated more than 50 times to involve local people and to create photo opportunities for campaigns.

Now Mr Nott is working with local surf lifesaving clubs to raise the funds to install solar panels and wind turbines so that each club along each beach is a focal point for clean energy and the fight against climate change.

"We are now hoping to turn this into a national campaign. We want to include all

Wind power

More than 3000 people made a human sign on Tathra Beach, in show their support for Matthew Nott's initiative

305 surf clubs in Australia, so we have six down and only 299 to go," Mr Nott said.

In its short life, CEFE has already attracted more than $100,000 from the Federal Government to undertake a feasibility study for a planned two-megawatt community-owned solar farm, which will be built using photovoltaic cells and reflective mirrors. Estimated to cost $8 million, the Federal Government has already offered $1 million subject to the outcome of the studies, with CEFE now looking for state and corporate involvement.

"If this comes off, it will be the first such solar farm in Australia, which while an achievement is also an indictment. In a country like Australia that has so much sun, it is pathetic that we don't have them spread across the country," Mr Nott said.

"We are also looking to set up the town of Bega to have all its energy needs provided by renewable energy sources within five years. We are in a marginal electorate and Bega has a long history of being in the forefront of the environment movement and now many residents are committed to showing the rest of the country what can be achieved if people just get involved.

"If this comes off, it will be the first such solar farm in Australia, which while an achievement is also an indictment."

"The campaign took off because the message fell on fertile ground, many people here were very frustrated at political inaction and decided to act.

"Renewable energy is probably going to be one of the largest, most innovative industries in the world and by thinking outside the square we are hoping to show that tackling climate change does not necessary have to have a financially negative impact – it can in fact generate jobs, tourism and investment.

"We are thinking big, but climate change is a big problem."

Mr Nott works out of the Bega District Hospital, the Bega Valley Private Hospital and the Cooma District Hospital. While, in a bid to reduce his carbon footprint, he no longer flies to international conferences as much as he once did, Mr Nott has switched from surfing the ocean to surfing the net to keep the campaign afloat.

He said that while he was driven to act on behalf of his own and other people's children, his job as a surgeon was also an influence.

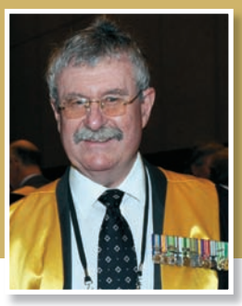
"As an orthopaedic surgeon I am in the business of taking away pain and that is extremely satisfying. That means that at the heart of what we do as surgeons is to care for people's well-being and the biggest threat to that right now is climate change," he said.

"People talk about the spread of tropical diseases but I also think of the impact of depression, anxiety, suicide and the trauma and injury of storm events and bushfires. Establishing this organisation has taken a great deal of work but the fact that we are kicking goals and that people are listening keeps us going.

"Yet there are some people who think I am a complete idiot, who think I have been sucked in by radical leftists, which is a staggering attitude that more often than not comes from well-read, intelligent people."

If you wish to become involved, visit www.cleanenergyforeternity.net.au

Professional Development



Professional development workshops in 2009

Rob Atkinson, Chair
Professional Development

Within its vision for the 21st century, our College Council states that "FRACS stands for excellence in surgical care." The challenge for all of us is to keep our knowledge and skills up-to-date so that FRACS stands for "excellence" throughout our working life. This means regularly taking part in educational activities as part of lifelong learning in order to maintain and further develop our competence and performance.

The 2009 professional development activities focus on the non-technical aspects of competence as identified in the College's definition of surgical roles and competence. These generic roles include communication, collaboration, management and leadership, health advocacy, scholar and teacher and professionalism – in addition to the clinical roles of a surgeon in relation to medical expertise, technical expertise and clinical decision making.

Two exciting new workshops are on offer in 2009, which aim to better support surgeons as managers and leaders: "Leadership in a Climate of Change" and "Providing Strategic Direction". These quality, face-to-face workshops are "stand alone" or can be combined with online distance learning modules to form an Advanced Diploma of Business Administration. They provide practical workplace focused training to effectively manage the strategic direction of a business through leadership, comprehensive business operations and financial management. Each has been uniquely tailored to enhance surgeons' leadership and management capabilities, in particular to assist them in taking up senior management roles in hospitals.

"Making Meeting More Effective" is another important learning opportunity that is a "must" for anyone who sits on a committee or a board. It explores the 10 principles for effective meeting and explores the role and responsibilities of the chair and members of committee.

I believe that Fellows at all stages of their careers need to embrace every opportunity for learning to ensure that FRACS always stands for excellence in surgical care.

I strongly encourage you to participate in these and other professional development activities listed in the 2009 Professional Development Workshops booklet.

Registration

Online registration for most courses is available through the Professional Development website. Visit www.surgeons.org, go to "Fellows" on the top menu, select "Professional Development" and click on "Workshop and Courses".

Registration forms are also available from the Professional Development section of the College website. Return completed forms by fax, +61 3 9276 7432, or mail. Alternatively, contact the Department on +61 3 9249 1106 or email PDactivities@surgeons.org

A chance meeting leads to help for the blind in Indonesia

Mark Ellis

She sat there with an expressionless face. People were moving around her as if she wasn't there. The Australian team of eye surgeons, nurses and optometrists were busily checking the post-operative cataract patients from the previous day. She had been sat there to await assessment for the new day of surgery.

Her first cataract operation was performed that day. The next day, her expressionless face changed when her patch came off. It was replaced with a lovely smile. She readily accepted the surgery to the other eye. The following day after the patch came off she walked unescorted out of the hospital grounds. She was 40 years old and now able to see.

For us, the smile and her walking out unaided were the reward. She was one of about 80 sight-saving operations, mainly cataract extractions, performed in that week in Waikabubak, West Sumba, Indonesia.

Our Melbourne based team had been sponsored by Glenferrie Rotary for a week of eye surgery in August 2008. The International Projects of the College provided the organisational expertise. I am a Glenferrie Rotarian and ophthalmic surgeon and had led a team previously to East Sumba in 2007. A great need for eye services was identified. A chance meeting in Sumba last year with Dr Claus Bogh, a Bali Rotarian and the Director of the Sumba Foundation, an American Charitable group, led to Claus inviting the team to conduct a similar trip to west Sumba. With his help, this year's trip was feasible.

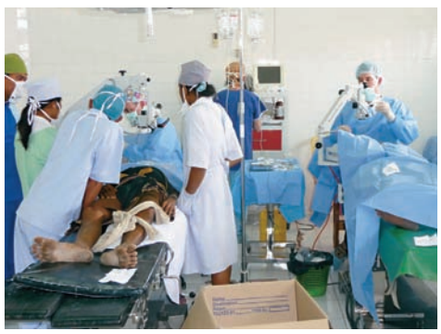
This year's team was comprised of Dr David Van Der Stratten and I for the surgery, two nurses, Julie Tyers and Jan Parker, and two optometrists Peter Lewis and Peter Stewart. Half of the team had accompanied me on prior trips to Sumba and East Timor. Robert Hogan, the current President of Glenferrie Rotary, was a volunteer providing great help in managing the people lining up for surgery. The optometrists were busy screening up to 600 people, dispensing glasses and examining for various eye complaints.

With funding from Glenferrie Rotary, Optometry Giving Sight and some private individuals, the trip was made possible. All found time to teach the local staff. We were able to identify suitable trainees for the future and plans are underway for the team return in 2009.

Once again, thanks to the continued excellent expertise of the International Projects of the College, especially Amelia Hartnett, who ran this project, and Daliah Moss for her support.

'I can see.' Mark on the post-op review

Peter Lewis screening in the villages



Theatre in action, teaching observers

INTERNATIONAL TRAVEL GRANT FOR ASIA PACIFIC SURGEONS 2009

Fellows are invited to nominate overseas surgeons from Burma, Cambodia, Laos, Vietnam and Indonesia who are not Fellows of the Royal Australasian College of Surgeons for the RACS International Travel Grant to attend the Annual Scientific Congress (ASC). The Travel Grant is provided to enable grantees to attend the ASC and for hospital visits in the host city. Up to three Grants will be awarded to outstanding surgeons from ASEAN (Association of South-East Asian Nations) and Oceania regions. Citizens of Burma, Cambodia, Laos, Vietnam and Indonesia are strongly encouraged to apply.

The Travel Grant will consist of registration for ASC in Brisbane, 6th to 9th May 2009 plus up to $2,000 towards economy travel costs and accommodation.

ELIGIBILITY

- The Travel Grant is available to overseas practising surgeons between the ages of 30–45 who are not Fellows of the Royal Australasian College of Surgeons.
- Surgeons practising in all fields of surgery are eligible however favourable consideration will be given to surgeons whose specialty is represented in the ASC surgical program.
- Precedence will be given to surgeons from ASEAN and Oceania regions who have been formally invited to participate in the RACS International Forum.
- Preference will be given to surgeons who are not likely to be able to fund their own attendance.
- The successful surgeons will be required to supply a report at the conclusion of the Congress on their experiences.

APPLICATIONS MUST INCLUDE:

- a letter of application, including the reasons for applying and anticipated benefit
- a brief curriculum vitae
- two written supporting professional references
- incomplete applications will not be considered

APPLICATIONS CLOSE ON 28 FEBRUARY 2009

Applications may be mailed to:
International Scholarships Officer
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street Melbourne
Victoria 3000 Australia

OR BY FAX OR EMAIL TO:
International Scholarships Officer
Telephone: + 61 3 9249 1211
Fax: + 61 3 9249 1236
Email: international.scholarships@surgeons.org
Website: www.surgeons.org

2008/2009 Rowan Nicks
Australian & New Zealand (ANZ) Scholarship

RACS - The College of Surgeons of Australia and New Zealand invites suitable applicants who are citizens of New Zealand to apply for the 2008/2009 Rowan Nicks ANZ Scholarship. Rowan Nicks Scholarships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country in their chosen surgical speciality area.

The 2008/2009 Rowan Nicks ANZ Scholarship is offered to a surgeon from New Zealand to take up the scholarship in Australia. The scholarship is intended to provide an opportunity for the surgeon to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The scholarship is not only a personal award but is planned to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base. The scholarship will be awarded for any period up to a maximum of twelve months.

Applicants should be under 45 years of age and have completed the FRACS. As the scholarship is for training within Australia if the applicant has a sponsor in Australia and or wishes to work in a specific centre, this will be considered by the selection committee. Applicants must undertake to return to New Zealand on completion of the scholarship program.

APPLICATIONS MUST INCLUDE THE FOLLOWING:

1. Cover letter that outlines intended program and any sponsor in Australia if such exists (this is not obligatory)
2. CV
3. Copy of basic medical degree and Fellowship

FORWARD APPLICATION TO:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street Melbourne VIC 3000 Australia
Email: international.scholarships@surgeons.org
Phone: + 00 11 61 3 9249 1211
Fax: + 00 11 61 3 9276 7431

James Aitken,
WAASM Chair

The WA Audit of Surgical Mortality

Over the next five years the focus of the WAASM will move to patients and their outcomes

The Western Australian Audit of Surgical Mortality (WAASM) now has five annual reports. It is an opportune moment to review how WAASM has progressed, and to look to the future.

