THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL NEWS

Vol:9 No:9 October 2008

October Highlights:

PAGE 10 MEDICO LEGAL NEWS

"At present the committee is seeking to ascertain what CPD activities fit in best with current practice."

PAGE 18 SEXUAL HARASSMENT

"Too often the response to sexual harassment is to be dismissive or to reframe the person who reports sexual harassment as a stirrer or a trouble maker."

PAGE 38 OLD CHINA HANDS

China is a vast country, profoundly varied in its history, its ethnicity and prosperity.

Car racing's close links to surgery, page 44

The College of Surgeons of Australia and New Zealand

2008 Professional Development Calendar

RISK MANAGEMENT
Mastering Consent

DATE: Saturday 8 November 2008
WHERE: Royal Australasian College of Surgeons, Melbourne (VIC)
CPD: 7 points Category 7

Run by the Cognitive Institute and Dr Peter Henderson (Avant Mutual Group), the workshop challenges surgeons to listen, reflect and identify techniques to confirm patient understanding of surgical procedures. Utilising presentations, case studies and group discussions, the workshop will help you to give clear and easily understood information to your patients and assist in decreasing your risk of litigation.

VIC

- 24 Oct SAT SET, Traralgon (Victorian ASM)
- 24 Oct Mastering Intercultural Communication, Traralgon
- 8 Nov Risk Management Foundation: Informed Consent, Melbourne

TAS

- 14 Oct SAT SET Hobart (Orthopaedics)

NZ

- 16 Oct SAT SET, Palmerston North

2009 Provisional Dates (January– May)

Did you miss out on our workshops in 2008? Don't worry! In 2009 the College has got more exciting new workshops for you. Simply reserve a spot by filling out the Expression of Interest form and we will be in touch about your registration early in 2009.

NEW! PRACTICE MADE PERFECT: SUCCESSFUL PRINCIPLES FOR PRACTICE MANAGEMENT

This new whole day workshop focuses on the six principles of running a surgical practice. Practice managers and practice staff are encouraged to join these workshops for a valuable learning experience. Fellows are also welcome to attend.

NEW! MAKING MEETINGS MORE EFFECTIVE

This whole day workshop will focus on the role and responsibilities of the Chair and members of committee and how to have more productive meetings. It explores the ten principles for effective meeting and the roles and rights of individual committee members. You will improve your skills for chairing outside and inside meetings as well as develop strategies for gaining consensus. This workshop is a 'must' for anyone who sirs on a committee or a board.

SURGICAL TEACHERS COURSE

Are you interesting in learning more about assessing and managing surgical trainees? Do you want to know some of the most useful teaching methods in the operating room? The course, consisting of two and a half days of challenging and interactive activities, enhances the educational skills of surgeons responsible for the teaching and assessment of surgical trainees. The course is open to Fellows and final year trainees.

QLD

- 19-21 Mar Surgical Teachers Course, Brisbane
- 25 Mar Interviewer Training*, Brisbane
- 2-4 May Younger Fellows Forum, Brisbane
- 5 May Writing Reports For Court, Brisbane
- 5 May SAT SET (ASC)

NSW

- 7 Feb SAT SET Facilitator, Sydney
- 26 Feb Polishing Presentation Skills, Sydney
- 1 Apr Interviewer Training, Sydney
- 29 Jul Mastering Intercultural Interactions, Sydney
- 30 Jul 1 Aug – Surgical Teachers Course, Canberra

SA

- 4 Mar Beating Burnout, Adelaide

VIC

- 2 Apr Mastering Intercultural Interactions, Melbourne
- 29 Apr Interviewer Training, Melbourne
- 6-7 Mar From the Flight Deck, Melbourne

NZ

- 17-19 Sept Surgical Teachers Course, Auckland

*Participants must be nominated by specialties for Interviewer Training

**Supervisor and Trainer for SET Courses (SAT SET)

FURTHER INFORMATION

Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org select the Fellowship and Standards menu, click on Professional Development then 'Workshops and Courses'.

Easy online registration is available for all workshops.

President's Perspective

Ian Gough, President

Professionalism and our culture – ongoing codification and challenges

The medical profession has centuries of tradition in providing care and support to the community. Much of this has been based on altruism and the highest of ideals. Our philanthropic work is lauded and desired. However, the culture of medicine and surgery is no longer a homogeneous blend. The imperfections that are seen in society, in the system and occasionally in ourselves are producing a world of increasing regulation and codification to capture the best and legislate out the worst. Some of this is worthwhile but other efforts are often only a thinly veiled removal of professional autonomy.

National Patient Charter and surgical competence and performance

The National Charter was endorsed by the Australian Health Ministers on 22 July 2008. This applies to all designated health services so is beyond the traditional hospital sector and is also applicable in all states and territories. It prescribes minimum standards of rights, expectations and entitlements for patients that are broad and would be acknowledged by all of us. The seven rights are:

1. Access to public health care.
2. Patients are entitled to receive safe and high quality care.
3. Patients are entitled to be shown respect, dignity and consideration.
4. Communication to patients needs to provide information about services, options and costs.
5. Patients have a right to participation in informed decision making.
6. Patients have a right to privacy and their personal health information being kept confidential and secure.
7. Patients are entitled to comment on their own care and have their concerns addressed properly and promptly.

I think all Fellows and Trainees would "sign up" to these principles but it is the ongoing daily interpretation and implementation that is vital. Some surgeons who were trained in a more hierarchical society and health sector than what is evident today might need to re-think approaches that may have been acceptable some decades ago. Over the past month the College has circulated the RACS Competence and Performance booklet, which is a really valuable starting off point for your internal reflections and discussion with colleagues.[1] The booklet speaks to all of the issues within the charter and gives examples and understanding to many of our competencies as well.

Codes of conduct and interaction with industry

The Australian Medical Council is now compiling a Code of Conduct. Many of these already exist with the College having published its own several years ago.[2] Groups like the General Medical Council of the United Kingdom and the American Orthopaedic Association are also substantially advancing the expectations of what these documents cover. The College is contributing to this development but it is distinctly a sign of society's expectations that what we are expected to do and not do will be increasingly profiled.

The College is actively reviewing our own Code and focusing at the moment on the interaction of health with industry. Surgeons have traditionally been worried about the impact of the pharmaceutical industry on the use of medications in clinical practice. Many surgeons have expressed concern about the increasing use of very expensive therapeutic agents, which seem to be closely associated with particularly profiled clinicians. However, there is also an increasing focus on the surgical arena and the use of prosthetics or surgical equipment. The health sector needs the support of industry. This has been active for many years but it will be very important that the association is at arms' lengths and is not seen to be influencing clinical choice.

Raising the profile and our own expectations of professional behaviour

Many Fellows would identify with a culture that existed when they were being trained of aversive teaching methods including public belittlement or humiliation, as well as occasions of physical and sexual abuse, racial or ethnic discrimination. It is a sad history that confirms that this has been part of medical education that has traditionally been seen as male-dominated, hierarchical and resistant to change. Harassment and in particular sexual harassment may well have its roots in such a culture.[3,4]

Rates of harassment in the health sector are variably reported between 18 – 60 per cent. A paper in the September issue of the *New Zealand Medical Journal* reported that 50 per cent of junior doctors at Auckland Hospital had experienced bullying, mostly from medical consultants and nurses. However, this is not an issue only of the health sector with recent human resource literature revealing the complexity and the ongoing search for solutions to this.[5]

The College does not directly employ either our Fellows or Trainees and if these issues are occurring then the local human resources and occupational health and safety issues of the employer apply. However, the College does have an obligation to better define the norms of our professional behaviour. To assist this, the College will be regularly profiling articles on these issues in *Surgical News*. I encourage your ongoing participation in this discussion as we move to address this significant cultural issue. →

College engagement in South-East Asia

One of the key areas of our new strategic plan is to improve our interaction with South-East Asia. Consequently, the President and other senior councillors will continue to support, by our attendance at meetings in places like Thailand, Malaysia, Papua New Guinea, Fiji, Philippines and China. Surgical outreach is a substantial service provided by surgeons but it is important to understand that our focus is now on building capacity. At a recent meeting I attended in Papua New Guinea presentations emphasised the ongoing importance of ensuring the ownership by the recipient country and mutual accountability. In countries where per capita income is very low and families need to pay for education and health requirements the choice is often not to access a health service or educate a child. AusAID is now being directed to the three major areas of health, education and infrastructure and requirements that the funds are being spent where they are needed. In developing countries the government needs to be actively involved to ensure the coordination of the various groups and funders for the benefit of the community's health. Our growing commitment is to assist the development of capacity in the countries where we are involved. That is the only long term solution that will see these important neighbours sustainably improve the health of their populations.

In countries where per capita income is very low and families need to pay for education and health requirements the choice is often not to access a health service or educate a child.

1. *Surgical Competence and Performance*. 2008, Royal Australasian College of Surgeons: Melbourne.
2. *Royal Australasian College of Surgeons. Code of Conduct*. 2006, Royal Australasian College of Surgeons: Melbourne.
3. Neville, A.J., *In the age of professionalism, student harassment is alive and well*. Medical Education, 2008(42): p. 447-448.
4. Rademakers, J., et al., *Sexual harassment during clinical clerkships in Dutch medical schools*. Medical Education, 2008(42): p. 452-458.
5. McDonald, P., S. Backstrom, and K. Dear, *Reporting Sexual Harassment: Claims and Remedies*. Asia Pacific Journal of Human Resources, 2008(46 (2)): p. 173- 195.
6. Scott, J., Blanshard C., Child S., *Workplacebullying of junior doctors: cross-sectional questionnaire survey*. New Zealand Medical Journal, 19th Septmber 2008.

*The 2009 College diary is in this month's *Surgical News**

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

Letters to the editor should be sent to:
letters.editor@surgeons.org

or The Editor, Surgical News,
Royal Australasian College of Surgeons,
Spring Street, Melbourne Victoria 3000.

Tel:+61 3 9249 1200; fax: +61 3 9249 1219;
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Managing the transition to digital diagnostic imaging

Ian Dickinson, Vice-President

The Australian healthcare system is currently experiencing a fundamental change in the way diagnostic images are produced and transmitted, with a transition from diagnostic images exposed or printed onto film to images produced and transmitted digitally. This change is occurring both in the public health system in hospital imaging departments and in private imaging practices. It is being driven by the potential productivity improvements that are achievable with digital imaging, as well as imaging technology advances which continue to improve and speed up diagnosis.

The College has played a leading role over the past 12 months to address the transition to digital imaging and to ensure the best healthcare outcomes can be achieved for our patients.

In December 2007 the College wrote to the Hon Nicola Roxon, Australian Federal Minister for Health and Ageing, on behalf of the College's Fellows, our Specialty Societies, the Royal Australasian College of Physicians and its Specialty Societies raising concerns about the transition process. Concerns included the reduced capacity of specialists to access and read images from compact disc, reduced access to suitable computer hardware and incompatible software. The correspondence also expressed concern regarding the increasing instances of radiologists providing a report only (without film or digital image) as part of diagnostic imaging services.

The Commonwealth government subsequently released a discussion paper on managing the transition to digital imaging in February 2008, which received responses from 33 stakeholders, including a detailed response from the College.