Without question the most important change over the last five years has been the environment within which WAASM operates. Five years ago Clinical Governance was a concept being aired in the United Kingdom. Clinical Governance is now central to the Quality and Safety program developing in Western Australia. Five years ago WAASM was voluntary. The advent of the Western Australian Review of Mortality (WARM) has made mortality review of all in-hospital deaths mandatory. Five years ago Western Australian surgeons were an isolated group pioneering a statewide surgical audit. The College has now established the Australian and New Zealand Audit of Surgical Mortality (ANZASM).

The biggest change during the next five years is going to be the environment within which WAASM operates. This change will be fast, substantial and focused on patients and their outcomes. In the United States Pay for Performance (P4P) and in the UK Payment by Results (PbR) are becoming well established. It is absolutely certain that the extra public health funding the current Australian Federal Government has promised the states will be linked to a requirement to publicly report outcome measurements. These demands will include the private sector that receives substantial federal government subsidies. The federal government has a moral and political responsibility to ensure it spends taxpayers' money in the most clinically effective way. Neither politicians nor patients are going to tolerate resistant doctors or hospitals withholding the publication of outcome data they believe they have the right to see and have paid for. The Australian medical community appears to be ill-prepared for the demands that are going to be placed on it.

Those who doubt that change is coming to Australia, and more rapidly than they think, need only look to the National Health Service (NHS). Mortality rates for individual UK cardiac surgeons have been available on the website for three years, which now has 12,000 hits a month. This is strong evidence that patients want and use this data. The UK cardiac surgeons themselves acknowledge that there is compelling evidence to show that publication of this data has improved outcomes. The same data also refutes initial claims this would lead to case selection, risk avoidance and other outcome gaming. Not only have UK cardiac surgeons crossed the Rubicon, nobody drowned on the way! Indeed life on the other side is probably better as the results of cardiac surgery in the UK are now the best in Europe.

This positive experience has prompted the NHS to extend this process and by late 2008 similar outcome data for hip and knee replacements and aortic aneurysm surgery will be available on the NHS website. Outcome data for other specialities will follow as data quality becomes more robust. Initially this data will be based on units, but the NHS is committed to publishing a wide range of individual consultant data. In WA the Department of Health's decision to mandate participation in WARM is only a gentle introduction of what is to come.

The College has invested considerable time, money and potentially its reputation in establishing ANZASM. The College has been unwavering when arguing that its core business is establishing and maintaining surgical standards. It will be difficult for those outside the College to understand how attendance at Conferences could be mandatory, but participation in arguably the College's most important quality and safety initiative is not. It would seem inevitable that complete participation in ANZASM will become a mandatory requirement of Continuing Professional Development (CPD), as anything less will have the potential to jeopardise the College's reputation for safety and quality. It will only take one non-participating surgeon to hit the media for the wrong reasons and the

College will appear unable to discharge one of its self-proclaimed core responsibilities. The College cannot afford for ANZASM to fail. WAASM would encourage those few WA surgeons who are not participating to submit all of their deaths.

During the last five years WA hospital accreditation committees have not embraced WAASM as they might. Hospitals should have already made participation in WAASM a requirement of accreditation. In the UK consultants undergo an annual appraisal and surgeons must include details of their national mortality audit participation. WA hospitals accreditation committees need to take a greater interest in ensuring that safety and quality processes are not only in place, but take place. Once again the profession should note that in the absence of an adequate response the WA Department of Health took it upon itself to make mortality audit mandatory in public hospitals through WARM. It will inevitably extend this to private hospitals through the licensing process. The next step will be for this data to become public in some form.

Florence Nightingale recorded that patients left the hospital "dead, relieved or unrelieved". In Australia 150 years later we only know whether patients leave dead or alive. Patient Reported Outcome (PROMS) are being strongly promoted by Sir Bruce Keogh, the NHS medical director. A leading advocate of PROMS over the last 10 year has been the British United Provident Association (BUPA), then the UK's largest private hospital operator, who considered this data when reviewing consultants' admitting rights. BUPA is currently expanding into Australia as a health fund and there is every reason to believe they will support the introduction of a quality process they found valuable in the UK. Health minister Lord Darsi's final review (*High Quality Care for All*) has open publication outcomes as one of its core goals. Of note, both Sir Bruce and Lord Darsi are surgeons.

Surgeons have understandable concerns about the validity, interpretation and verification of their outcome data. The surest way to ensure accurate data is for surgeons to take responsibility for the process from its collection through to its dissemination. Others will rightly argue that surgeons have a professional responsibility to know what they are doing and how they are doing it. It is certain that if the profession does not do this, others will.

In the UK the inquiry into cardiac surgery in Bristol was a watershed event. Despite a number of widely reported failures of care, there has not yet been such an event in Australia. A manslaughter trial in Bundaberg may yet prove to be that watershed event. The Australian surgical community needs to be prepared.

In May 2008 the Royal College of Surgeons England held a seminar on "Outcome Measurement in Surgery". Sir Bruce warned the representatives of the medical colleges "There is no going back." The Department (of Health) is not seeking your permission. It is merely seeking your help. "All changed, changed utterly."

Early Management of Severe Trauma – 20 years on

Michael Hollands, Past Chair, EMST Committee

Director workshop, September 2008

Twenty years ago, almost to the day, the first Early Management of Severe Trauma (EMST) Course was held at the College in Melbourne. Today, over 900 courses and 13,000 doctors later, EMST is still thriving. Worldwide, over 1,000 Advanced Trauma Life Support (ATLS) courses are held annually and over 300,000 doctors have been trained.

The origins of the course go back to 1976 when James Styner became disoriented during a storm and crash landed his six-seater aircraft in a wheat field. His wife was killed instantly and his four children were seriously injured. Styner fractured his ribs, and one orbit, effectively blinding him. He evacuated his children and then in subzero temperatures, walked over half a mile to the nearest road. Three cars passed before one stopped and took them to a local hospital where the nurse refused them entry until the doctor arrived. The treatment offered was incomprehensible by present standards – only one IV line was inserted, and there was no attempt to protect the cervical spine.

Appalled with the treatment they received, Styner called his partner in Lincoln and arranged for him and his family to be transferred. They were met in Lincoln by Dr Ron Craggy. Craggy and Styner started to consider how treatment procedures could be improved. Teaming up with Jodie Becktov and assisted by the Advanced Cardiac Life Support personnel and the Lincoln Medical Education Foundation, they developed a course for rural Nebraska, naming it ATLS.

The ATLS course was approved by the American College of Surgeons (ACS) Committee on Trauma in 1980, is now taught in over 50 countries and has been nominated for a Nobel Peace Prize. As James Styner said, ATLS is like a really good malignancy, it just keeps spreading.

Its early origins in Australia and New Zealand are a little difficult to disentangle from the mists of time. Gordon Trinca was asked to develop a trauma education program at around the same time that Stephen Deane attended an ATLS Course in the US. At first, the attitude of the American College seemed to be that ATLS was for home consumption only. However, with the encouragement of Chad Herring, Chair of the ACS Committee on Trauma, preparations were made for a team of Australian surgeons to be trained as ATLS Instructors. Generous financial assistance was obtained from the Transport Accident Commission in Victoria and the College Road Trauma Trust. In September 1986, Stephen Deane, Peter Danne, John Graham and Christine Reid travelled with Gordon Trinca to San Francisco to complete a course specifically designed for overseas doctors.

So, with great support from successive

"My experience with EMST demonstrates that giving something back can be rewarding."

Early photograph of Brian Miller, John Graham, Stephen Deane, Peter Danne and Ian Civil - singing the EMST song

Early photograph of Stephen Deane, Ian Civil, Peter Danne, Christine Allsopp, Garry Phillips and John Graham

College presidents and forceful advocacy from surgeons such as Ian Civil, the ATLS course was transplanted to Australia and New Zealand. EMST remains unique, the only ATLS course with a different name and the opportunity to adapt to local conditions.

In early December 1988 the inaugural Australasian course was run in Melbourne with a select group of participants. EMST instructors were multi-disciplinary from the start, reflecting the very nature of the team managing the injured patient. The first open participant course was run in March 1989 in Orange, NSW, signifying the commitment of EMST to rural Australia and New Zealand from the beginning. Soon after, the first New Zealand course was run. In 1990, just prior to Australian troops leaving for the Gulf War, we held our first ADF Course. Around this time the College determined that successful completion of EMST was a mandatory requirement for completion of surgical training.

In 1993 the first course in Papua New Guinea was held with EMST's curriculum and the skills taught being just as appropriate in Fiji, PNG and the Pacific Islands as they are in Melbourne or Auckland. We taught our first course in Fiji in 2000. It has since been attended by doctors from nations as remote as Kiribati, Tuvalu, Tonga and Samoa. In 2003, the first ATLS course was held in Thailand with the support of RACS.

From an educational perspective, EMST provides evidence-based core knowledge and a range of skills applicable to all doctors, independent of speciality or working environment. Emphasis is placed on treating threats to life and limiting disability before definitive diagnosis with participants being provided with a means of assessing and treating injured patients. There is now a corpus of literature demonstrating skill acquisition and retention and anecdotal evidence suggesting these skills are put to use. Attempts to determine whether EMST or the parent ATLS course alter outcomes are conjectural. A prospective study from the Netherlands demonstrated a change in the approach to examination and investigation, rather than a change in outcome. Such studies are almost impossible to conduct because, as the terms and phraseology of ATLS are now part of the lexicon of doctors who care for injured patients, a true control group of doctors without exposure to EMST principles would be all but impossible to recruit.

So how do we assess the success of the EMST Course? Perhaps we can best answer this question by a short SWOT analysis of the program. Its most obvious perceived strength is quality. Quality refers not only to the curriculum but also to the faculty, coordinators, educators and to the quality control of each and every course. We achieve this by providing a clear framework of expectations, regular reviews and audits, an excellent instructor course and ongoing involvement with our educators. One of the fundamental strengths of EMST is that our faculty teach pro-bono; without this commitment, the course could not function.

I must not be tempted to paint too rosy a picture, being popular also has a cost. Many of the threats to EMST are also its weaknesses. It is expensive and labour intensive. While a high ratio of tutors to participants is necessary in educational terms, it demands a large faculty pool. With over 2,000 doctors now waiting to do the EMST course, course numbers have increased to 75 in 2009, requiring the full commitment of our 350 active instructors. Incentives to teach EMST include golf shirts and scholarships - but the real reason people instruct is their absolute belief in what they teach.

There are opportunities for EMST to be more innovative in its delivery of education. Our relationship with the American College is strong, with the EMST committee inputting into the curriculum development of the 8th edition of ATLS, which is being rolled out next year. The ninth edition of the ATLS manual will almost certainly be e-based. The EMST program and the College are grateful to the American College of Surgeons Committee on Trauma and especially the ATLS sub-committee for their assistance, support and collaboration.

In cold, hard terms, what are the achievements of EMST over the last 20 years? The language of EMST is now part of trauma care idiom, used not only by EMST-trained doctors, but also by ambulance officers, nurses and medical students. It is the foundation on which other trauma courses are based. Knowledge and acceptance of its principles are expected, not encouraged. It is the best example of various medical disciplines from different facets working together. I have made a lot of friends through my involvement with EMST and I believe in the so-called EMST family. My experience with EMST demonstrates that giving something back can be rewarding and enjoyable. For those of you not engaged in the program – join us.

Finally it is important to maintain the rage. There is an enormous challenge initiating change, which brings with it a sense of excitement, allowing everybody associated to be infected. For now, EMST must focus on consolidating what it has achieved, evaluating those achievements and ensuring for itself a viable future by continuing to be exciting, innovative and delivering the "gold standard" it is renowned for.

Grays' Anatomy

op10

Henry Gray and St Georges Hospital

Felix Behan

My medico-legal secretary, Margaret, told me she was commencing study of anatomy for a radiography course. When she asked me about the anatomy of the wrist, I gave her my early *Gray's Anatomy* to help her on her way. Therein begins an interesting tale.

Margaret's mother told her she had heard on Radio National about a new publication called *The Anatomist* by Bill Hayes. This focused on the life and times of Henry Gray and the story behind his first textbook of anatomy with illustrations by Henry Van Dyke Carter (a misspelling from the classical reference). Hayes had noted that no mention was made of Henry Carter in his edition (it was deleted in the 17th edition, in 1909, by Howden). This set him off on an investigation.

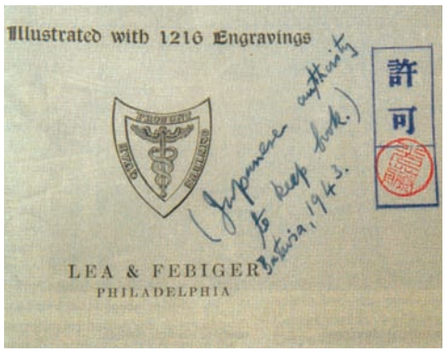
This year is the 150th anniversary of that first edition, which was commenced in 1855 and released in August 1858 and for which Gray's original title was *Anatomy – Descriptive and Surgical*. Marking the anniversary is an exhibition at the Royal College of Surgeons of England. Featured in it is a special copy of *Gray's Anatomy* found in a prisoner of war camp in the Far East in World War II. The book belonged to Nowell Peach who was working in a casualty clearing station with the Australian Army medical core under Weary Dunlop. Weary bought the book in Java and gave it to the budding young surgeon. A Japanese war stamp shows the text was to be retained for surgical and educational purposes.

I was amazed to find that Henry Gray, anatomist and surgical consultant, worked at St George's Hospital, Hyde Park Corner, where I myself spent three years in postgraduate training in the field of head and neck reconstructive surgery with the late Ian J. S. P. Wilson. During my time at St George's the hospital paid only a peppercorn rent to the Duke of Westminister as long as it remained a hospital. This site is now a five-star hotel called the Lanesborough; St Georges has gone to Tooting SW 17.

Lanesborough Hotel

Benny Rank was keen on anticipating the future pathways of head and neck reconstructive oncology. My mentors, Don Marshall and Michael Long, went to Roswell Park to work with Bekamjian (of delto-pectoral flap fame) thanks to John Hueston's introduction and Benny's support. My London appointment was the result of an invitation by my colleague (and best man), the late Alan MacLeod. Over lunch one day at the hospital in October 1970, David Conroy, on hearing I had passed the Fellowship and planned to go to London, suggested I do the English Fellowship course and meet the cream of London surgical talent while staying at Nuffield College. This interesting time, initially a six-week period, stretched to three years as I became a fixture, and eventually Deputy Warden of Nuffield College at Lincoln's Inn Fields. I sat my English fellowship, which I obtained with David David in 1971, and my viva was spent informally discussing Marice Ewing's transition to the Antipodes – to the Department of Surgery at the Royal Melbourne Hospital.

Back to the history of *Gray's Anatomy*. Hayes describes Gray's residence in Wilton Place, an area I passed many times oscillating between the Marsden and Westminster as part of the Wilson team in the reconstructive service. He writes of how Gray became an eminent figure in the hospital establishment. Also, the stories about private anatomy museums and their development are all in *The Anantomist*; how Frederick III of Germany permitted



"Gray's first edition was quite readable, with 365 illustrations using special woodcuts done by Carter."

dissection in the 13th century, how Leonardo Da Vinci did them by candlelight against the Church's ruling, and how in revolutionary France they allowed Le Fort to establish his anatomical classifications of facial fractures.

Like all good medical developments, duet processes and clinical partnerships work: Fleming and Florey (penicillin), Rodney Smith and Charles Robb (hepato-biliary surgery) and Watson and Crick (DNA). Gray's first edition (with Gray and Carter printed on the spine) was quite readable, with 365 illustrations using special woodcuts done by Carter. These colour illustrations were deleted in the 1880s with the onset of colour printing, only to return in the early 20th century as the woodcut technique was superior.

In the 17th edition, in 1909, Howden deleted Carter's name (to explain Hayes's quandary) and the second title became *Anatomy descriptive and applied*. As Ruth Richardson says in the introduction to the current (39th) edition, Gray's lucid writing style with editorial help from Holmes and Carter's illustrations was the secret behind the text's success. While Carter did not achieve the eminence of Gray, it was Carter's particular style of nominating the anatomical sites, the fascial planes and tissue location that established a gliding facile visual axis, similar to earlier maritime maps, as opposed to the traditional "box and arrow" technique of other (inferior) texts.

Gray was appointed to the surgical staff at St Georges in 1861 under the chairmanship of Sir David Brodie (of Brodie's abscess fame). The selection committee acknowledging his appointment was awaiting his arrival that fateful afternoon. He failed to arrive, quite unfathomably for a person of his social and academic standing (his father was an emissary to George III). Why? It soon became known Gray had died that afternoon of smallpox at 34 years of age. The contents of his house were burnt as part of the fumigation process, hence there was no memorabilia.

Finally, a few passing comments about the hospital, as Gray and Carter would have experienced it. Even at my junior level I met the governors of the hospital board on social occasions at Ian Wilson's Chelsea residence. In May we watched the Queen's Cavalary riding down Horseguards Parade in preparation for Trooping of the Colours. Hunters Statue adorned the northern pediment, Harrods was our local supermarket. I remember one Friday evening going to the basement library at Hyde Park Corner where the famous Jenner's cowhide hung. (William Haulrich from Medical Meanings described how Jenner made the link between cowpox inoculations and smallpox immunity. His paper was rejected, in 1797, by the Royal Society of Medicine as it was in variance with established knowledge and practice – how could he taint this august body with such trite information?) I felt a shaft of "scientific enlightenment" that evening when I looked up Dorlands' dictionary and came upon the word "angiotome" to describe a new terminology for axial and random vascular flaps, which has led me down the pathway of the keystone island flap principle.

The residents' quarters overlooking Hyde park. The residents bar drinks were covered by a honour system and monthly tab (as is now experienced at 36 Collins St). Sir Rodney Smith, Lord Smith of Marlow, had a reservation brass plaque for his elbow like they do at the Hotel Martinez in Cannes for the film festival, as the likes of Bogart and Gable would have.

Besides being a noted bridge player, Rodney was a talented violinist, and someone asked him why he had not pursued a musical career. His response was simply "being a surgeon I can do both". Another famous quote was the description of himself as "a self-taught surgeon with great respect for the master" and finally a paraphrasing of Gertrude Stein, who observed "Anyone with ability, can certainly survive bad teaching." It was Rodney Smith who reiterated to me "plastic surgeons are general surgeons who finished their training," which I had heard from Benny Rank during my own training. Obviously there are British links to this precept.

I learnt from Rodney that you do ward rounds, at the Private Wing at Marie Tempest ward at 7am when the nursing staff are fresh (the women were too embarrassed to emerge from the sheets and the men were too sleepy to ask questions).

As Ruth Richardson recounts, Gray took a six-month sabbatical to complete the text. She describes the lineage of St George's men as "*Gray's Anatomy* men" because of the number of editors. Finally, in the 27th edition in 1938, the title was changed definitively to *Gray's Anatomy*.

Fellowship Services

Graeme Campbell, Chair Fellowship Services

New website for the College

The revamped site is easier for both members of the College and members of the public to use

User-centred approach

The College website has been revamped with a focus on user friendliness. The new site features a vibrant new look, with information on the site reorganised in a way that will make more sense to most people. To help users of the website find what they are looking for quickly and easily, the drop down menus have been simplified and a new, improved search engine introduced. The main headings on the website have overview pages which contain a mini-site map of what you will find in that area.

Public relations

The new website promotes the College's publications and activities with attractive images that lead to further information. There are new areas for medical students wanting to know about becoming a surgeon, and more resources for surgeons brought together under the Fellows banner. Specifically targeted areas for members of the public and the media are being developed and will be available soon.

The new website's homepage

There have been 23,000+ searches on Find a Surgeon in the past 12 months and it is clear that members of the public are coming to the College website to find out more about surgeons and surgery. Information on the website is now increasingly focused on how surgeons benefit our communities, through their skills, training, experience and pro-bono work.

Member areas

Member areas such as the Online Library and CPD Online continue to be developed. The login box is now above the red banner, on the right hand side. You can login when you first come to the site or when you come to a member-only page and you will stay logged in until you log out or close your browser.

The Library and Website Department would love to know what you think about the new site, and to hear what would make the site even better for you. Please email anne.casey@surgeons.org with your feedback.

Brian Smith Memorial Award 2009

in association with The Cabrini Clinical Education & Research Unit

Application to the Brian Smith Memorial Foundation, ANZ Trustees, GPO Box 389, Melbourne, Victoria 3001 are to be received by 12 December 2008.

Successful applicants will be notified as soon as a decision has been made.

For further information 1800 808 910

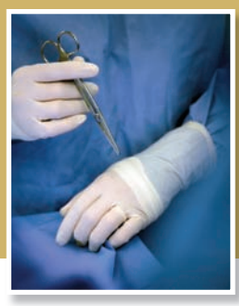
Application are invited for the Award for the year 2009

An award of $25,000 is available to facilitate research, including associated travel by a practitioner actively pursuing professional development. As Brian Smith's main surgical interest s were disease of the colon and rectum, the Committee of the Brian Smith Memorial Award will give preference to practitioners with a special interest in the applied anatomy, physiology or pathology of the colon or rectum.