As Vice-President, I convened a Digital Diagnostic Imaging Forum in June 2008 to bring together the key stakeholders to discuss managing the transition. The meeting involved representatives from a number of surgical specialist societies, medical colleges, interested professional groups and the Commonwealth Department of Health and Ageing. The meeting resulted in the development of a consensus statement (below) and recommended the establishment of an ongoing working party to monitor progress on the transition to digital imaging and ensure clinician input.

Mr Bernie Bourke, vascular surgeon, is the Chair of the Digital Imaging Working Party, which met for the first time in September 2008. Members include representatives from the College, Royal Australian and New Zealand College of Radiologists, Australian Diagnostic Imaging Association, Australian Medical Association, the Spine Society Australia and the Australian Orthopaedic Association.

The working party will establish and review guidelines on digital imaging and advise clinicians, hospitals and governments on current and changing minimum standards. By collaborating with our specialist peers in this forum, I believe we will achieve a consensus on minimum standards for digital diagnostic imaging.

We will work together, so that the transition leads to the expected better outcomes both during the transition and also when the transition has occurred, and digital imaging has become both the standard form of performing radiology and also accessing the images by the clinicians. →

Census 2008 Update

This year's census of all Active and Retired Fellows in Australia and New Zealand will be distributed in October of this year.

As you know, data from the census will be used to identify areas of concern to our members, and to identify issues that can be used by the College to advocate on your behalf for better processes and conditions.

New Format

The College only undertakes a census every two to three years. In this year's census important changes to the format have been made following a number of consultative rounds with Fellows and advice from a specialist in survey methodology. These changes include the following:

- **Completion time only eight to 15 minutes:** This depends on the amount of detail Fellows may wish to make in comment boxes.
- **Workload and Related Questions:** Workload questions will address all facets of a Fellow's range of work, not only surgery, and there will be questions addressing issues that affect each Fellow's ability to work effectively.
- **Format:** Fellows will be given the opportunity to respond in either an electronic or hardcopy format, and there will be several comment boxes for confidential disclosure of issues.
- **Confidentiality:** Full confidentiality is guaranteed.

Incentives

In order to encourage early responses, an incentive program is being put in place which will include high quality gifts for the first Fellows to respond to the census. I look forward to your participation in this important event.

Definitive Surgical Trauma Care Course (DSTC)

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) is pleased to announce the courses for 2008.

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

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

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.

Please register early to ensure a place!

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

2008 COURSES

Melbourne
18 & 19 November 2008
Auckland
2 & 3 March 2009
Brisbane
9 & 10 March 2009
Sydney Military Module
21 July 2009
Sydney
22 & 23 July 2009
Adelaide
3 & 4 September 2009

Consensus Statement

Managing the Transition to Digital Diagnostic Imaging July 2008

- The transition to digital diagnostic imaging has the potential to add value to the healthcare system through quicker and more efficient access to images, fewer lost and repeated studies and greater diagnostic information content of the studies.
- The referring and treating practitioner should have access to clinically relevant diagnostic quality images.
- A radiology service comprises both the clinically appropriate diagnostic image and the report.
- During the transition to digital diagnostic imaging, it is important that referring and treating doctors have access to appropriate imaging in an appropriate format. This may include printing images on film.
- Different referral groups will have different requirements and these need to be recognised by the referrer, the treating doctor and the imaging provider.
- An element of training is seen as an important component of the transition to digital diagnostic imaging.
- The implementation of a Code of Practice for provision of digital diagnostic imaging is supported.
- It is recognised that the transition will involve increased costs to the referrer, to health institutions (e.g. PACS in the wards, clinics and theatres) and to the provider of the service. Appropriate additional funding to cover such increased costs will need to be made available.

Delivery

- The delivery medium of imaging to a referring doctor will change during the transition period from film through to portable digital media, ultimately to intranet and internet services.
- Digital image data delivery should comply with the Digital Imaging and Communications in Medicine (DICOM) standards and the IHE (Integrating the Healthcare Enterprise) profiles, including that for portable digital images.

Access and Viewing

- Interoperability is a key element to the effective delivery of digital images between providers and referrers. The IHE profiles are supported as a useful methodology. There must be national guidelines for media used for digital diagnostic image transfer such that images are quickly, reliably and easily viewed and manipulated.
- Standards for viewing platforms must be devised in a way that ensures compatibility between the media and the referrer's viewer. Viewers shall permit the simultaneous viewing of images from more than one examination (for comparison purposes).
- These standards must be set in a way so that the standards can be improved as improvements in technology occur.
- There must be engagement with hospitals to ensure that adequate numbers of appropriate viewing stations are provided in operating theatres, wards and clinics.
- Wide bandwidth fast internet networks are essential for the best use of digital diagnostic imaging. Government must provide adequate broadband capacity, nationally and locally, in order to facilitate the optimum delivery of images to the point of patient care.

Public and Private settings

- Improved communication between public and private sectors is required, such that data transfer between providers is readily achieved, in the interest of safe and efficient patient care. Obstacles of privacy, security and commercial considerations need to be addressed.

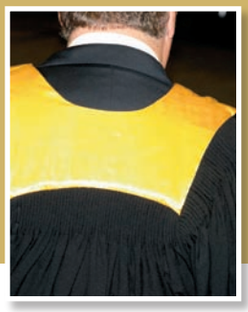
Storage

- During the transition period the patient will be the agent for the storage of images on durable portable media. It is envisaged that an internet based offsite storage facility will develop with time.
- With the transition to digital imaging, there will be an increasing need for the provider of imaging to store the diagnostic imaging data for an appropriate minimum time. Patient and specialty specific archiving requirements need to be noted.
- During the transition from film-based to digital storage, high quality diagnostic standard imaging must continue to be available.
- The delivery and storage of image data solely on CD or DVD is frequently inadequate.

Stakeholders

- A working party of interested groups will be formed to include:
- Australian Diagnostic Imaging Association
- Australian Orthopaedic Association
- Australian Medical Association
- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Radiologists
- Surgical Specialty Societies

New to Council



Encouraging surgeons to be – it is not in a name

I.M.A Newfellow

Last month I told you about the banned expression within the College: "the orange comic". This month I am going to tell you about another, "pre-SET". Now there is potential for confusion here as there is also a similarly named "Presets", as we were informed by our President. They are a Sydney rock duo, Julian Hamilton and Kim Moyes. Now I bet most of you did not know that, but our President did.

According to *The Age* of June 13, 2008: "The Presets are leading a changing of the electronic musical guard. Inspired as much by Daft Punk and 1990s techno as Depeche Mode, the thriving scene is often described as 'nu electro'. It's a clumsy term for a deliberately clumsy type of music: loud, hypnotic, rock-styled electronica brimming with pop hooks." Now do you know what that means? I certainly don't but I am informed by the young lady, Ruth Charters, who is responsible for the production of *Surgical News* that is "spot on". She also said that she loves their music and will play me some when I am next in Melbourne (Oh, dear!).

Now why should we ban the name of pre-SET? Surely it is an apt description of those young doctors, aspiring surgeons who are not yet in SET but would like to be. It is a term that has been thrown around but will

The Presets

now be expunged. Why? Because it implies some ownership of that group of persons by the College. (It reminds me of the removal from most of the monuments in Egypt of the image of Nefertiti).

This does not mean that the College, and we as individual surgeons, should not encourage, advise and mentor this group of aspiring surgeons. However, we have no more ownership or responsibility to them that do the medical schools have to high school students who want to study medicine. Every surgeon, except possibly the most cantankerous, would at some time have had a young medical student or intern ask advice or express an interest in surgery as a career.

The College does have a mentoring programme that has been less successful than we would wish. This is the official programme where the College coordinates a connection between an aspiring surgeon or a Trainee and a senior Fellow. However, there is an unofficial programme, which is recorded in no office where surgeons encourage young men and women in their surgical aspirations. When I pause for a moment I realise that I have never been involved in the official programme as I have been "too busy", but there are six or so Trainees in my specialty who have sought my advice in last year and on whom I keep an eye. It is very rewarding and I would encourage all (except perhaps the curmudgeons and the female equivalent amongst us) to do the same.

Well, back to pre-SET or the Presets. Our President says that he is an opera fan but in view of his knowledge of Presets, I am wondering – could he be a secret lover of "loud, hypnotic, rock-styled electronica brimming with pop hooks"? If you think that Sydney pub migraine-music is more interesting than surgical training (and it may well be – who am I to judge?) go to www.thepresets.com

FUNDRAISING CONCERT for **DILI HOSPITAL, EAST TIMOR**

Saturday 25th October 2008
8.00 pm Concert

At GLENFERN
417 Inkerman Street,
(Corner Inkerman and Hotham Streets),
East St Kilda, Melway ref. 58 F10

Featuring:

Zhang Chi
Mendelssohn – Fantasy in F sharp minor
Haydn – Sonata in F major Hob. XVI/23

Hsiao-Ni Axtens
Chopin – Ballade in G minor
Barber – Ballade

Jennifer Li
Beethoven – Sonata in F minor, Op. 57 ("Appassionata")
Stravinsky – Etude in F sharp major

Please contact karen.moss@surgeons.org or +61 3 9276 7436 for ticket information

Law Report

Michael Gorton,
College Solicitor

A rise in medical manslaughter?

Despite some recent examples, cases of criminal negligence are likely to remain rare

Until recently, reported cases of medical practitioners being charged or convicted of manslaughter arising out of negligent medical treatment in Australia have been rare.

However, recent cases in Queensland (*Patel* and *Ward*) show that the threat of criminal sanctions against doctors remains present.

In recent years, doctors in Australia have certainly been concerned with the increasing risk and cost of civil litigation, with patient claims against doctors increasing both in number and in value. A substantial response from the Federal and State governments addressed many of those issues so as to alleviate the sharp rises in medical indemnity premiums and to address processes dealing with civil claims. Recent evidence now suggests that claims have plateaued and medical indemnity premiums have stabilised.

However, the threat of a criminal charge, compared with a civil claim for negligence, has a far greater impact and notoriety. A criminal charge against a doctor will inevitably attract a media frenzy, and almost permanently affect the doctor's reputation, whether or not the charges are proven.

As stated, manslaughter charges against a doctor are rare. However, during the 1990's in New Zealand, for example, the fear of manslaughter charges being considered was heightened by the realisation that in New Zealand, a manslaughter conviction could be based on simple negligence, rather than the criminal standard that would apply in Australia and other countries such as the UK and USA. The standard for manslaughter in New Zealand of simple negligence or "mere inadvertence" was a much lower standard – and alarmed the medical profession at the time. A concerted lobbying effort by medical colleges and doctors groups in the 1990's led to substantive amendments to the law, with an amendment to the *Crimes Act 1961 (New Zealand)* to provide that manslaughter would require evidence that "the omission or neglect is a major departure from the standard of care expected of a reasonable person ... in those circumstances".

In Queensland, the *Patel* case has sensationally raised these issues. The case will consider whether his conduct was of the required criminal standard. The *Ward* case in Queensland arose from treatment in 2002 where it is alleged that the patient died from massive blood loss and organ failure after a major vein was punctured and the patient prescribed a blood thinning agent. In both these cases the prosecution will need to establish that the conduct of the doctors was so gross and so culpable that it should attract criminal sanctions – rather than simply being of the usual civil standard of negligence.

What is the standard for manslaughter?

It is settled law in Australia that simple negligence is not sufficient to justify a finding of manslaughter, which is similar to the position in the United Kingdom.

The position is the same in states under the common law and those Australian states that have codified criminal law.

Common law states (Victoria, New South Wales and South Australia)

Like in the United Kingdom, the common law in Australia is that simple negligence is insufficient to warrant conviction for manslaughter:

"Negligence which is essential before a man can be criminally convicted must be culpable, exhibiting a degree of recklessness beyond anything required to make a man liable for damages and civil action. It must be such a degree of culpable negligence as to amount to an absence of that care for the lives and persons of others which every law abiding man is expected to exhibit."
(*R v Gunter (1921) 21 SR (NSW) 282*).

"Negligence is defined ... as failure unjustifiably and to a gross degree to observe the standard of care which a reasonable man would have observed in all the circumstances of the case. In our opinion if negligence in this sense is established and the negligence proved is of the same degree as that required to support a charge of manslaughter ... Accordingly the jury may be directed that the act or omission must have taken place in circumstances which involved such a great falling short of the standard of care which a reasonable man would have exercised, and which involved such a high risk that grievous bodily harm would follow, that the act or omission merits punishment under the criminal law."
(*R v Shields (1981) VR 717,* see also *R v D (1984) 3 NSW LR 29*).

Code states (Queensland, Western Australia and Tasmania)

Each of these states has a specific provision in their criminal codes.

For example, the Queensland and Western Australian provision is as follows:

"It is the duty of every person who, except in a case of necessity, undertakes to administer surgical and medical treatment to any other person or to do any other lawful act which is or may be dangerous to human life or health to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty."
(see *Queensland s.288, Western Australia s.266,* see also *Tasmania s.149*).

In the leading Australian authority, the High Court case of *Callaghan v The Queen (1952) 87 CLR 115*, it was determined that mere negligence, based on the civil standard, is not sufficient for a person to be convicted of manslaughter under these provisions.

In Callaghan, the High Court stated:

"The threat of a criminal charge, compared with a civil claim for negligence, has a far greater impact and notoriety."

"It is in a criminal code dealing with major crimes involving grave moral guilt. Without in any way denying the difficulties created by the text of the criminal code, we think it would be wrong to suppose that it was intended by the code to make the degree of negligence punishable as manslaughter as low as the standard of fault sufficient to give rise to civil liability."

Australian cases involving breaches of the criminal code have concluded that a breach of this duty could sustain a conviction for manslaughter only if it involved negligence of the degree required for manslaughter at common law. (*R v Scarth (1945) ST.R.QD38* and *Evgeniou v The Queen (1964) 37 ALJR 508*).

New Zealand

Since 1997, the required standard to establish medical manslaughter in New Zealand arises under section 150A of the *Crimes Act 1961*.

Section 150A(2) provides that "a person is criminally responsible for ... neglecting a legal duty ... only if, in the circumstances of the particular case, the omission or neglect is a major departure from the standard of care expected of a reasonable person ... in those circumstances".

It is expected, therefore, that the standard in New Zealand will now match that applicable in Australia.

Distinction between civil negligence and criminal negligence

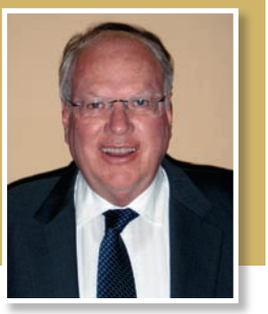
There is a commonality of understanding in the various formulations of "criminal negligence":

1. "Negligence is ... a failure unjustifiably and to a gross degree to observe the standard of care which a reasonable man would have observed in all the circumstances of the case. In our opinion if negligence in this sense is established the negligence proved is of the same degree as that required to support a charge of manslaughter." (*R v Shields*).
2. "There are two categories of manslaughter ... the first is that of criminal negligence, in which it is necessary for the Crown to establish such a high degree of negligence or disregard for the life and safety of others as to be regarded as a crime against the community generally and as conduct deserving punishment." (*R v Pullman (1991) 25 NSW LR 89*).
3. "In order to establish manslaughter by criminal negligence, it is sufficient that the prosecution shows that the act which caused the death was done by the accused consciously and voluntarily, without any intention of causing death or grievous bodily harm but in circumstances which involved such a great falling short of the standard of care which a reasonable man would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment." (*Nydam v R (1977) VR 430*).

In many cases, criminal negligence may be easily shown (e.g., treatment whilst under the influence of drugs or alcohol). In many cases, the ordinary risks of the treatment or procedure will suggest that the conduct may be negligent, but not criminal. Doctors can be assured that the standard for a criminal action will be "very high" – and therefore cases for our criminal system should remain rare.

Michael W Gorton
Principal, Russell Kennedy

I am grateful for the assistance of Alexander Johnson-McDiarmid in the preparation of this advice.



Neil Berry, Chair, Medico Legal Committee

Medico Legal Committee update

Fulfilling the duty of care for "follow-up" is primarily a matter of communication supported by good systems

Follow-up – Would your practice systems stand up to scrutiny?

Fulfilling the duty of care for "follow-up" is primarily a matter of communication supported by good systems. The compelling question asked by the courts is 'does the doctor's conduct conform to the standard of reasonable care, which is demanded by the law'?

Case law has required a doctor to demonstrate that there are adequate and reliable systems in place to ensure that patients are followed up appropriately, particularly where there may be a likelihood of a potentially serious adverse outcome for the patient.

Once a doctor has recommended a procedure or treatment or a patient has undergone investigation or treatment, then the doctor has an ongoing duty to remind the patient to have the recommended tests, procedure or treatment and to follow up the results and advise the patient.

A doctor must generally "follow-up" investigations or advice notwithstanding the failure of the patient, or indeed a hospital or pathology laboratory, to follow advice or normally accepted procedures. It is not acceptable for a medical practitioner to leave "follow-up" to someone else.

Systems

In assessing whether a standard of care has been met the courts have looked favourably on doctors who have shown they have a follow-up system to record if a result is received by the practice and communicated to the patient.

We suggest taking the time to evaluate the systems that exist in your practice by reviewing the policies and procedures that are in place. Medical Insurance Group Australia (MIGA) offers a Practice Review and Evaluation Program (PREP) for Member's enrolled in the IRM Program. If you would like information about PREP please email the Risk Management Department at prep@miga.com.au.

Chairman's Comment

Dear Members

It's been an active time for the committee since the Hong Kong ASC. At present the committee is seeking to ascertain what CPD activities fit in best with current practice. It is important that all members of the section are given the opportunity to have their say, particularly with recent changes to personal injury laws, and we look forward to receiving member's feedback.

It is my intention to report on the results of the questionnaire in the medico legal newsletter. If you have any other comments or queries about the questionnaire or the section, please contact the medico legal secretariat on +61 3 9276 7473.

Neil Berry
Chair, Medico Legal Committee

In the meantime consider the following:

- Is there a system for tracking the ordering and return of laboratory results?
- Are staff aware of the system?
- Is there a system for checking that all results have been reviewed and actioned by a doctor prior to being filed?
- Is there a recall system in place if the patient does not receive the results?
- Is there a designated person responsible for follow-up?

Documentation

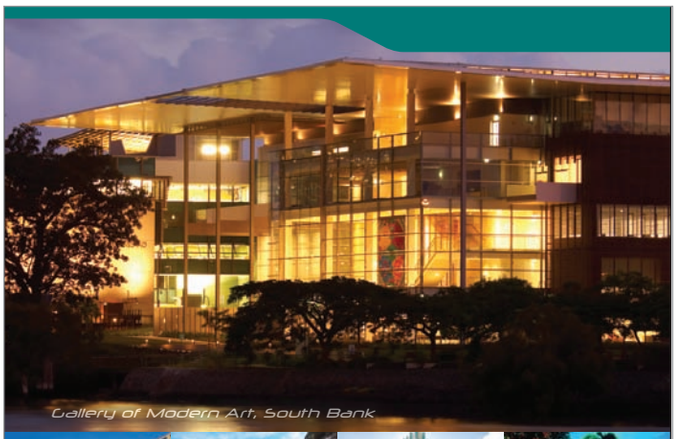
Documentation is imperative and is not limited to recording in the patient medical record. The policies and procedures that make up your follow-up systems should also be well documented. Supporting documentation will place you in a better position to defend any allegations in the event that a claim or complaint is made. All practices should consider establishing policy and procedure documents in a formal manual that is accessible to all staff and reviewed and updated regularly.

At a minimum, the following should be documented in the medical record:

- The consultation and importantly symptoms, complaints, examination findings and recommendations
- Any management plan – if a 'watch and see' then clearly document the plan to review
- When the results are received and when you inform the patient
- If the results are not received your attempts to follow-up with the patient or the service to which the patient was referred e.g. pathology service
- All attempts to follow up either by phone or by letter
- The advice given on follow up re on-going consequences of not taking the advice.

Failing to have follow-up systems in place which incorporate tracking of results, informing the doctor, advising the patient and offering treatment where necessary may, in the event of an adverse patient outcome, give rise to a patient complaint, Medical Board investigation or claim for compensation.

Liz Fitzgerald
Clinical Risk Manager



78th Annual Scientific Congress
6 - 9 May 2009

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Royal Australasian College of Surgeons

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Scientific Research Forum	12 February 2009
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Eric Frykberg *USA*
Chris Giannou *Switzerland*
Jeffrey Hammond *USA*
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Michael Sise *USA*
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College Conferences and Events Management

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

Meeting Announcement

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Victorian State Meeting

Sebel Heritage, Yarra Valley
24 - 26 October 2008

Invited Speakers

Jeffrey Cadeddu
Associate professor of Urology and Radiology
University of Texas Southwestern Medical Center,
Dallas, USA

Roger Dmochowski
Professor, Department of Urology
Vanderbilt University,
Nashville, USA

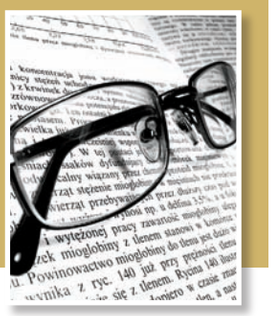
Andrea Gregori
Vice-Chairman, Department of Urologic Surgery
"Luigi Sacco" University Medical Centre,
Milan, Italy

Douglas Lording
Endocrinologist
Cabrini Medical Centre,
Malvern

Conveners

Jamie Kearsley & Daniel Moon
Niall Corcoran – *Trainee Representative*
Helen Crowe – *Nurses Representative*

Email conferences.events@surgeons.org
to obtain a provisional programme



Allan Scott, Chair, Surgeons as Educators Committee

Motivating learners

The principles of adult learning are well-suited to working with Trainees

Similar interest groups and professions commonly use jargon. In the operating room or under emergency conditions, jargon allows medical professionals to communicate quickly and effectively where common language would take much longer. Education is no different and by taking time out to understand education terminology, supervisors and trainers can better support and motivate Trainees to learn.