Your application should include the following:

- **Contact details**
- **A copy of you curriculum vitae**
- **An explantation of how you would apply the award**

Winding Down



When to hang up the scalpel?

A presentation from the senior surgeons session at the Conjoint Annual Scientific Congress in Hong Kong

Elizabeth Lewis, Senior surgeon

There are many myths (and truths) about the appropriate age for a surgeon to retire. These include "most surgeons don't know when to quit"; "as long as I can help my patients I will continue to operate"; "older surgeons practising alone on the periphery of cities have more claims"; "when a surgeon is 70 years old and a problem arises it has to be malpractice"; and "strength, stamina, fine motor skills, sharp eyesight are traits associated with youth."

Airline pilots in the United States have biannual then annual assessments, starting arbitrarily at 50 years before they retire at 60 years. This is a rigorous yearly assessment with no scientific basis and approaches safety like the LD50 in the investigation of drugs on rats.

Musicians have no retirement age. String players go on well into later age, and there is no regular assessment in an orchestra. It depends on the Principal to note one of the players is not up to standard. It requires a mix of youth and experience to make a good sound.

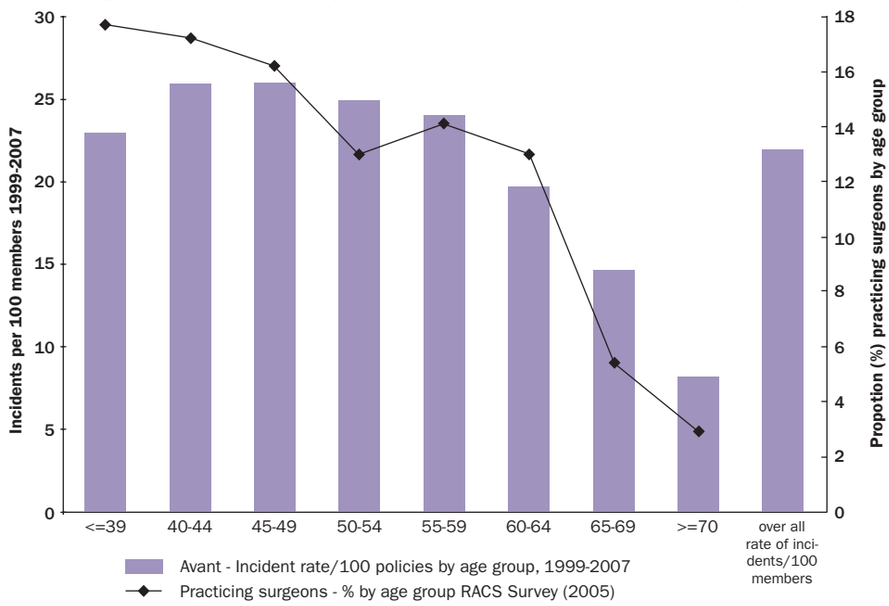
Surgeons equate to the musician's view. It depends on subjective assessment and that of their peers. But is there any evidence? And is this a reasonable analogy? Members of the audience do not risk death if the musician plays a wrong note!

Until about 20 years ago the Medical Defence Union gave free membership to those who had been members for over 40 years. Their unpublished data suggested that in the medico-legal climate prevailing at that time there was no perceived risk to them in making this offer.

Claims data from Avant Mutual Group Limited was examined to look at the possible risks to Avant of older surgeons. The figures were produced with the help of Dr Richard Clark, clinical epidemiologist at Avant.

The figure shows RACS figures of self-reported practising status plotted against the rate of adverse clinical incidents from the Avant data. The x-axis shows the surgeons' age in five-year groups and the y-axis the number of adverse incidents per 100 surgeons in that group. In the over-60 year age group there is a fall in adverse incidents compared with the peak in the 41-45 year age group. This younger group of surgeons is at the peak of their skills, confident and healthy. There is anecdotal evidence that some clinicians focus more strongly on risk management following a claim. The decreasing incident rate in older surgeons mirrors a reduction in self-reported professional activity. A possible explanation for this observation may be that older surgeons manage risk by either by ceasing practice or reducing the volume and complexity of their operations.

Figure 1. Comparison of surgeon incident rate and self-reported practising status



The figures from Avant do not suggest there is an age to give up the scalpel. A more detailed article is planned, using patterns of practice derived from Medicare data to demonstrate further evidence that age is not a factor increasing the risk of being sued.

Good risk management and timely planning of retirement should be the key to a successful and happy post-surgical life.

1. Richard L Rovit To everything there is a season and a time to every purpose: retirement and the neurosurgeon(2004) 100 J Neurosurg 1123–1129
2. Melbourne Symphony Orchestra. Personal communication
3. The Surgical Workforce 2005 Based on the 2005 Census of the Surgical Workforce http://www.surgeons.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTFILEID=19065 (accessed August 2008)

Thinking about retirement in the next 10 years? Two 'Building Towards Retirement' workshops are on offer on 2009. *See page two.*

Mike Sexton, Chair, Divisional Group of Rural Surgery

Representing rural surgeons - Where to from here?

The provision of surgical services to non-metropolitan areas has become an important issue politically both in Australia and New Zealand. It is important also for the College as there is a concern about our ability to train general surgeons with skills broad enough to equip them for practice outside of the subspecialties. There is also concern by on-call surgeons providing acute services that their increasingly narrow scopes of practice are making them uncomfortable at dealing with problems of a more general nature. This issue affects surgeons in both rural and metropolitan units.

The Divisional Group of Rural Surgery (DGRS) was established thanks to the dogged efforts of individual rural surgeons who were able to convince their colleagues that rural surgeons and their issues were important. The importance of rural surgical representation is recognised in that the Chair of DGRS is a co-opted Councilor.

In addition, there are projects that the College administers with Commonwealth funding through the Department of Health and Ageing that are part of the DGRS portfolio.

However, the DGRS box sits awkwardly within the College administrative structure, which in the latest iteration has DGRS reporting to the Fellowship Services Committee as part of the Professional Standards and Development Board. In addition, the DGRS Chair is a member of the Board of Regional Chairs.

The Provincial Surgeons of Australia (PSA) meeting was first held in 1965 and has met every year since then. It was set up as a scientific and collegial forum for rural Australian surgeon. The meeting saw many who were not Australasian College fellows and therefore not encouraged to take part in the College meetings. Its theme was based on a "fair dinkum, no bullshit" and "no one-upmanship" philosophy. Participants were encouraged to bare their souls and talk about their failures as well as their successes in a supportive forum which acknowledged surgery is a risky profession and we can all learn from each other. Over the past two or three years there has been a growing enthusiasm for aligning this rural forum more closely with the College.

> "DGRS and PSA were created out of the climate of their times and there has been a significant change since then ..."

DGRS and PSA were created out of the climate of the times and there has been a significant change since then, both in terms of political recognition, and in the way the College functions and relates to its Fellows and Specialties. The College continues to review its governance and organisational structure. It is always timely therefore for us to look to position rural surgeons for the future challenges as well.

Significant relationships have developed between the College and the Surgical Specialties in the Memoranda of Understanding and Service Agreements signed by the College and Specialist Societies. These define the functions of training and continuing education that the Societies have agreed to be responsible for.

After a shaky beginning General Surgeons Australia (GSA) has, this year, signed a service agreement with the College defining the training and education functions that it will be responsible for. This has brought it into line with the agreement that the New Zealand Association of General Surgeons (NZAGS) ratified some years ago. Is GSA the forum of the future for Australian rural general surgeons?

When NZAGS was created, its constitution entrenched the principles of the importance of being representative of metropolitan and non-metropolitan surgeons by building a balance of executive members and officeholders to reflect their backgrounds and practice. There are misconceptions amongst the target surgeons about who GSA actually represents but these can be overcome so that it may be regarded as an advocate for the rural general surgical community.

The DGRS does not exclusively represent general surgeons as other larger specialties have rural members who actively participate in both organisations. So should DGRS be retained as a "box" in the College structure or should the specialist societies ensure rural advocacy through their structures as NZAGS has done?

The PSA has provided an educational forum for rural surgeons and has acted as the meeting place to discuss broader issues. It has not itself had a political function. Perhaps the administrative, political and surgical training needs of rural surgeons could be best represented under the GSA umbrella. As GSA now has its own scientific meeting, PSA could retain its own so that the rural surgical flavour of the meeting is maintained and participation by the other specialties would not be lost.

Finally, what of the co-opted rural Councillor? Over recent years rural surgeons have shown their democratic maturity by electing rural nominees to Council as part of the College ballot. Assuming the next governing structure includes a widely representative group of surgeons including those nominated and voted in by their rural colleagues, then there seems little point in retaining a co-opted position.

The opinions in this article are individual to the author and do not reflect the policies of the organisations mentioned.

Medico Legal Committee update

A new course will offer surgeons increased capacity to supervise patients returning to work

Neil Berry, Chair, Medico Legal Committee

Dear Fellows

We remain in very challenging times both professionally and financially. The Executive will be meeting this month to consider the results of the recent survey of medico legal section members. My thanks to all those who responded and I would welcome any further views that any Fellow wants to put forward.

WorkSafe in Victoria and WorkCover in New South Wales are pushing for most medico legal assessments to be done by surgeons in clinical practice and this will have far-reaching implications for senior surgeons. If you are affected you should be in contact with your regional branch and local AMA. The executive will keep this under review.

Neil Berry, Chair, Medico Legal Committee

Occupational Medicine Bridging Course (Surgery)

Why are we considering offering this course?

A core value in surgical management is supervision of the recovery phase of injury and/or surgery to achieve the best outcome. This can be either a satisfactory return to full former activities or the best possible level that can be achieved.

In many cases the condition has been effectively treated once the course of conservative treatment or operation has been seen to be successful after several weeks. Sometimes later care can be managed by the referring GP or a physiotherapist without further specialist input, which is often important for time-poor surgeons.

However, in many cases there would likely be a very substantial benefit to patients for surgeons to be in a position to provide continuity of care to their return to work; rather than leave this to non surgeons and, in some cases, to chance.

Currently it seems that a perceived lack of surgeons' engagement/skills has resulted in surgical cases being managed by non-surgeons and assessment of work and accident injuries, which are often within the existing skill set of surgeons, are being referred/managed elsewhere.

Access to a suitable course to gain recognised relevant experience and training and increase skills and capacity to supervise return to work is becoming increasingly important.

The Course

- Modelled on the College of Occupational Medicine curriculum modified to target surgeons likely needs and interests.
- Designed to commence with the recognition of surgeons existing knowledge and to build on this.
- Will consist of a rolling series of worksite visits and lectures.
- Worksite visits to gain factory experience comprising factory tours, case discussion and in some cases lectures on specific factory and industry issues.
- Lectures on clinical, legal and industrial issues. In part this will be run by the Medico-legal section and also conjointly with other medical colleges and organisations.