For instance, Dr Malcolm Knowles[1] popularised the term "adult learning", recognising that adults:

- Need to know why they should learn something and must consider it important to acquire this new skill, knowledge or attitude.
- Need to be self-directing and decide what they want to learn.
- Have a far greater volume and different quality of experiences than young people so that connecting learning experiences to past experience/s can make the learning experience more meaningful and assist them in the acquisition of new knowledge.
- Become ready to learn when they experience a life situation where they need to know.
- Enter into the learning process with a task-centred orientation to learning.
- Are motivated to learn by both extrinsic and intrinsic incentives.

Adult learning theory tells us that one way to motivate adults to learn is by providing regular feedback. Feedback is a more effective motivator if it is immediate, specific, objective and refers to behaviour which can be changed; keep doing this, do more of this, this will improve if, etc.

Assessment is often used as the basis for this feedback as it documents, usually in measurable terms, a learner's knowledge, skills, attitudes and beliefs. We can use assessment to provide feedback to learners on how well

they are doing in relation to predetermined standards; their current level of skills/knowledge, strengths and weaknesses as well as an improvement over time.

Assessment that is not used to give a pass or fail grade is called formative assessment. Some formative assessment tools used in the Surgical Education and Training Program (SET) include the Mini Clinical Examination (mini CEX) and Directly Observed Procedural Skills (DOPS). These provide an excellent basis for giving feedback about performance as they address a range of competencies; medical expertise and clinical decision-making in addition to professionalism, management and leadership, communication and collaboration. Other formative assessment tools include the mid-term assessment, 360 Degree Survey (MINI-PAT) and Case-Based Discussion (CBD).

Motivation can also come from summative assessment. Summative assessment is often associated with a pass or fail grade, e.g., an examination. It can be used to provide feedback about whether a Trainee has acquired a satisfactory level of knowledge and skills within the required timeframe.

The distinction between formative and summative assessment relates more to their purpose rather than the timing or type of task. For example, the end of rotation/run report could be a formative or summative assessment. If there is an opportunity for Trainees to improve their performance in the following placement, the report could be seen as formative.

Providing clearly defined learning objectives is another way of motivating adults to learn. Learning objectives define the knowledge and skills to be developed and later assessed so help adults to understand why they should learn something. It is important that these objectives are defined at the beginning of the learning process and expectations clearly outlined. Any discussion about learning objectives should also provide the learner with clear guidance about the standard of performance that is expected. These standards are often described as performance criteria; a statement against which a trainee's work and/or performance is to be judged. The mini CEX and DOPS in-training assessment forms contain good examples.

As adult learners, Trainees are best motivated if they are involved in early discussions about how and what they are going to learn. The start of rotation/run meeting is an ideal opportunity for supervisors to apply the principles of adult learning. They can outline the training program including its purpose, expectations and assessment tasks. It is also an opportunity for Trainees to discuss their past experience and identify future learning objectives that build on their existing skill set and knowledge base.

1 Knowles, M. S. (1975). *Self-directed learning: A guide for learners and teachers*. Englewood Cliffs: Prentice Hall/Cambridge.

Want to know more? If you are a supervisor or trainer, attend a SAT SET: Supervisor and Trainer Course or a Surgical Teachers Course. Contact PDactivities@surgeons.org or call +61 3 9249 1106.

30% of all red blood cell transfusions are inappropriate

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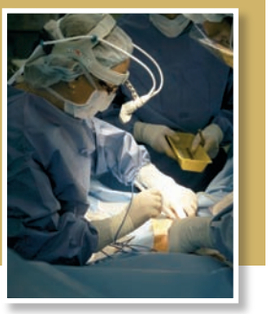
Human Factors



Human Factors Engineering in Healthcare

Liz Fitzgerald
Clinical Risk Manager,
The Medical Insurance Group

In medicine, increasing concerns over safety generated an interest in human factors as an opportunity to help develop clinical process efficiency, improve the quality of care, and boost the satisfaction of patients and clinicians. Such opportunities exist not only in terms of equipment and medical device design but also in the often complex systems and procedures that exist during the delivery of health care.

Human Factors Engineering (HFE) refers to the study of human abilities and characteristics as they affect the design and smooth operation of equipment, systems, and jobs. The field concerns itself with considerations of the strengths and weaknesses of human physical and mental abilities and how these affect the systems design. Human factors analysis does not require designing or redesigning existing objects.[1]

Study, practice and motivation do not make a person mistake-proof. Each day experienced and well-intentioned clinicians go about their work in systems that are set up to fail them, further complicated by the set of human factors that individuals bring with them each day.

"Most serious medical errors are committed by competent, caring people doing what other competent, caring people would do"[2] but fortunately, most errors are minor or inconsequential but occasionally they cause serious harm. These mistakes are made, not because a person has made an incompetent error, but because their single act was the final link in a chain of errors and failures.

There are numerous human factors that influence the risk of patient harm but in general terms include:

1. Fatigue, related to work hours and workload
2. Team behaviours
3. Leadership and communication styles.

Fatigue

Sleep deprivation, night shifts and shift rotation all have a significant impact on performance by way of influencing levels of attention, judgment and reaction times. Heavy and/or stressful workloads lead to burnout and a consequential lack of motivation and diminishing attention provided to patients; predominantly not communicating effectively and failing to complete adequate documentation.

Team behaviours and leadership

Patient care, like other technically complex and high risk fields, is an interdependent process carried out by teams of individuals with advanced technical training who have varying roles and decision-making responsibilities.[3]

Poorly functioning teams can undermine clinical performance and compromise the safety of care. In the UK, the reports of the Confidential Enquiries into Maternal Deaths have consistently cited lack of teamwork (and communication) in obstetric and midwifery teams and in multidisciplinary teams working among the causes of substandard clinical care leading to 'indirect' maternal deaths.[4]

Communication

Communication skills, including active listening, are at the heart of health professionals interactions, whether with patients and family, or with other professionals. The failure to communicate or poor communicating/listening skills have been cited as one of the leading causes of inadvertent patient harm.[5]

Research has shown that poor communication between:

- patients and staff elicits most complaints about attitude and behaviour
- staff create ambiguity, ineffective transfer of information and therefore poor decision making.

Understanding the relationships of human factors invites us to consider our environment, and the context within where we work. In the case of hospitals and private practices, the workplace can be dangerous, diverse and busy with technical and non-technical skills.

The team structure, its members, the dynamics and its ability to function and communicate will influence the potential for harm. Integration of risk management strategies, learning and sharing safety issues and implementing solutions to prevent harm creates a setting that is capable of managing the human factors and as a result is healthy for staff and patients.

Risk Management Tips

Human Factors – creating and managing a healthy team

- Make risk management part of your day-to-day business
- Acknowledge that most errors occur as a result of system failures
- Support an environment in which staff are encouraged to report errors and near misses
- Listen to staff concerns and facilitate change to avoid error and harm to patients
- Be alert for the human factors that may contribute to errors in your practice.

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MIGA August Bulletin, 2008

1 http://www.webmm.ahrq.gov/popup_glossary.aspx?name=humanfactors
2 Donald Berwick MD MPP
3 http://www.ahrq.gov/Clinic/ptsafety/chap44.htm
4 CEMACH (2004) Why Mothers Die 2000-2002. The Sixth Report of the Confidential Enquiries into Maternal Deaths in theUnited Kingdom. RCOG press, London.
5 Leonard M, Graham S, Bonacum D (2004) The human factor: the critical importance of effective teamwork and communication in providing safe care (Suppl 1 Simulation and team training): Qual and Saf in Health Care 13 i85-i90

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:

Albert Frank Bencsik NSW
Geoffrey Watkins Burgess CANADA
John Victor Leonard Colman NSW
Douglas Orson Oldfield VIC
Mark Xavier Shanahan NSW

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. Click on www.surgeons.org then click on Fellows and click on In Memoriam

Informing the College

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

ACT	eve.edwards@surgeons.org	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		

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.

Brian Smith Memorial Award 2009

in association with The Cabrini Clinical Education & Research Unit

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**

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

Pictured: Jean-Claude Theis

ASM 2008: Palmerston North

An excellent program and a superb dinner made for another successful ASM in New Zealand

1. Tony Hardy and Rob Robertson after being awarded the RACS Medal 2. Peter Shin, David Dunlop and Pravin Kumar 3. Mike Young, Maree Weston and Magda Sakowska 4. The Trainees ukelele band 5. Bruce Mann 6. John Windsor with the Louis Barnett Prize winner Anubhav Mittal

This year's Annual Scientific Meeting (ASM) focused primarily on clinical areas of relevance to general surgery. While its attendance may have been smaller than other recent meetings, the visiting speakers (James Church, Bruce Mann, Julie Miller and John Windsor) were all of high calibre and the program of great interest to those present.

The ASM provides the opportunity for College "ceremonial" activities. On this occasion, Mr Tony Hardy and Mr Rob Robertson were presented with their RACS Medals for distinguished service to the College. The presentations were made by the Censor in Chief, Mr Ian Civil, on behalf of the College President. Professor John Windsor from the Auckland Medical School delivered the Gordon Bell Memorial Lecture. His topic, "Academic Surgery – Conscience of the Profession", explored the role of academia in everyday surgery and the interrelationship between universities and Colleges.

I am informed by those with knowledge of these matters that the standard of papers presented for the Louis Barnett Prize was very high. The prize, $2,500 and a certificate, was won this year by Dr Anubhav Mittal for his paper on "Changes in the Protein Composition of Mesenteric Lymph Secondary to Haemorrhagic Shock".

Once again Palmerston North provided a superb conference dinner. The venue was different – we were seated on the stage of the Regent Theatre – the food was magnificent and the entertainment memorable; it ranged from opera singers in the audience area to the Trainees (and others) ukulele band.

The College's thanks go to Mr Mike Young, the ASM Convenor, and the members of the Organising Committee (Messrs Richard Coutts, Chris Daynes, Pravin Kumar, Bruce Rhind and Colin Wilson) for their work over many months in putting together the program. Palmerston North may not be considered a great tourist venue but the locals' hospitality and enthusiasm are a wonderful backdrop for any meeting.

Written by Justine Peterson, NZ Manager

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

Photo courtesy of James Farmer

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

Confronting the facts

Too often the response to sexual harassment is to be dismissive or to reframe the person who reports sexual harassment as a stirrer

Helen Szoke, CEO, Victorian Equal Opportunity & Human Rights Commission

Sexual harassment is unlawful and has been for nearly 25 years. Why then is recent research still showing that people in workplaces still have to deal with sexual harassment? What are the responsibilities of employers in relation to protecting workers against this sort of behaviour?

The research, which was presented at the Margins2Mainstream conference in Melbourne in September 2008 shows that 79 per cent of those who experience unwanted sexual advances at work are women. It also demonstrates that there is a strong link between sexual harassment and mental health problems. This behaviour is costly and preventable. Further, complaints relating to sexual harassment remain the second largest category of complaints to the Victorian Equal Opportunity & Human Rights Commission; a significant concern given that the behaviour has been unlawful for over 20 years.

Too often the response to sexual harassment is to be dismissive or to reframe the person who reports sexual harassment as a stirrer or a trouble maker. And yet the effects of it are a huge cost to the people involved and businesses in general.

Sexual harassment is, essentially, unwelcome conduct, remarks or innuendo of a sexual nature. It is behaviour that could reasonably be expected to make a person feel offended, humiliated or intimidated.

Sexual harassment is not sexual interaction, flirtation or attraction if consensual. The fact that the recipient of a comment or gesture is silent, however, does not mean the behaviour is welcome. Nor does the fact that the recipient may have themselves behaved in an inappropriate sexual manner on other occasions. Although an isolated incident can amount to harassment, there is often a series of incidents or persistent unwelcome conduct before a complaint is made. Sexual harassment may involve a person harassing a member of the opposite sex or of the same sex.

Sexual harassment is unlawful in the workplace – between employees, contractors, directors, etc. Those in a common workplace (even though employed by different entities) are also covered.

The Victorian Equal Opportunity Act 1995, for example, states that one person sexually harasses another in the following circumstances:

- by making an unwelcome sexual advance or an unwelcome request for sexual favours to the other person; or
- by engaging in any other unwelcome conduct of a sexual nature in relation to the other person; in circumstances where it is reasonable to anticipate that the other person would be offended, humiliated or intimidated.

Sexual harassment can permeate every area of employment from recruitment to termination. There have been cases of people who have been sexually harassed in job interviews, and of people who have been forced to resign because of harassment. It can occur between supervisors and trainees Sexual harassment that occurs offsite, or after work, can also be linked with employment, depending on the circumstances. For example, behaviour that occurs at work drinks or at a conference might be connected closely enough to work so that unwelcome sexual behaviour could be unlawful sexual harassment.

The Victorian legislation covers workers who work in the same workplace but are employed by different employers, and protects an employer from sexual harassment by employees. It is also unlawful to sexually harass another when providing or receiving goods or services.

Conduct covered by the legislation can consist of many things including:-

- intrusive questions asked at employment interviews
- unwelcome touching such as kissing, patting, pinching or touching in a sexual way
- sexually suggestive comments or jokes
- sexually explicit pictures, posters, graffiti, screen savers, notes, phone calls, SMS messages or emails
- requests for sex
- unwanted requests to go out on dates, form a relationship or love letters
- intrusive questions about a person's private life or body
- insults, name-calling or taunts that relate to sex
- staring or leering
- unwanted brushing against another body, standing too close
- behaviour which would also be an offence under the criminal law, like sexual assault or indecent exposure.

"Although an isolated incident can amount to harassment, there is often a series of incidents or persistent unwelcome conduct before a complaint is made."

Complaints of sexual harassment in employment or in the provision/receipt of goods and services can be made to the Victorian Equal Opportunity & Human Rights Commission or other State or Territory body. The Commission is also able to provide free and confidential information about how to deal with sexual harassment in the workplace, and provides fee for service training and consultancy services.

More information can be accessed by visiting www.humanrightscommission.vic.gov.au or phoning the Commission on +61 3 9281 7100.

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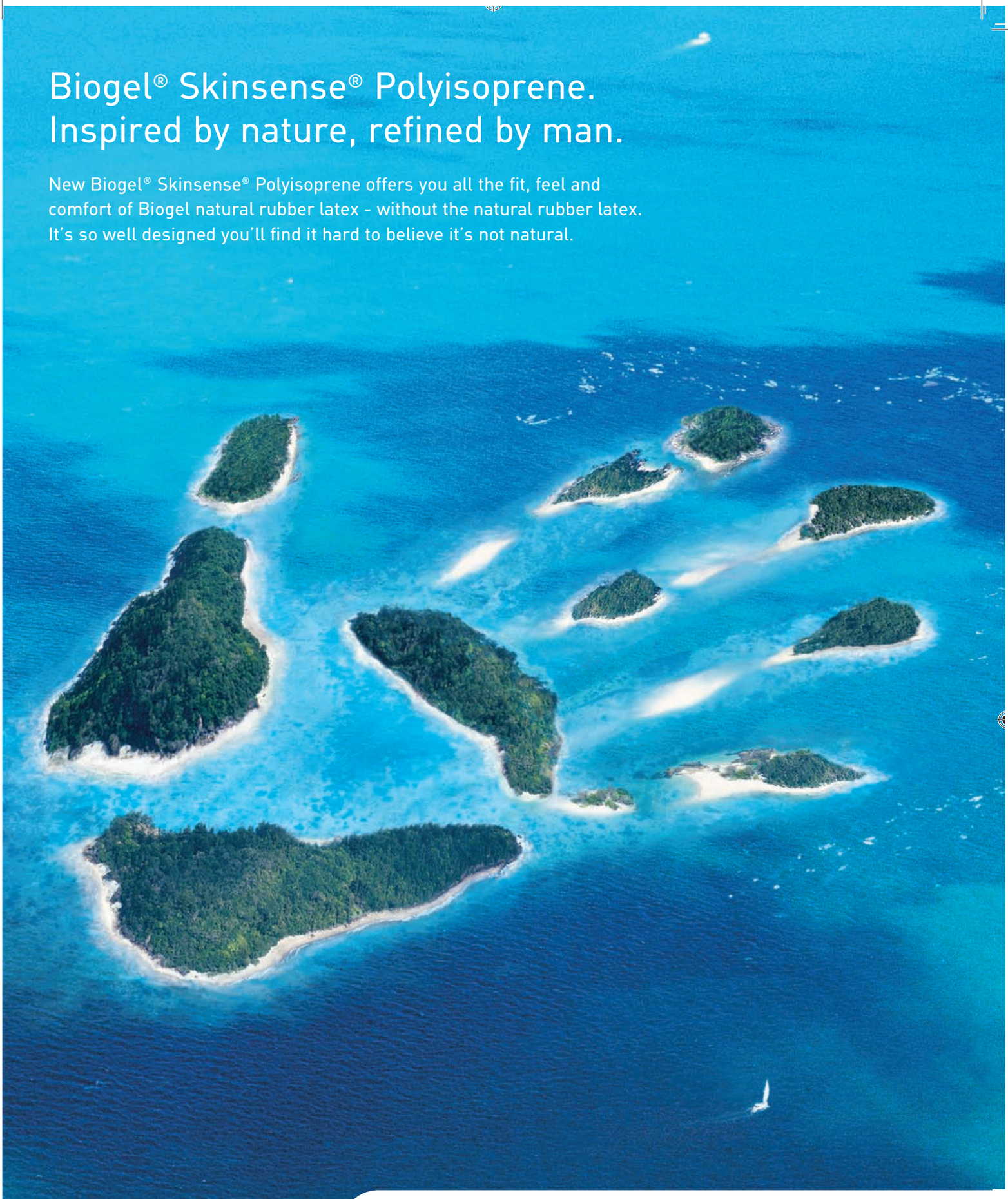

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Surgical training in PNG

Thanks in part to the College, our northern neighbour now staffs all its hospitals with surgeons born and trained there

The formal and informal collaboration that has existed between the College and neighbouring Papua New Guinea (PNG) for more than 50 years has proven to be one of the stand-out success stories of the College's many international assistance programmes. While the relationship began with individual Australian surgeons working in the impoverished nation to help treat the ill and provide basic training along with short-term specialist visits, the College is now sending surgical academics to assist local candidates trained at the local university to fulfil the requirements of the Master of Medicine Degree (MMed).

When PNG aquired its independence 30 years ago, there were no trained local surgeons to treat the then population of more than two million people and only 16 expatriate surgeons available across the country. However, since the first two local surgeons graduated in 1979 from the University of Papua New Guinea's Medical School, more than 50 general surgeons have followed.

All major hospitals in PNG are now staffed by locally-born and trained surgeons. Surgery is the only medical specialty to achieve this.

While training in PNG remains focussed on general surgery because of both the health needs of the population and limited facilities, a sub-specialisation program, which began in 1994, has now also trained 13 postgraduates in, paediatric (two) and orthopaedic surgery (five), urology (two), neurosurgery (one) and head and neck surgery (three). Nine ENT surgeons, 10 ophthalmologists and two oral surgeons have also graduated MMed since 1993.

Now, too, with the posting of national specialist surgeons to Port Moresby, all modules of the General Surgery Master of Medicine programme are being taught by Papua New Guineans, a development hard to imagine even in 1993.

Yet the College still remains committed to assisting the developing nation, with a request made in 2006 for senior academic surgeons to visit the country to tutor Master of Medicine candidates in preparation for their mandatory theses due to the departure of the UPNG's highly respected Professor of Surgery, Professor Chung (2004-2006).

In the past two years, the Colleges' Tertiary Health Services Project has funded 15 visits by Australian surgical specialists to support the teaching program.

Professor David Watters, who was himself Professor of Surgery at the UPNG from 1992 to 2000, has visited PNG twice this year to conduct tutorials and a research workshop. The workshop covered the purpose and structure of the MMed thesis, helping the candidates develop hypotheses, present statistics, analyse data and access key literature and internet resources.

Some of the thesis research projects include understanding the trauma patterns seen at Angau hospital, the HIV seroprevalence in surgical patients, prostatectomy outcomes in PNG, the causes and treatment of cervical spine injuries, the incidence of abdominal tuberculosis and colorectal carcinoma.

"The quality of the teaching and the calibre of candidates are very high for the MMed program and the Dean of Medicine at the UPNG, a physician cardiologist, Professor Sir Isi Kevau, is an outstanding academic so it is a privilege to be of assistance," Professor Watters said. Further academic support has been provided by Mr David Hamilton who has also visited twice this year and was the surgeon in Rabaul from 1975-1989.

"In the late 1990s, the UPNG embarked on a restructuring program that led to the formation of the School System. At the same time its traditional medical course, which had been taught up to 2000, was replaced by one centred on problem-based learning built around the Newcastle Model.

"That means the UPNG was ahead of Melbourne University in its approach to medical education and surgery is the outstanding program within the medical school in producing postgraduates."

Professor Watters said the Master of Medicine programme was a four-year postgraduate degree based around general surgery making the training broader but less specialised than that provided in Australia or New Zealand.

While it is not transportable, it is equivalent to the FRACS and was designed with particular attention to local needs and circumstances.

All MMed surgical programs take four years to complete with the first year of study focused on Basic Medical Sciences including work as a surgical registrar, the study of common core subjects relevant to all disciplines and a specialist core.

The surgical specialist core consists of applied anatomy, pathophysiology and surgical pathology. In addition, each trainee must perform satisfactorily as a supervised surgical registrar for all four years.

The first year or two of training are conducted under supervision of a national specialist in a regional/provincial teaching hospital (Lae, Goroka, Mt Hagen, Rabaul or Madang). The third year is sometimes spent overseas in Darwin or Alice Springs.

At least the last year is spent in Port Moresby where there is a critical mass of surgeons and registrars for a vibrant teaching program. The MMed degree is awarded after successfully passing all the components, including the presentation of a thesis up to publishable standard. Professor Hamish Ewing (University of Melbourne) has been external examiner in surgery for the years 2005-2008.

"The aim of the program is to produce a general surgeon capable of being the only surgeon

Surgeons and Trainees at a research workshop, Port Moresby, March 2008, the workshop was conducted by Professor David Watters and Mr Joseph Ragg

in a provincial hospital in PNG. Such a surgeon must be able to carry out a laparotomy, resect bowel, drain an extradural haematoma, open a chest, relieve an obstructed urinary tract, manage complications from congenital anomalies, treat complicated wounds and fix common fractures," Professor Watters said.