The rolling series of events is proposed to provide a flexible structure to allow surgeons to take part in the program as time allows with the aim of covering the curriculum over time.

Participation in the course is always to be optional.

Key Questions

If you are interested in the workshop, we are currently asking Fellows the following questions:

1. Are you currently involved in the management of patients who are returning to work (Occupational Medicine)? ☐ Yes ☐ No

2. Would you be interested in attending a bridging course in Occupational Medicine designed specifically for surgeons?

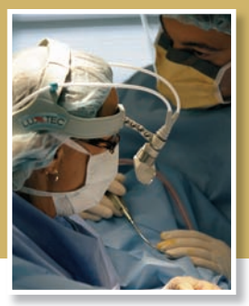
☐ Yes ☐ No ☐ Maybe

3. If yes, what content would you like included - ☐ Workplace Assessment ☐ Legal Issues ☐ Organ systems and disease groupings ☐ Assessment report writing ☐ Interactions with government & non-government organisations ☐ Rehabilitation processes in the workplace ☐ Other _____

We trust the course will be of interest and value to many surgeons.

If you wish to comment or express an interest in the course please contact the Professional Development Department on +61 3 9276 7473 or e-mail PDactivities@surgeons.org

Vascular Surgery



Realistic cadavers provide invaluable surgical training

Jeffrey Hamdorf
Director, Clinical Training & Education Centre

The innovation of highly realistic tissue handling has led to The University of Western Australia's Clinical Training and Education Centre (CTEC) raising the national benchmark for Australian vascular surgical training.

CTEC recently hosted surgical trainees and consultants from Singapore and across Australia in its inaugural Vascular Surgery: Anatomy of Advanced Approach Workshop. The two-day, hands-on workshop afforded participants the opportunity to learn new skills and practice performing complicated vascular exposures crucial for vascular surgical training.

The 10 participants had the privilege of receiving training using fresh frozen cadavers, a teaching model superior to embalmed cadavers because of their greater anatomical realism, near normal tissue properties and the opportunity for endoluminal access.

The workshop was aimed at specialist vascular surgery trainees and recently qualified consultants seeking familiarisation with lesser-used open vascular surgical approaches.

Workshop Convenors, Consultant Shirley Jansen of Sir Charles Gairdner Hospital and Associate Professor of Curtin University, said the ultimate aim was to improve surgical safety, operative confidence and operative efficiency in a way that could not be provided by routine surgical supervision or other simulated environments. It was based in CTEC's fully equipped Medical and Surgical Workshop.

"The use of fresh frozen cadavers in surgical training is a relatively new model in the practice of surgery," said Professor Jansen.

"It is much more representative of the human situation than the traditional formalin-fixed models surgeons used at medical school. In terms of tissue quality and integrity these models are much more similar to real life."

Professor Jansen said the rare presentation of the more unusual, complicated exposures meant some trainees and consultants gained invaluable grounding from training using realistic cadaveric models, rather than gaining that first experience with a difficult exposure on a live patient.

Associate Professor Jansen convened the course with the assistance of Anatomist Professor Paul McMenamin, Professor Paul Norman, Associate Professor Patrice Mwipatayi and Mr Marek Garbowski.

Vascular Surgery: Anatomy of Advanced Approach recently was approved for credit in the Royal Australasian College of Surgeons' Continuing Professional Development (CPD) Program. Participation in the workshop qualifies for 16 Category 4 credit points.

CTEC Director and Professor of Medical Education, Jeff Hamdorf, said he was pleased by the Colleges' recognition of this key learning activity.

"The innovative teaching model offered by this workshop continues a strong tradition of vascular surgery training in Western Australia," said Professor Hamdorf.

"I am confident that this workshop in future offerings will be highly popular amongst trainees and consultants in vascular surgery."

Professor Hamdorf said the success of the Vascular Surgery: Anatomy of Advanced Approach workshop paved the way for the development of future Advanced Approach courses, minimally invasive vascular courses and courses that utilised the fluoroscopic capabilities of CTEC's Medical and Surgical Workshop.

The workshop was made possible by the generous support of Covidien, Johnson & Johnson, St Jude Medical, WL Gore & Associates and Cook Australia.

For further information contact:-
Professor Jeffrey Hamdorf
MBBS, PhD, FRACS
Director, Clinical Training and Education Centre
The University of Western Australia
Tel: (08) 6488 8551
Fax: (08) 6488 8586

Notice to Retired Fellows of the College

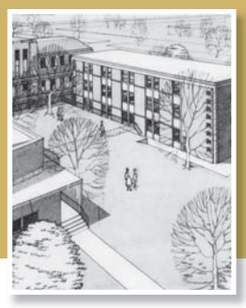
The College maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College.

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve.

We will acknowledge your donation and place your name on the gown, if you approve. **If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.**

Alternatively, you could mail the gown to Jennifer C/o the Conferences & Events Department, Royal Australasian College of Surgeons, College of Surgeons Gardens, 240 Spring Street, Melbourne 3000.

The College would like to acknowledge Mr Peter Harbison, FRACS on the generous donation of his academic gown



Landscape painting by Charles Bush

The landscape is painted in oil on board. The view depicted looks over the inlet and Painkalac Creek towards the Split Point lighthouse

Keith Mutimer,
Honorary Treasurer

The large landscape painting which is now hanging above the fireplace in the Library in Melbourne is the work of renowned Australian artist Charles Bush. It is a view of Airey's Inlet, a small seaside town on the Great Ocean Road, about 120km south-west of Melbourne.

Landscape painting by Charles Bush

Airey's Inlet is one of the oldest settlements on this part of the Victorian coast. It derives its name from John Airey, who took up a pastoral lease at Point Roadknight, slightly to the east, in 1839. In 1887 the area was subdivided into 100 building blocks, but because it was quite inaccessible by land, it remained largely undeveloped until the early 20th century. Timber getting was the main industry in the area at this time. Painkalac Creek, which flows through the inlet, derives its name from the language of the Wathaurong people, the words "paen" meaning "fresh water" and "killok" meaning "camping place".

Until the building of the first section of the Great Ocean Road (1920-24), Airey's Inlet was reached by travelling along the beach from Anglesea at low tide. With the construction of the Road, tourism began to grow, and eventually came to dominate the economy of the town. Since the 1950s, the town has been a favourite summer resort for Melbourne academics.

Charles Bush was born in the inner Melbourne suburb of Fitzroy on 23 November 1919. After attending high school in Coburg, he entered the National Gallery of Victoria art school in 1934 and studied under W.B. McInnes. He enlisted in 1940, and was appointed an official war artist from 1943 to 1946. In 1950 he won a British Council travel grant which enabled him to go on a study tour of Great Britain and Europe. A versatile and gifted artist, he won many prizes and awards throughout his career. He was equally at home in many genres of painting and drawing, but he excelled at portraits and landscapes. He died in Melbourne in November 1989.

The landscape is painted in oil on board. The view depicted looks over the inlet and Painkalac Creek towards the Split Point lighthouse, built in 1891. There is a yacht sailing on the inlet, and figures on the path in the middle distance. In the left foreground is a painter at an easel, probably Bush's longtime companion and fellow artist Phyl Waterhouse.

The picture is framed, and measures 105 x 136cm overall. It was probably painted in the early 1950s. A brass plaque attached to the frame records that it is the gift of W.E.A. Hughes-Jones, a member of the Court of Examiners from 1952 to 1962.

Written by Geoff Down

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Budget 2009

Keith Mutimer, Honorary Treasurer

The College Finances & Budget 2009

The Budget 2009 for the College was reviewed and approved at the October meeting of Council

In June 2009, the Council held a budget strategy meeting to review and approve the strategic initiatives for 2009. These initiatives formed the basis of the budget which determines the resource allocation to fund the activities of the College for 2009 year.

Key attributes in the budget process included:

- Identify new key activities to commence in 2009 year in line with the Strategic Plan 2008 – 2010.
- Consider a global perspective to ensure all activities are included.
- Enable all stakeholders adequate input into the budget process.
- Budget surplus - break even or small surplus of two per cent for College activities in accordance with the strategic plan.
- Minimal cross subsidisation between areas of activity where ever possible and cross subsidies must be apparent to Council.
- College Projects only undertaken if they fully cover all costs and only those deemed by Council to be strategically important will be allowed a "College subsidy"
- Complete College projects – 50 per cent of surpluses (after all direct costs and College overheads) are to be allocated to the Foundation for Surgery for ongoing commitment to International Projects and Surgical Research.
- Subscriptions to be increased by CPI forecast - 4.0 per cent in 2009.
- Determine Examination and Training fees and ensure all related activities are self funding.
- College infrastructure usage, including offices, to be maximised for the benefit of all Trainees and Fellows.
- Trainee activities - aim is to ensure that all educational expenditure is fully funded from Trainee's fees.
- Fellow related activities - aim to ensure all expenditure is fully funded from annual subscriptions.
- Inflation for 2009 has been at 4.0 per cent.

A costing model is used to identify direct costs of activities and to allocate the indirect costs of the Relationships and Resources Divisions to the operating Divisions of Education, Fellowship and Standards, External Affairs and Research, Audit and Academic Surgery.

The new Surgical Education and Training (SET) program is now established in 2009 after planning and developing the program for most of 2008.

The College operating and project activities continue to maintain a positive financial position and in 2009 will achieve a modest operating budget surplus of $558k (2008 – $307k). The surplus for 2009 is in line with the College strategic plan of achieving a two per cent operational surplus. Also in accordance with College policy, this surplus excludes any returns from the investment reserve or Foundation for Surgery, some of which are distributed as research grants and scholarships, as Council continues its policy of not relying on investment returns to fund operational or project activities.

The 2009 Budget continues to the ongoing investment in Fellows' services and educational and research activities whilst supporting the organisational structure and facilities necessary for our College to progress as the professional organisation responsible for surgical education and training in Australia and New Zealand.

College Activities in 2008

During the current year there has been considerable activity across the College operations including:

- Consolidation of the SET program.
- The College manages a diverse number of research, aid and audit projects with a total life contract value in excess of $49.8 million ($56.0 million). Project activities are funded by external agencies and funding providers with a minimal funding of $176k ($330k) from the College.
- Continued development and expansion of courses and workshops for surgical Trainees and continuing professional development for Fellows.
- Ongoing development of relationships with the Specialist Surgical Societies and Associations regarding surgical training for the SET program and the operation of the Service Agreements into 2009.
- Ongoing administration of training in conjunction with Specialist Societies.
- Support for the Trainee Association in line with prior years.
- Ongoing review of the International Medical Graduates (IMGs) assessment process, with emphasis on support for IMGs in Area of Need (AoN) positions
- Support for the Basic Surgical Training (BST) program through to 2010.
- Ongoing development of the College website – www.surgeons.org with a revised format and improved functionality.
- Commencement of new projects with the Commonwealth Government including Surgical Simulation Skills Program, Papua New Guinea Tertiary Health Service III, and continued development of the Surgical Morbidity and Mortality Audits, the Australian Timor Leste Program of Assistance for Specialist Services (ATLASS) and Colorectal Cancer Audit.