"To an Australian surgeon, the facilities are quite basic and there is not a lot of technology available so local surgeons need to know how to do more with less, and the training program prepares them for this.

"Obtaining the FRACS was not a viable option as it would have required the Trainees to spend long periods in Australia, with their services lost to PNG along with a high risk of them being seduced into staying, adding to the brain drain already occurring from developing nations in the Pacific.

"However, that is also another aspect of the success of PNG's surgical training program because of the more than 50 national surgeons who have graduated, only five are currently working long-term outside the country."

Professor Watters also said that initial concerns expressed at the beginning of the specialisation program in 1994 – that such surgeons could be unwilling to provide general surgical services training – did not eventuate.

Another issue raised at the time was the fear that the specialists would demand better equipment and remuneration. Professor Watters said such specialists had argued well and wisely in demand for such equipment to treat their patients but not always succeeded in being awarded the higher salaries they deserved. There is no doubt their skills had resulted in improved surgical care.

Professor Watters is now a Professor of Surgery at the University of Melbourne based in Geelong Hospital. Chair of the International Committee and a College councillor, he is also the Director of the PNG Tertiary Health Services Project, which is soon to be transformed into a different program managed by the Medical School of Port Moresby. The new program will be called Health Worker Education and Traning and Specialised Services in PNG (the "PNG HWETSS Program"). The College component will involve supporting the Medical School in capacity building for specialised services through the education and training of specialist health workers.

Professor Watters also said an international search was now underway in a bid to find a new Professor of Surgery to lead and maintain the progress in surgical training.

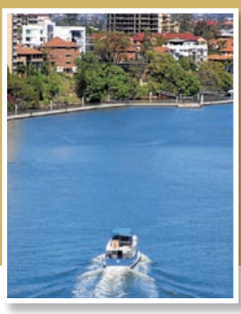
"There has not been a replacement for Professor Chung since 2006 and we are concerned that it may take up to four years to find someone to replace him. It is not a position or a location that would suit everyone," he said.

"You have to be brave and bold to work in PNG ... my wife and I and family loved our time living there, so if you have a sense of adventure it can be a very rewarding experience, even with young children.

"I think it could also appeal to someone who is older, perhaps, who would like such an adventure as they head toward retirement but they would need to be able to work without all the back-up available in Australia. They would not necessarily have to be currently a professor level but they would need to be academically inclined and ideally have some experience of tropical medicine, even if only as a volunteer on visiting teams."

Professor Watters said interested surgeons could contact Professor Sir Isi Kevau at UPNG for further information on the chair in Surgery (isi.kevau@gmail.com).

ASC 2009
Brisbane



Campbell Miles,
Annual Scientific Congress
Co-ordinator

Gathering of talent

The draft program of the 78th ASC shows a conference loaded with quality content

The 78th Annual Scientific Congress (ASC) returns to the sunshine and blue skies of South Bank, Brisbane after an interval of six years. The convening group led by Mark Smithers (Convener) and Andrew Stevenson (scientific convener) have been at work for 18 months with the executive and scientific committees to ensure a Conference that will fully repay attendance with great plenaries, great sessions and great restaurants. The theme for the meeting is "Surgery and the Community" and this will be addressed in the plenary session on Thursday provocatively titled "Surgery to the needy at home and abroad – what the bloody hell can I do?" The plenary will be followed by the President's Lecture from Dr Rowan Gillies, Past International President of Medicins Sans Frontieres. The remaining two plenaries are titled "Recertification – the future for all Australian and New Zealand surgeons" and "How do we ensure the future of the profession in Australia and New Zealand".

The Australian Orthopaedic Association (AOA) is involved in the ASC in partnership with other sections, especially in the areas of trauma and military surgery and the Medicolegal and Pain Medicine programs, whilst the plenary program at every Congress has relevance to all specialties. Clearly the ASC cannot nor does it wish to reproduce the excellent content of the AOA's own annual scientific program, but there are large areas of common interest. The prominent Canberra orthopaedic surgeon, David McNicol has accepted the invitation to deliver the Hamilton Russell Memorial Lecture.

Tuesday 5 May – Workshop program

The scientific program will be held from Wednesday, May 6 to Saturday, May 9, but on Tuesday there will be multiple workshops including advice on how to get your research published from John Hall and Cameron Platell from the *ANZ Journal of Surgery* ("Publish or Perish: a pragmatic approach to writing abstracts and articles"). Delegates can register for one of the SAT SET courses to be held during the day and Richard Hanney is convening a full day course on "Why choose a career in academic surgery in Australia or New Zealand?"

An outstanding panel of international and national experts have accepted invitations to attend the meeting across the 25 specialties and special interest groups.

British Journal of Surgery Society Lecturer

The British Journal of Surgery (BJS) Society will sponsor an annual lecturer to the ASC program, the selection to be in the hands of the organising committee. Our inaugural BJS lecturer is Richard Canter, an ear nose and throat surgeon from Bristol with impeccable credentials in surgical education. Professor Canter was responsible for setting up the Intercollegiate Curriculum for Surgical Training in the United Kingdom and he has written widely on topics related to surgical training. The College is grateful to the BJS Society for this enduring sponsorship, which also recognises the quality of the College's annual scientific conference.

Convocation

The Convocation will be held on Tuesday, May 5 at 4.30pm at the Conference Centre. During the Convocation the distinguished British head and neck and skull base surgeon, Professor Michael Gleeson, will be awarded the Honorary Fellowship of the College for distinguished service to trainees and Fellows of our College over many years. Professor Gleeson was a RACS Visitor to the head and neck program at the ASC in Brisbane in 2003.

Colorectal surgery program

The Colorectal surgery program is being convened by Michael Doudle and it extends over Wednesday to Friday with a workshop on Tuesday on Laparoscopic colorectal surgery and a masterclass on Friday addressing current management of large bowel obstruction. The entire program will offer practical advice applicable in the clinical setting whilst emphasising minimally invasive and laparoscopic approaches to large bowel surgery, in addition to screening and the genetics of bowel cancer. The program will benefit enormously from two outstanding visitors – Professor John Monson from the UK (now in Rochester, USA), chosen for his expertise in MIS, rectal cancer and bowel cancer screening. John's expertise from the UK scene will be complemented by Professor Cameron Platell from Perth. Cameron is a leading Australian academic surgeon with extensive experience in colorectal cancer management and bowel cancer screening. Research abstracts for the Mark Killingback Prize can be submitted by clicking "ASC" at www.surgeons.org

Hand surgery program

The Hand Section meets with the ASC on alternate years. This year Shireen Senewiratne and Daniel Rowe are convening the program on Tuesday, Friday and Saturday. Their College visitor is Dr Raja Sabapathy, Professor of Hand and Plastic Surgery from Coimbatore, India. He works in an area with a high incidence of limb trauma, especially of the upper limb and he achieves excellent results despite chronically underfunded facilities. Limb replantation is an area of special expertise and Professor Sabapathy will discuss this at his masterclass for Trainees on Friday. Dan Rowe is also convening a program during the Tuesday workshop session on "Hand plating" that will provide invaluable "hands-on" experience with current fixation systems.

The provisional program will be posted to all Fellows and Trainees in early November. You can remain current with the program and all other aspects on the conference website www.surgeons.org

Call for Abstracts

Gallery of Modern Art, South Bank

78th Annual Scientific Congress
6 - 9 May 2009

Brisbane Convention & Exhibition Centre
Brisbane • Australia

Surgeons and the Community

Royal Australasian College of Surgeons

Surgeons and the Community

Submission of Abstracts for Research and Invited Papers

Abstract submission will be entirely by electronic means. This is accessed from the College website www.surgeons.org/asc2009 and click on 'Abstract Submission'.

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the Call for Abstracts, the Provisional Program and on the Abstract Submission site. Abstracts submitted after the closing date will not be considered.
2. The title should be brief and explicit.
3. Research papers should follow the format – Purpose, Methodology, Results, Conclusion.
4. Non-scientific papers, eg. Education, History, Military, Medico-Legal, may understandably depart from the above.
5. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1,750 characters and spaces (approximately 250 words). In MS Word, this count can be determined from the 'Tools menu'. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT appear in the abstract book.
6. Abbreviations should be used only in common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
7. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be available in the Congress Provisional Program and in correspondence sent to all successful authors.
8. Authors submitting research papers have a choice of two specialties under which their abstract can be considered. Submissions are invited to any of the specialties or special interest groups participating in the program (see page 3).
9. A 50 word CV is required from each presenter to facilitate the Chairman's introduction.
10. The timing, presentation and discussion of all papers is at the discretion of the Convener of each Section. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
11. Tables, diagrams, graphs, etc. CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
12. AUTHORS MUST BE REGISTRANTS AT THE MEETING FOR THEIR ABSTRACT TO APPEAR IN THE PUBLICATIONS.

Important Note

The submitting author of an abstract will ALWAYS receive email confirmation of receipt of the abstract into the submission site. If you do not receive an email confirmation within 24 hours it may mean the abstract has not been received. In this circumstance, please email Binh Nguyen at the Royal Australasian College of Surgeons (binh.nguyen@surgeons.org) to determine why an email confirmation has not been received.

Scientific E-Posters

All posters will be presented electronically during the Congress and will be available for viewing on computer screens at the venue. The poster will also be placed on the Virtual Congress in addition to the abstract.

Research Prizes

Please ensure that you indicate on the Abstract Submission site whether you wish to be considered for the Mark Killingback Prize (best scientific paper in Colon & Rectal Surgery given by a surgical trainee or Younger Fellow). Other prizes to be awarded during the meeting are – the Tom Reeve Prize in Endocrine Surgery (best research paper from a trainee); the Surgical Education prize (for best research paper) or the C.R. Bard Prize (best research paper by a trainee related to hernia management, including incisional, hiatal and parastomal hernias in the General Surgery program). Other prizes to be awarded during the meeting will be indicated on the Abstract Submission site.

Important Information

The closing date for scientific paper abstract submission is **19 January 2009**.

The closing date for abstract submission by speakers invited by Conveners is **9 March 2009**.

Please note that paper or facsimile copies will not be accepted, nor will abstracts be submitted by College staff on behalf of authors.