College Budget in 2009

The budget for 2009 was developed and included the following key points:

- The parameters for the budget strategy approved at the June 2008 meeting of Council to be incorporated into budget 2009.
- The budget would generate a modest operating surplus of for Category 1 activities

Total College Budget - 2009

	Budget 2008 $000's	Budget 2009 $000's	Increase / (Decrease) %
Revenue	36,573	43,822	19.8% ⬆
Expenditure	35,804	42,800	19.5% ⬆
Operating Surplus	769	1,023	32.9% ⬆
Transfer to Foundation/ Investment Reserve (non operating activities)	1,308	1,011	(22.7%) ⬇
Total Surplus	2,077	2,034	(2.1%) ⬇

in accordance with the strategic plan.
- Subscriptions to be increased by CPI of 4.1 per cent to $2,055 ($1,975).
- SET and Course fees will increase by an average of 5.1 per cent in order to minimise subsidies.
- Cross subsidisation of activities will be minimised or made apparent.
- The subsidy for projects administered by the College will be $176k ($330k).
- All new projects will not be subsidised unless strategically important.
- College investments are budgeted for a 10 per cent return (10 per cent) with an estimated return in 2008 of <5 per cent.
- The Treasurer's contingency has been increased to $250k ($125k) reflecting the difficult times predicted for 2009.
- The Investment reserve retains all unallocated investment returns for future College initiatives including supporting the College Foundation for Surgery.

College Activities by category

The activities of the College are categorised as follows:
- Category 1 – College Operations and includes the operational and administrative services for the Educational, Governance and Resource activities of the College.
- Category 2 – College Projects and includes College funded Research, Audit and Aid projects managed and administered by the College.
- Category 3 – Foundation and Investment Reserve and includes all activities relating to the Foundation for Surgery and the Investment Reserve.

Category 1 - In 2009 revenue for operational activities has increased by 8.3 per cent to $29,881k ($27,586k) while expenditure is estimated to increase by 7.6 per cent to $29,323k (27,263k). Overall this will result in a surplus for Category 1 activities of $558k ($323k).

Expenditure on category 1 activities will include:
- Staff Payroll and Oncosts – increase by 13.1 per cent to $11,079k ($9,799k) and includes an allowance for CPI increases of 4.0 per cent ($428k), net increase in new positions and increases for any internal and external salary reviews of $240k.
- New staff positions included in Budget 2009 are 2.4 FTE made up of:
  - Rural Management A/O – 1.0 FTE
  - SAT/SET Administration – 0.8 FTE
  - NZ Trainees A/O 0.6 ETF
- Consultants Fees – clinical - $413k – activities for clinical/medical support and assessments, usually provided by Fellows of the College.
- Travel & Accommodation - $3,187k ($3,361k) - increased activities in 2009, especially in Education activities offset by reallocation of travel of $225k for RACS visitors to Grants.
- Property maintenance - $1,054k ($ 942k) - maintenance and restoration program for College properties in 2009.
- RACS scientific visitors program - $307k ($265k). This is a benefit for all Fellows with many scientific visitors attending specialty society meetings.
- College Scholarships & Fellowships - $709k ($704k) – College funded scholarship program. This expenditure is in addition to scholarships funding of $793k ($732k) from bequest funds in category 3 for 2008. Overall scholarship funding (Cat 1 & Cat 3) totals $1,503k ($1,437k) or 4.6 per cent.
- A subsidy for College projects of $176k ($330k) is included in expenditure for a number of projects administered by the College. This subsidy represents the difference between the total indirect overheads incurred on the project and the amount which is allowed to be charged to the project in accordance with the contract.

Category 2 - Revenue for College project activities in 2009 has increased by 63.9 per cent to $12,603k ($7,689k) while expenditure is estimated to increase by 62.6 per cent to $12,526k ($7,705k). Overall this will result in a modest surplus for Category 2 activities of $77k (deficit of $16k).

Expenditure on category 2 activities will include:
- Staff Payroll and oncosts - $2,973k ($2,388k) as noted for category 1 expenditure reflecting increased project activity.
- Consultants Fees - Clinical - $1,275k ($827k) – relates to professional services from external consultants for clinical / medical support and assessments provided to the College projects.
- Travel & Accommodation - $2,261k ($1,715k) – increase in College activities in 2009 reflect these increases.

Category 3 - Revenue for all activities relating to the Foundation for Surgery and the Investment Reserve has decreased to $2,683k in 2009 ($3,130k). In 2009 the surplus will reduce due to decreased investment returns to $1,399k surplus ($1,770k).

Economic Conditions – 2008 and 2009

Council has approved the budget for 2009. However there was some concern regarding potential downside to the budget revenue and expenditure estimates in view of the current economic conditions. As such, management has been directed to consider the potential impact on College activities and associated revenue and costs and identify areas of potential reduction in or cancellation of activities and associated costs. The report will be presented to Council in February 2009. →

Budget 2009

Balance Sheet

As at 31 December 2009, it is estimated that the College Net Assets will be $50,352k ($48,318k). During the period, the Investment Reserve is budgeted to increase from $5,009k to $6,018k, reflecting investment return on funds not already committed to Research Scholarships and Grants or transferred to the Foundation for Surgery.

College Properties

The College owns properties in Adelaide, Brisbane, Melbourne and Sydney in Australia as well as Wellington in New Zealand. In Canberra, Hobart and Perth accommodation is leased for College offices.

The investment in and maintenance of these properties continues to be significant cost in 2009 given the heritage nature of these properties. Overall expenditure for 2009 will be $1,054k ($942k) as well as allowing for capital expenditure on properties of $3,130k ($1,074k).

In 2008 and into 2009, the maintenance programs will continue to ensure that all properties are maintained on a continuing basis up to an acceptable standard.

The "Stables Project" restoration works, in New South Wales, are continuing in accordance with the project timetable with an estimated completion by the end of October 2008 at an overall cost of $388k.

The College purchased the ANZCA share of the New Zealand property in May this year. The NZ office is currently reviewing the maintenance and refurbishment program for 2008 and 2009 with some additional funding incorporated in budget for 2009.

The planning for the Queensland Surgical Education and Communication Centre redevelopment on the Queensland property is progressing. At its meeting in February 2008 Council approved the project with a total overall project cost of $7.5 million (exc GST). The approved option is for a medium size project based on current future estimated requirements of the Queensland Committee. Total area is 1,085 sq metres with approximately 45 car spaces - basement and surface.

The 'design application" phase of the project will be completed and lodged for approval by early 2009. While awaiting approval, the Council will reassess the project timetable in light of the current economic circumstances.

After considering the redevelopment options for the West Wing, Council approved the Level 1 redevelopment project in February 2008 to meet additional accommodation for both College staff and a number of specialist societies as well as additional storage requirements for the College archives. The project cost estimated at $1,470k for construction and fit out and the costs to fit out offices for tenants will be fully recovered.

The ANZ debt related to the East Wing development will be paid out in 2009 however the facility will be renegotiated to accommodate funding for the approved capital works program in Queensland and Victoria.

In Closing

The College has achieved significant progress during 2008 in completing the key activities outlined in the Strategic Plan. The proposed initiatives for 2009, which I have outlined in my report, will ensure that the College continues to meet its challenges and progress in 2009.

I would like to thank my Deputy Treasurer, Mr Mike Hollands, for his continued support during 2008 and his oversight of property matters.

I would also like extend my warm thanks to the Honorary Advisers of the College, Mr Robert Milne, Mr Brian Randall, Mr Michael Randall, Mr Anthony Lewis and Mr Ken Welfare for their ongoing advice and support. Also the advice, excellent service and support from Mr Graham Hope, Investment Adviser, of Goldman Sachs J B Were have continued to benefit the College enormously.

The support provided by our Honorary Financial Advisers is exceptional and has been provided to us over many years. It is with regret that I note the passing of Mr Doug Oldfield OAM in August this year. Mr Oldfield joined the College as an honorary adviser in 1984 and attended countless meetings providing counsel and support to all. He will be greatly missed.

Also I would like to thank the Resources staff and the Director, Mr Ian Burke, for their commitment, support and hard work in assisting me in my role as Honorary Treasurer.

In these challenging times, the financial position of the College is sound and is a solid base for the coming budget.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
SUMMARY OF SUBSCRIPTIONS, EDUCATION & TRAINING and OTHER FEES for 2009

	2009 Fees		
SUBSCRIPTION & ENTRANCE FEES	**Exc. GST**	**Inc. Aus GST**	**Inc. NZ GST**
* **Annual Subscription - 2009** payable on 1 January 2009	$2,055.00	$2,260.50	$2,311.88
Fellowship Entrance Fee payable in full (10% discount applies) or over 5 years	$5,550.00	$6,105.00	$6,243.75
EDUCATION & TRAINING			
Surgical Training			
Administration Fee - exam pending and interruption	$645.00	$709.50	$725.63
* BST Annual Training Fee (Year 1,2,3 & 4)	$2,470.00	$2,470.00	$2,778.75
Selection Processing Fee - (Note 6)	$550.00	$605.00	$618.75
Selection Registration Fee	$365.00	$401.50	$410.63
* SET Training Fee	$5,100.00	$5,100.00	$5,737.50
Examinations			
Clinical Examination Fee	$1,665.00	$1,665.00	$1,873.13
Fellowship Examination Fee	$6,060.00	$6,060.00	$6,817.50
Generic Surgical Science Examination Fee	$2,915.00	$2,915.00	$3,279.38
Orthopaedic Principles & Basic Science Examination Fee	$1,460.00	$1,460.00	$1,642.50
Paediatric Anatomy and Pathology Examination Fee	$1,460.00	$1,460.00	$1,642.50
Plastic and Reconstructive Surgical Science & Principles Examination Fee	$1,460.00	$1,460.00	$1,642.50
Speciality Surgical Science Examination Fee	$1,460.00	$1,460.00	$1,642.50
Skills Courses - refer to note 4			
ASSET Course	$2,635.00	$2,898.50	$2,964.38
CCrISP Course	$2,205.00	$2,425.50	$2,480.63
CLEAR Course	$1,075.00	$1,182.50	$1,209.38
EMST Course - Provider	$2,205.00	$2,425.50	$2,480.63
EMST Course - Refresher	$1,410.00	$1,551.00	$1,586.25
PROFESSIONAL DEVELOPMENT WORKSHOPS & COURSES			
Beating Burnout	$225.45	$248.00	$253.63
Mastering Difficult Clinical Interactions	$669.09	$736.00	$752.73
Expert Witness	$826.36	$909.00	$929.66
From the Flight Deck	$875.45	$963.00	$984.88
Interviewer Training	$0.00	-	-
Making Meetings More Effective (New in 2009)	$450.00	$495.00	$506.25
Polishing Presentation Skills	$335.45	$369.00	$377.38
Practice Management for Practice Managers	$481.82	$530.00	$542.05
Risk Management - Mastering Professional Interactions	$307.27	$338.00	$345.68
Supervisor and Trainer Course (SAT SET)	$0.00	$0.00	$0.00
Risk Management Foundation	$462.73	$509.00	$520.57
Surgical Teachers Course (STC)	$229.09	$252.00	$257.73
Building Towards Retirement	$172.73	$190.00	$194.32
Writing Reports for Court	$680.00	$748.00	$765.00
Mastering Intercultural Communication	$229.09	$252.00	$257.73
Leadership in a Climate of Change	$1,790.00	$1,969.00	$2,013.75
Strategic Direction	$1,430.00	$1,573.00	$1,608.75
OTHER FEES			
Appeals Lodgement Fee	$5,200.00	$5,720.00	$5,850.00
Distance Learning (Exam Preparation) Fee	$500.00	$550.00	$562.50
International Medical Graduates			
Paper Based Assessment Fee	$4,160.00	$4,576.00	$4,680.00
Paper Based Assessment & Interview	$6,295.00	$6,924.50	$7,081.88
Supervision / Oversight Fee- onsite	$5,100.00	$5,610.00	$5,737.50
Supervision / Oversight Fee - remote	$14,560.00	$16,016.00	$16,380.00
MOPS - Maintenance of Professional Standards			
Australia & New Zealand	$1,645.00	$1,809.50	$1,850.63
Occupational Training Visas	$800.00	$880.00	$900.00

Notes
1 All fees are payable in either Australian or New Zealand Dollars as invoiced. **2** All New Zealand fees, including Examinations undertaken in New Zealand, are subject to the Goods & Services tax of 12.5 per cent. **3** All Australian Fees will be subject to GST of 10 per cent except approved Education courses. **4** Examination & training fees have been approved by the Australian Taxation Office as GST free for all courses relating to the awarding of the RACS Fellowship. **5** Subscriptions and Fees marked within asterisk (*) may be paid to the College by four equal instalments during the year by AMEX, Visa or MasterCard credit cards only. Further details will be made available when fees are raised. **6** Fee is charged for selection by General Surgeons Aust & NZ, Paediatric, Otolaryngology, Vascular, and Plastic Surgery Aust & NZ. Other specialty programs will publish their own selection processing fees

What has happened to the College Investment portfolio?

Since late last year the performance and value of the College portfolio has continued to deteriorate in adverse market conditions.

The overall value of the portfolio has decreased marginally from $35.4 million at the beginning of the year to $33.8 million at 30 September 2008.

The portfolio consists of $26.2 m of committed funds and $7.6m of uncommitted funds. The committed funds relate primarily to the Foundation, including bequests, of $17.0m, research projects of $5.1m and funds held on behalf of societies of $5.1m. The uncommitted funds relate to working capital and cash held for investment purposes.

Performance

Over the past three to four years, the College portfolio has performed well and achieved returns above the benchmarks in each period even now in the 'down' market condition the returns continue to exceed the index.

In the full 12 months to 31 December 2007 the total portfolio returned 17.03 per cent compared with the benchmark of 11.52 per cent. This compares with the result for the nine months to 30 September 2007 of 24.46 per cent (benchmark 20.53 per cent).

The cash and fixed interest components of the portfolio, as well as the working capital account, have increased and currently represents around 35 per cent of total investments. These funds will be reinvested in equities when the outlook becomes clearer. Meanwhile, the rising trend in cash and fixed interest rates is enabling a return of seven per cent + on these funds to be achieved.

In 2008, to the end of September, the total portfolio had a negative return of (16.70 per cent) which was favourable to the benchmark indices for the portfolio.

Whilst the returns for 2008 and into 2009 are less than optimal, it should be noted that over five years from 2002 to 2007 returns have averaged 17.75 per cent from the portfolio.

Impact on College Operations.

The activities of the College are now split in to three distinct areas

- Category 1 – Core College business and administration.
- Category 2 – Externally Funded Projects
- Category 3 – Scholarships from Bequests, Investment Income and the Foundation for Surgery.

As the majority of investment funds are held for category 3 purposes, any diminution in returns and capital values does not impact materially on the business and administration of the College.

The activities in category 1 are funded by revenue from Fellows subscriptions, Trainees training and examination fees and Course fees from Trainees and external participants to College courses and workshops.

Market Direction & Economic Outlook

In June 2008 the market was predicted to improve to around 5900 by 31 December 2008 by analysts at the leading broking houses. However recent turmoil on US and the overall global market has made these estimates unachievable and revised estimates now see a market at 4525 by December 2008 rising to 5350 by December 2009.

Events over the next few weeks may provide a clearer picture as to the future direction.

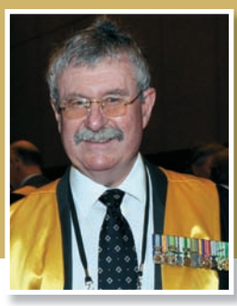
In the meantime, the College will retain a significant holding in cash and fixed interest securities.

Outlook for 2008 and beyond.

The Investment Committee has tended to be conservative in predicting returns looking forward.

However, it is estimated that if predictions, noted above, are correct the portfolio will achieve an overall return of zero to (five per cent) for the 2008 year and for the annual budget in 2009 a return of 10 per cent is considered achievable.

Weary Dunlop



A bridge too far? – Never!

The second half of the Weary Dunlop Oration from the Hong Kong Conjoint ASC 2008

Robert Atkinson

At the same time as Weary was in the camps, the 100th Division of the United States Army was recruited. This was a Japanese Division with recruits from Hawaii and California whose families were placed behind barbed wire. In South Australia we did the same thing in the First World War, placing our German ancestor's families behind barbed wire while their sons went off to fight Germany in Europe. All part of the immigrant democratic diaspora as we struggled to maintain our communities against the rigidities and complexities of the "old world".

The 100th Division, the Japanese division of the United States Army, was not used in the Pacific for obvious reasons but was in fact used in Europe. This was the most decorated division in the United States Army in the Second World War. What was going on? The Japanese-Americans were proving they were good citizens.

So the Japanese were no different to any other human being, and it was a system that produced the worst in human behaviour. In the end Weary recognised this, so after the war he possibly began his best work in the strategic sense given his enormous experience as a surgeon prisoner of war. He built bridges at a post-war time when nobody really wanted to know about the rest of the world, let alone the ex-enemy.

There is a Churchillian statement: "To be resolute in defeat and magnanimous in victory." This was not new, as seen in the American Civil War. There was a charge named Chamberlain's Charge at the First Battle of Gettysburg. At the end of the day the Union troops, basically being out-manoeuvred in one end of the line, and Chamberlain charged, as a Union Officer with his troops, basically out of ammunition, and stopped with sudden force from the turning of the Union line. He changed the tide of battle in that one instance. Chamberlain was a teacher who volunteered and went on to become a Brigadier-General in the Union Force. At the end of hostilities the Southern troops marched and surrendered to him. When they were about to lay down their swords, weapons and flags. He refused this, and allowed them to march forth with their weapons, with their bayonets, with their swords and their flags flying. He recognised this was a time for healing, to build the bridges between enemies and move forward.

Weary and his former Korean guard at Hintok Mountain camp on the Burma railway

People like this, like Weary, who should be immersed in hatred, see things differently and take us places that we should go. To build on Weary's work is certainly a challenge, and in the end reconciliation prior to war, settling differences without the killing, would seem to be the legacy. In other words, preventative action.

How do we reconcile differences?

Probably the worst activity the human race does is go to war, and in fact given the weapons available today it is probably the only thing apart from a massive disaster, such as the comet that killed the dinosaurs, that is likely to kill off the human race as we know it today. You might argue there, but there are some very strong drives to reconciliation based on the concept of "mutually assured destruction". MAD!

For those who are locked in their beliefs to such a degree and cannot see anything more than their supremacy of these beliefs do not seem to care about this destruction. This is tricky but needs to be recognised to enable preventative action. We need to open every avenue of communication to reconcile our differences. Another Churchillian statement: "It is better to jaw jaw than to war war."

A French philosopher once said: "When trade stops the soldiers follow." Every peaceable bridge that is built helps a little and the pragmatism and acknowledgement of the spiritual dimension of the human person needs encouragement, and certainly that pragmatism has been my experience in Asia.

In the Vietnam War we would go to a village which would have a shrine with the Buddha in the middle. Another village may have a shrine with a picture of the Pope in the middle. To my mind it went like this, when the soldiers turned and said what religion are you, the people said, "What would you like us to be?" The recognition of each other's spirituality with pragmatism to avoid conflict would almost seem to be fundamental to any religion. I mention Confucianism but Taoism is also a deep Chinese philosophy that to my mind almost seems environmentally-friendly formal Confucianism, and the world seems to be struggling towards seeking a balance. At the extremes of religion the balance is unhinged. Bridges need to be built here.

The Medical Model

So if we consider war to be the worst social disease left, its symptoms, signs and special tests could be developed, although when the killing starts the diagnosis is easy. The pathology of war is history and therein lays knowledge. But how do we treat war? And particularly, how do we prevent war?

Given Weary's experience it would be remiss of me not to explore bridge building prior to war and not after. War is the result of small steps leading to bigger steps – the path to escalation. Surgeons have commonality, as do all health carers, in that we share ethics and a desire to treat our patients. For we are an international family in many ways, embedded in each Nation, acknowledging the College as unique, incorporating Australia and New Zealand. Surgeons are one group that overarches the world, and of course the United Nations is penultimate group. The United Nations Charter is a wonderful document and a challenge to what could be, if we follow it, as a forum for debate, communication and reconciliation, with success and failures. There was a failure in Korea in the '50s when Australia and other nations were at war with the Peoples Republic of China.

Colonel Don Beard, an eminent military surgeon, was with 3 Battalion, my old battalion I might say, at the Battle of Kapyong. Many years later Don caught up with a Chinese surgeon who was on the opposite side. They discovered much in common and a firm bridge was built.

But returning to the UN. Could we combine the universality of medicine under the banner of the UN to provide preventative action? For example, if there was a standing UN Medical Force that was able to respond within 12 hours to a disaster, what could this achieve? As all nations have signed up to the UN, then all it requires is the Security Council to say "go" and they could go. The Peoples Republic of China is a permanent member of the UN Security Council. When there is a disaster, like the Tsunami, then the victims who need help do not care who turns up and what uniform they wear, as long as somebody comes and helps. Twelve hours is the watershed as people who could be saved will die after that.

National governments have sensitivities and thus another country's uniform on the ground in your country is, in theory, an act of war. If the United Nations Security Council gives the green light and the blue helmet is worn then the international law is obeyed and this is not an act of war but an act of aid.