If there are any difficulties regarding this process, please contact Binh Nguyen, Project Officer, for assistance on +61 3 9249 1279 or email binh.nguyen@surgeons.org

Important Dates

Abstract submission opens	2 October 2008
Closure of abstracts	19 January 2009
Closure of early registration	16 March 2009

Brisbane 2009 Executive

Convener	**Assoc Prof Mark Smithers**
Scientific Convener	**Dr Andrew Stevenson**
Committee Member	**Dr Julie Mundy**
Committee Member	**Dr Nicholas O'Rourke**
ASC Co-ordinator	**Mr Campbell Miles** campbell.miles@surgeons.org
ASC Manager	**Ms Lindy Moffat** lindy.moffat@surgeons.org
Queensland Regional Manager	**Mr David Watson** david.watson@surgeons.org
ASC Secretariat	**Ms Jennifer Hannan** jennifer.hannan@surgeons.org or telephone +61 3 9249 1248

78th Annual Scientific Congress
6 - 9 May 2009

Brisbane Asc 2009 Overview

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7.00am - 8.20am</td><td></td><td>Masterclasses</td><td>Masterclasses</td><td>Masterclasses</td><td>Masterclasses</td></tr>
<tr><td>Session 1
8.30am - 10.00am</td><td rowspan="8">Workshop Program</td><td>PLENARY</td><td>Scientific Session</td><td>Scientific Session</td><td>Scientific Session</td></tr>
<tr><td>10.00am-10.30am</td><td>Morning Tea</td><td>Morning Tea</td><td>Morning Tea</td><td>Morning Tea</td></tr>
<tr><td>Session 2
10.30am - 12noon</td><td>Scientific Session 2</td><td>PLENARY</td><td>PLENARY</td><td>Scientific Session 2</td></tr>
<tr><td>12noon - 12.30pm</td><td>Pre-lunch Keynote lectures</td><td>President's Lecture</td><td>Pre-lunch Keynote lectures</td><td>Pre-lunch Keynote lectures</td></tr>
<tr><td>12.30pm - 1.30pm</td><td>Lunch</td><td>Lunch</td><td>Lunch</td><td>Lunch</td></tr>
<tr><td>1.30pm - 2.00pm</td><td>Post-lunch Keynote lectures</td><td>John Mitchell Crouch Lecture
Keynote lectures</td><td>American College of Surgeons Lecture
Keynote lectures</td><td>Post-lunch Keynote lectures</td></tr>
<tr><td>Session 3
2.00pm - 3.30pm</td><td>Scientific Session 3</td><td>Scientific Session 3</td><td>Scientific Session 3</td><td>Scientific Session 3</td></tr>
<tr><td>3.30pm - 4.00pm</td><td></td><td>Afternoon Tea</td><td>Afternoon Tea</td><td>Afternoon Tea</td><td>Afternoon Tea
(ASC concludes)</td></tr>
<tr><td rowspan="2">Session 4
4.00pm - 5.30pm</td><td rowspan="2">4.30pm Convocation

6.00pm Welcome Cocktail Reception</td><td>Scientific Session 4</td><td>Scientific Session 4</td><td>Scientific Session 4</td><td rowspan="2"></td></tr>
<tr><td></td><td></td><td>RACS AGM</td></tr>
<tr><td>7.00pm - 11.00pm</td><td>Sectional Dinners and Younger Fellows & Trainees Dinner</td><td>Sectional Dinners</td><td>Congress Dinner</td></tr>
</table>

Research Paper Specialties

Authors of research papers and posters are invited to submit abstracts for consideration and inclusion in the scientific program in the following areas:

Bariatric Surgery
Breast Surgery
Burns
Colon & Rectal Surgery
Endocrine Surgery
General Surgery
Hand Surgery
Head & Neck Surgery
Hepatopancreaticobiliary Surgery
International aid delivery (International Forum)
Medico-Legal aspects of surgery
Neurosurgery
Paediatric Surgery
Pain Medicine
Plastic Surgery: Reconstructive and Cosmetic Surgery
Rural Surgery
Surgical Education
Surgical History
Surgical Oncology
Thoracic Surgery
Transplantation Surgery
Trauma Surgery
Upper GI Surgery
Vascular Surgery
Women in Surgery




Surgeons and the Community

Scientific Conveners

ANZBA (Burns)	Dr Michael Rudd
Bariatric Surgery	Dr George Hopkins
Breast Surgery	Dr Daniel de Viana
Colon & Rectal Surgery	Dr Mark Doudle
Endocrine Surgery	Dr Teresa Nano
General Surgery	Dr Michael Donovan
Hand Surgery	Dr Shireen Senewiratne and Dr Daniel Rowe
Head & Neck Surgery	Dr Maurice Stevens
Hepatobiliary & Upper GI Surgery	Dr Robert Finch
International Forum	Dr Richard Lewandowski
Medico-Legal	Dr Terence Coyne
Military Surgery	Dr Peter Sharwood
Neurosurgery	Dr Martin Wood
Orthopaedic Surgery	Dr David Morgan
Paediatric Surgery	Assoc Prof Deborah Bailey
Pain Medicine	Assoc Prof Leigh Atkinson
Plastic & Reconstructive Surgery	Dr Gerard Bayley
Rural Surgery	Assoc Prof Richard Turner and Dr Roxanne Wu
Senior Surgeons	Dr Glen Merry
Surgical Education	Dr Julie Mundy
Surgical History	Dr Reg Magee
Surgical Oncology	Dr Andrew Barbour
Transplantation Surgery	Dr Jonathan Fawcett
Trauma Surgery	Professor Michael Schuetz
Vascular Surgery	Dr Douglas Cavaye
Women in Surgery	Dr Marianne Vonau

Racs Visitors & Industry Sponsored Visitors

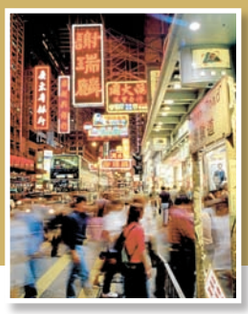
Bariatric Surgery	Dr Gerhard Prager	Austria
	Dr George Fielding	USA
	Dr Christine Ren Fielding	USA
Breast Surgery	Professor Emiel Rutgers	Netherlands
	Dr Pat Whitworth	USA
Colon & Rectal Surgery	Professor John Monson	USA
	Professor Cameron Platell	Australia
Endocrine Surgery	Mr Peter Malycha	Australia
	Professor William Inabnet	USA
General Surgery	Mr Timothy John	UK
	Mr Mervyn McCallum	Australia
Hand Surgery	Dr S. Raja Sabapathy	India
Head & Neck Surgery	Dr Randal S. Weber	USA
Hepatobiliary & Upper GI Surgery	Professor Irvin Modlin	USA
	Mr Simon Dexter	UK
Medico-Legal	Dr Christopher Wallace	Canada
Military Surgery	Brigadier Jeffrey Rosenfeld	Australia
Neurosurgery	Professor Guilherme C. Ribas	Brazil
Pain Medicine	Professor Andrew Rice	UK
Plastic & Reconstructive Surgery	Dr Peter Neligan	USA
	Mr Brent Tanner	UK
	Dr Joseph Hunstad	USA
Rural Surgery	Dr Jacob O. Jacob	Australia
Surgical Education	Professor John Collins	Australia
	Professor Alastair Scotland	UK
Surgical History	Sir Barry Jackson	UK
Surgical Oncology	Professor John Thompson	Australia
	Dr Daniel Coit	USA
Transplantation Surgery	Mr Giles Toogood	UK
	Dr Robert Montgomery	USA
Trauma Surgery	Professor Timothy Pohlemann	Germany
	Professor C. William Schwab	USA
Vascular Surgery	Dr Timothy Chuter	USA

Photos: Brisbane Marketing & Tourism Queensland

Royal Australasian
College of Surgeons
ABN 29 004 167 766

College of Surgeons' Gardens
Spring Street
Melbourne, Victoria, 3000
Australia

T: +61 3 9249 1273
F: +61 3 9276 7431
E: conferences.events@surgeons.org
W: **www.surgeons.org**



Officially a success

Feedback paints a glowing picture of the recent CASC in Hong Kong

Rob Atkinson, Chair, Professional Development Committee

This year's Conjoint Annual Scientific Congress (CASC) attendance figure was approximately 2200, which included about 1200 Fellows and Trainees from our College plus 500 other health professionals. This figure compares very favourably to the ASC in Christchurch, which was attended by approximately 1300 Fellows and Trainees.

The College truly appreciates the 350-plus delegates who took the time to complete the conference evaluation.Thank you to all those who responded! Evaluation is an integral component of the planning and delivery of educational activities such as the ASC. It is critical to obtain feedback so that future educational content meets the learning needs of the delegates. Evaluation can also "value add" to your learning by prompting you to reflect on it. Therefore, I would like to encourage all the delegates who didn't complete an evaluation to take the time to do so next year.

The decision to hold a conjoint conference in Hong Kong received an overwhelming thumbs up from evaluation respondents, with many commenting favourably on the venue and location. Based on this feedback, the ASC Planning and Review Committee is now giving serious consideration to the suggestion that an overseas location be built into the ASC cycle every four to five years.

Overall, respondents felt that the Congress enabled them improve their knowledge, skills and competence so they could refine their practice. All scientific programs received a positive rating in regard to their educational value; Pain Medicine, Surgical History, Surgical Oncology, Trauma Surgery, Vascular Surgery and Women in Surgery were particularly well received. The master classes were also identified as excellent learning opportunities, although some complained about the early morning starts. Too many collegiate social activities, perhaps?

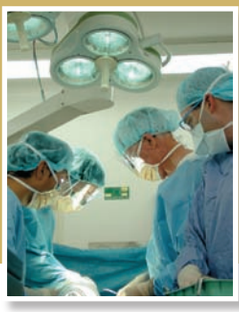
Dr James Lee, the winner of the CASC Evaluation Prize

There were a number of recommendations for the next ASC in Brisbane. Some participants suggested more combined or cross-specialty sessions and others wanted a greater focus on rural and remote surgery. There also were requests for a greater number of sessions addressing non-technical competencies and broader lifestyle issues, building on the success of these innovative programs introduced in Christchurch.

For the first time delegates were asked if they had used the ASC Virtual Congress; 33 per cent of respondents indicated positively and many flagged their intention to visit the 2008 Virtual Congress. Some of the more IT savvy delegates suggested providing presentations as pod or webcasts with downloadable content to either a laptop or mobile and using of RSS (Rich Site Summary) feeds for ASC updates. These recommendations and the others will certainly be considered for 2009 and beyond.

Our thanks also go to Vince Cousins (CASC Convenor), John Graham and Michael Hollands (Immediate Past and Current Chairs, ASC Planning and Review Committee) and Campbell Miles (ASC Co-ordinator) and the scientific session chairs for their efforts in promoting the evaluation. Obtaining feedback from delegates in relation to the ASC is an ongoing challenge. The 2008 evaluation return rate was 23 per cent, slightly less than 2007. The Professional Development Committee is keen to get your ideas about how to improve the response rate for 2009; we are willing to "think outside the square". Please contact Merrilyn Smith on +61 3 9276 7441 or merrilyn.smith@surgeons.org with your suggestions.

Successful Scholar



Statewide surgical assessment

The WA Safety and Quality of Surgical Care Project maintains an enviable database of hospital statistics

The College last year granted a $40,000 research grant to Professor David Fletcher to continue the world class research coming out of the WA Safety and Quality of Surgical Care Project (SQSCP).

One of the most comprehensive statistical databases in the world, the SQSCP was established in 1996 to evaluate the safety, quality, clinical epidemiology and outcomes of surgical procedures across WA. The data links all hospitals admissions and readmissions across the state.

Professor Fletcher, Chair of the State Executive Committee of the project and a Professor of Surgery at the University of Western Australia, received the funding through the Surgical Service Delivery Research Grant.

So successful has the project been, that since its inception it has generated 150 published scientific papers, 229 scientific presentations and has received approximately $6 million funding from the National Health and Medical Research Council and other sources.

"The population-based statistics that we have gathered over time allow us to evaluate the outcome of various procedures on an average patient being treated by an average surgeon using average equipment.

"This is in contrast to many other research projects that look at novel or high-end procedures often conducted in specialist units," Professor Fletcher said.