In recent times the Minister of Defence in Malaysia has spoken of such a structure. Could this structure be used to prevent escalation along the path to war? Possibly, yes.

Although in Weary's day medical officers were unarmed, these days that is not so. A uniformed Health Officer carries a weapon under international humanitarian law, which enables them to defend their person and their patients from harm. The law is silent on the type of weapon and thus you could facetiously argue one could carry a nuclear bomb as long as the intent was to protect one's person and patients. Technology could be advantageous.

There is thus an opportunity to produce a United Nations Hospital and Medical Sanctuary protected by legitimate and lethal force. Could this have been effective in Rwanda and East Timor or even in Darfur today? A bridge that has not been built yet. What about non-government organisations, some of which have been sponsored by Weary including Fellowships. They are powerful bodies building bridges, but they can also be part of the problem. When an NGO group turns up in a country the warlord says "Go over here and treat these people and feed them." You might say "What about these other people over here?" And the war lord says, "Don't go there." So food and aid can become a weapon, this is well documented.

When a UN force turns up, even medical, with legitimate and lethal weapons under international humanitarian law, and indicates their plan, the warlord complies. This brings to mind the writings of Sun Tzu in *The Art of War,* noting it is a mind game. Certainly you need the equipment to wage war but in the end the moral ascendancy over your enemy is the key to not only winning the war but winning the peace, which is just as challenging if not more so! Maybe "war on war" gains that moral ascendancy.

Now, a multi-national medical force under the United Nations, armed appropriately, with the intent to obey international humanitarian law would seem an opportunity to build another bridge that leads us to an immediate response to both natural and man-made disasters. Given there are six-billion-plus people on this Earth and given our fragility of climate, it would seem the need has never been greater.

I think Weary would love to command a force such as this because it takes all of what he stood for from his developing years, his surgical training, his military commitment and his moral ascendancy with a sense of righteous mischief to take us forward on Auden's quote: ...

"A clock strikes,
And all sway forward on the dangerous flood,
Of history, that no one sleeps or dies,
And held for a moment, burns the hand."

I leave you with that as the debt and future challenge and would like to now finish with a small anecdote of Weary's life. We know that he was not easy. He was good with his fists. Good with his hands in surgery, good with his brain in many areas, and apparently his drinking habits were legendary, matched only by his ability behind the wheel of a car.

He had the state funeral he did not want in Melbourne. The members of his family approached the organisers and said they would like to stop the procession at this place at this time for a certain length of time. The organisers were aghast as this had been arranged to the last minute but said, "Seeing as you are family we will do this but could you please tell us why?" Weary's son said, "We think that Dad would like to stop the traffic in this place one last time." Stopping the traffic of war by building bridges between us should be Weary's legacy.

Thank you.

Acknowledgements

1. Dunlop, E.E (Ernest Edward) 1907-1993 *The War Diaries of Weary Dunlop*
2. Ebury, Sue. *Weary: The Life of Sir Edward Dunlop*
3. Gavin McCormack and Hank Nelson 1993 *The Burma-Thailand Railway: Memory and History*
4. COL Peter Byrne AM, RFD, ED, RAAMC
5. COL David Kings RAAMC
6. PROF Mobo Gao Professor of Chinese Studies, University of Adelaide
7. The Role of Defence Health in Military Operations Other than War – A Research Proposal, BRIG Rob Atkinson *Australian Defence Force Journal*, May/June 2002, No 154

Religious services at the Annual Scientific Congress

A multi-faith service is needed

I was disappointed to learn that the College has decided not to include a religious service in its ASCs ("Changing our religious profile" by Sam Mellick in Vol: 9 No: 6 *Surgical News*).

Although I am unable to attend ASCs now through physical disabilities, I used to attend and enjoy these highlights, particularly the one in Wellington NZ, during which there was a mild earthquake; the Bishop had the congregation move to the side under the collonade whilst he and his retinue hot-footed it down the aisle and outside! (The service had finished.)

Jokes aside, we should be aware that many of the values and principles which we, as surgeons, should follow are the result of the teachings in the New Testament and elsewhere. These are highly relevant even if one does not accept the tenets of any particular religion. The multifaith service, is, of course, the way to go and I am disappointed to find that no member of the Council attended this service in Hong Kong. If the Council supported and attended these services and a well-known, hopefully liberal, speaker were chosen, I have no doubt they would be better attended.

I thoroughly agree with Sam Mellick deploring of this move.

Kevin B. Orr
NSW, Australia

In Memoriam

Information about deceased Fellows

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

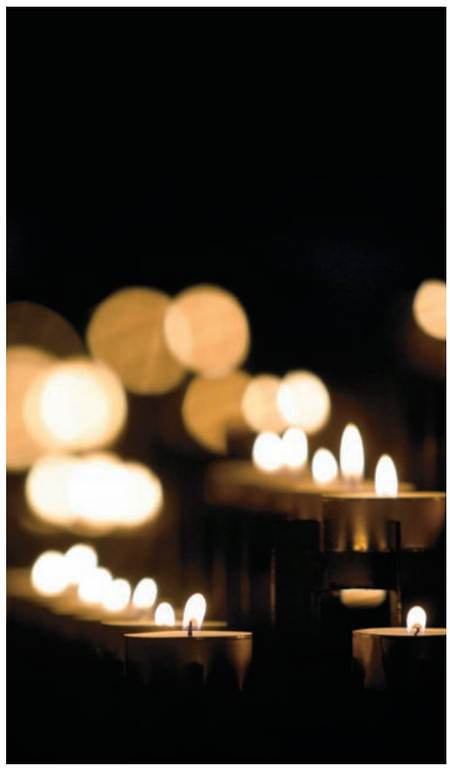
Desmond Albert Cooper, TAS
Andrew Zygmunt Jed, NSW
Gordon Kerridge, NSW
Sir Robert Shields, UK

We would like to notify readers that it is not the practice of Surgical News to publish obituaries. Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website
http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/Inmemoriam/default.htm

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	TAS	dianne.cornish@surgeons.org
NSW	beverley.lindley@surgeons.org	VIC	denice.spence@surgeons.org
NZ	justine.peterson@surgeons.org	WA	penny.anderson@surgeons.org
QLD	david.watson@surgeons.org	NT	college.nt@surgeons.org
SA	daniela.giordano@surgeons.org		



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College Awards

Congratulations on your achievements

Mr Tony Hardy – RACS Medal

Mr Tony Hardy has been awarded the RACS Medal in recognition of his dedicated contributions to the College.

Tony graduated MBChB in 1968 and then worked as a House Surgeon in Dunedin followed by an appointment as an Anatomy Demonstrator in the Otago Medical School. He then worked as a Surgical Registrar in Dunedin gaining the FRACS in 1973.

Tony was appointed as an orthopaedic position in the Auckland Hospitals where he has worked ever since with the exception of a year at the Princess Margaret Rose Hospital in Edinburgh in 1975. Tony was a tutor specialist in Auckland from 1977-79 and then was appointed in 1980 as a Visiting Surgeon to Auckland Hospital and in 1990 as Clinical Director of the Orthopaedic Department.

In 1982 Tony was awarded the ABC Travelling Fellowship to the USA and Canada.

Tony Hardy has been a long-term contributor to orthopaedics in New Zealand. He has served as Secretary and then Chair of the Auckland Orthopaedic Society. He was a member of the Executive of the NZ Orthopaedic Association followed by Vice-President and then President of that association.

Tony's significant involvement with College affairs began with his appointment to the Court of Examiners in 1992. He has subsequently been an elected member of the NZ National Board and the College Council representing orthopaedic surgery in both Australia and New Zealand. He has made a notable contribution to the NZ National Board through his excellent, succinct reports on council meetings.

Tony Hardy has been acknowledged as a skilful and wise clinician and has been a consistent and effective member of both the National Board and the College Council. His many contributions to the College are recognised through this award of the RACS Medal.

Citation kindly provided by John Simpson FRACS

Dr William Conolly – Award for Excellence to Surgery

Dr William Conolly has received the Award for Excellence in Surgery for his contribution and services to hand surgery.

William Bruce Conolly graduated from Sydney University in 1959. He completed his residency at Royal Prince Alfred Hospital and after obtaining the primary FRACS during 1961, a year in which he demonstrated Anatomy at Sydney University, he travelled to the UK to undertake training in General Surgery. He obtained the FRCS(England) in 1963 and the FRACS in 1965. He first came to Sydney Hospital as the Senior Surgical Registrar in 1965 and after two years took up a Research Fellowship and Assistant Professorship of Surgery, University of California. Bruce was involved in much of the basic research into wound healing in 1967-1968 and was greatly influenced by his mentors Professor Dunphy and Dr Eugene Kilgore, from whom his interest in Hand Surgery grew. In 1969, after completing a Hand Surgery Fellowship with Dr Robert Carroll in New York, Bruce returned to set up practice in Sydney and was appointed Honorary Surgeon at Sydney Hospital and St Luke's Hospital.

Over the next 10 years his expertise in and passion for hand surgery saw him reluctantly curtail his general surgery practice and by 1979 he had established the Sydney Hospital Hand Unit and was the major driving force that has seen that unit grow to its pre-eminent position in Australia. He was the Director of this unit from its inception until 1995 and continues as a part-time staff specialist in his present position as conjoint Associate Professor of Hand Surgery for the Universities of Sydney and NSW. He is the double recipient of the Archie Telfer Prize for outstanding service, nationally and internationally, for Sydney Hospital.

In 1986 he divided his practice between his wife Joyce's beloved Ireland and Sydney and in the next two years also spent time as a Visiting Hand Surgeon and Director of Hand Unit, IBN Al Bitar Hospital, Baghdad, Iraq.

Dr Conolly was a major influence on the concurrent development of the St Luke's Hospital Hand Unit from 1987 and the Director from 1997 until 2002. Since then he has intensified his interests in the development of overseas Hand Surgery Projects in Vietnam, Myanmar and Laos and is the present Director of Overseas Projects, St Luke's and Sydney Hospitals.

He is a member and past president of the Australian Hand Surgery Society, a member of the Hand Societies of UK, USA, South Africa and North Vietnam and a corresponding member of the Japanese Hand Society. In 2007 he was acknowledged as a "Pioneer in Hand Surgery" by the International Federation of Societies of Surgery of the Hand.

Bruce has authored or co-authored seven books on hand surgery and rehabilitation. He has contributed to many texts and has over 70 journal publications on Hand Surgery, Trauma and Wound Healing. He has been the Guest Professor of the South African, Japanese and numerous European and US Hand Societies.

In 1994 Bruce was awarded the AM for his services to Hand Surgery. In 1999 he was the recipient of the Paul Harris Fellowship, an international Rotary Award, for his work on overseas Hand Projects and was confirmed as the Variety Club's 2002 Humanitarian of the Year.

Citation kindly provided by Ian Isaacs FRACS

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