"As such, the SQSCP has become a very powerful tool enabling us to identify risks, determine skills, understand the surgical take-up of, and familiarity with, various new technologies and then how to avoid complications.

"Every patient admitted into a WA hospital can be linked with a 98 per cent linkage accuracy, in terms of following patients through hospital admissions and re-admissions, giving us an incredible capacity to do population-based studies.

Laparoscopy in progress

"The population-based statistics that we have gathered over time allow us to evaluate the outcome of various procedures on an average patient being treated by an average surgeon using average equipment."

"That is matched by only a few places in the world such as Sweden and Scotland."

Professor Fletcher said the SQSCP had looked at a variety of procedures to analyse outcomes such as the use of stents in the treatment of aneurysms, endoscopic and laparoscopic surgical treatments, hernia repair treatments and the outcomes of gastric banding as a surgical treatment for obesity.

Now the project team are investigating the outcome of various laparoscopic procedures as alternatives to open surgery for hernia repairs, arthroscopic surgery and colon surgery. The data is also being used to determine how long patients can wait for non-acute surgery – such as for the treatment of gall stones – before complications arise.

"It is still to be determined if laparoscopic surgery is better than open surgery for all procedures and the data we have available to us will allow us to look at that in great detail in terms of seeing any patterns of hospital readmissions," Professor Fletcher said.

"This is a truly significant project on many levels, but one in particular is that an individual surgeon may see one uncommon event in his or her lifetime but to properly assess safety we need to know how common such events actually are, why they occur and how to deal with them when they do," Professor Fletcher said.

"It allows us to marry together the prospective evaluation and the retrospective evaluation to be able to define and understand outcomes across all hospitals across the state.

"Already we have found that in some cases, surgeons rushed to use new techniques or new technologies before the advantages and risks were fully understood.

"The upshot of that has been a marked tightening of credentialing which has improved the quality and safety of surgery across Australia.

"One of the other central benefits of this project relates to the fact that research output is more productive when it combines the talents of clinicians with those of scientists, in this case epidemiologists in Public Health at the UWA (Professors Hobbs and Holman) and at Curtain (Professor Semmens).

"The former understand the questions that need answering and the latter have the skills to do it."

Professor Fletcher said the College funding had allowed the project team to employ a data analyst to help achieve new project objectives.

Royal Australian College Of Surgeons

Cowlishaw Symposium

Saturday 1 November 2008

Location: RACS Headquarters, College of Surgeons Gardens, Spring Street, Melbourne, Victoria 3000, Australia

Date: Saturday 1 November 2008

Fee: $110.00 inc. GST per person covers morning tea, lunch, afternoon tea and cocktail reception

Speakers include:

Marius Fahrer The Life and Times of Ambroise Paré
Wyn Beasley John Brown's Book
Donald Simpson From Lanfranc to Sunderland
Sam Mellick The Signal Achievements of James Lind, James Cook and Owen Stanley
Geoffrey Serpell Sympathetic Ophthalmia and Glaucoma before Ophthalmoscopy
Alan Thurston The Art of preserving Health
Philip Sharp Fridtjof Nansen: the Man who penetrated unknown Regions
Geoff Down will read a paper entitled "The Monsters of Ambroise Paré

The seventh Cowlishaw Symposium, inaugurated in 1996 Mr A.W. Beasley (then Reader to the Gordon Craig Library) to celebrate the contributions of Robert Gordon Craig, John Laidley, Kenneth Fitzpatrick Russell and Lesley Cowlishaw to the Fellowship that is the Royal Australasian College of Surgeons. This is a biennial event and it includes the Kenneth Russell Memorial Lecture.

Completed form should be returned to Ms Megan Sproule, Resources Division, Royal Australasian College of Surgeons, College of Surgeons Gardens, Spring Street, Melbourne, Victoria 3000, Australia.
Alternatively fax completed form to +61 3 9249 1219.

DELEGATE INFORMATION (Please type or print in BLOCK LETTERS)

Title (Prof/Dr/Mr/Mrs/Ms) Given Name (for Name Badge): .....
Surname: .....
Mailing Address: ..... **Postcode:** .....
Telephone (Professional): ..... **Facsimile:** ..... **E-mail:** .....
Dietary Requirements: .....

1.CHEQUES: Please make all cheques/bank drafts payable to Royal Australasian College of Surgeons (payable in Australian dollars)
2.CREDIT CARD PAYMENT: Please fill in your credit card details below

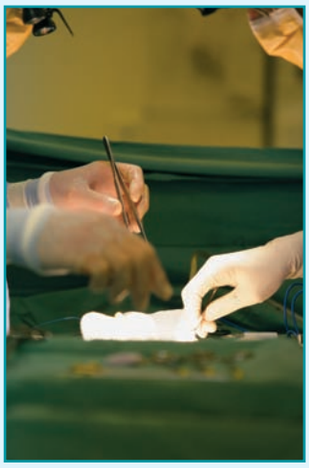
Amount (inc. GST): $ ..... Royal Australasian College of Surgeons ABN 29 004 167 766
Visa ☐ Mastercard ☐ Bankcard ☐
American Express ☐ Diners Club ☐

Card number: ..... Expiry date: ..... (must be completed to process payment)

Cardholder's name (Please Print) Cardholder's Signature Cancellations must be received in writing by the Resources Secretariat. Cancellations received prior to Friday 10 October 2008 will incur a 20% cancellation fee. Cancellations received after this date will not be refunded.
*Privacy Policy details can be viewed on the R.A.C.S. website at http://www.surgeons.org/AM/Template.cfm?Section=Disclaimer

ROWAN NICKS

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

SURGICAL SERVICE DELIVERY RESEARCH GRANT

Applications are sought from Surgical Research groups for grants of up to $20,000 to support research into areas with a demonstrated relevance to surgery not usually funded by government or industry. The focus of this grant is to fund research which demonstrates improvements of surgical service delivery, including cost effectiveness, access, safety and appropriateness. Applicants must be Fellows or Trainees of the Royal Australasian College of Surgeons.

Applications should not exceed 5 pages and include:

- ✓ A detailed research project plan
- ✓ Progress made to date (if any)
- ✓ Funding arrangements including details of any funding already sourced
- ✓ The names of key researchers and their CV's (in brief)
- ✓ The names of any collaborators and their affiliations
- ✓ Provision of two referees' names and their contact details

Completed applications must reach the Scholarship Office by 4pm Monday 10th November 2008. Applicants must submit one hard copy and one electronic copy in either Adobe pdf or Microsoft Word format. It is the responsibility of the applicant to confirm that their application has been received.

Preference will be given to projects that will use this grant to leverage other funding support though this is not a pre-requisite.

Please address written applications to:
Mrs Rosemary Wong
Scholarship Officer
Royal Australasian College of Surgeons
PO Box 553 Stepney SA 5069
and electronic applications to
scholarships@surgeons.org

Please direct enquires to Mrs Rosemary Wong, Scholarship Officer at
T: +61 8 8363 7513 F: +61 8 8363 3371

MELANOMA Institute Australia
Incorporating the Sydney Melanoma Unit

GREG POCHE FELLOWSHIPS
at the Sydney Melanoma Unit

The SMU invites applications for clinical fellowships in Melanoma and Surgical Skin Oncology. This position is formatted at a post fellowship level (FRACS or equivalent) and suitable for surgeons seeking to develop a vocational interest in the field.

The Sydney Melanoma Unit (SMU) is the largest clinical treatment centre for melanoma in the world, currently managing approximately 1,200 new cases each year. It is based in the Royal Prince Alfred and Mater Hospital campus.' It has the world's largest database of melanoma patients. Clinics are conducted within the Unit every day and more than 10,000 people with melanoma and skin cancer are seen through this clinical service.

Applicants need to hold a FRACS or equivalent, be eligible for registration with the Medical Board of New South Wales; have recently completed advanced training in plastic or general surgery and be seeking further experience in melanoma and surgical oncology. Applications are accepted from non-Australian candidates. Appropriate regulatory assistance will be given to facilitate the best overall candidate.

Further Information can be found at **http://www.smu.org.au/fellowship-opportunities/fellowship-opportunities.html**, or by emailing Nicola Groves (nicola.groves@smu.org.au).

Applications close on 30/10/08.

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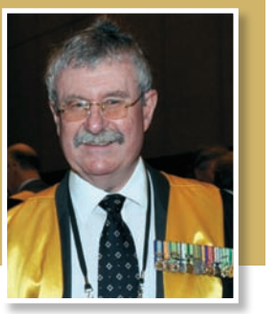
With Charlie Walsh OAM and Brett Aitken OAM

Weary Dunlop



A bridge too far? – Never!

Remembering Weary Dunlop in the oration given in his honour at the Hong Kong CASC 2008

Robert Atkinson

The theme that runs through all Weary Dunlop orations is that of reconciliation, so to give this oration in the presence of the Fellows of two Colleges and three Countries was most appropriate.

A biography of Weary Dunlop was given as a number of those present were not familiar with him.

One might ask why "Weary", when his name was Ernest Edward Dunlop. There are idiosyncrasies in Australia. We call red headed people "Blue" and sometimes short people are "Lofty". A quizzical sense of humour you might say. In this case, "Dunlop" manufacture tyres, tyre equals tired, thus: Weary.

Weary was born on July 12, 1907. When he died 10 days short of his 86th birthday his body was taken on a gun carriage to the shrine on St Kilda Road in Melbourne where he had stood so often on ANZAC and Remembrance Days as well as the February day marking the fall of Singapore.

He was born in Wangaratta in Victoria and had an ordinary life in the country. He was good at sports and swimming and was not averse to fisticuffs, particularly those arising from sibling rivalry. In 1923 at the age of 16 he left Benalla High School and became an apprentice to the local pharmacist. In 1926 he enrolled in a correspondence course with the Melbourne Pharmacy College where he topped his year, demonstrating a glimmer of his intellectual ability. He went on to Pharmacy College in Melbourne where he was awarded a Gold Medal and a Silver Medal with varying honours, effectively leaving the College with two gold medals.

He continued his education in Melbourne but as a country boy was not part of the mainstream fraternity. He boxed and he played Australian Rules football, had success in anatomy, trained further as a pugilist and was eventually recruited to play Rugby Union.

Weary's life progressed – a "ratbag" with sporting prowess, intellectual capability and a taste for the "occasional drink". Then he presented himself at the primary examination of the Royal College of Surgeons of England as Professor Buckmaster and Mr Gordon Gordon Taylor, English Examiners for the Royal College, had come to Australia. Weary passed and exploited loop hole that allowed him to achieve the equivalent of the primary Fellowship of the Royal Australasian College of Surgeons. He graduated MBBS including his primary in surgery very early. I consider this a lesson for the new Surgical Education and Training Program: intelligent, motivated people are going to find their way, all we need to do is give them the opportunities.

> "Weary's work in doing his best to keep the troops alive was heroic, and on a number of occasions he was threatened by the Japanese with a sword to his neck for imminent beheading."

Weary travelled to England for further surgical training and was specialist surgeon to the emergency service at St Mary's Hospital, Paddington when the Second World War broke out. Unusually, he was able to secure a position as Captain Dunlop in the Australian Army from London. So, in 1940, at 32 years of age, he was posted to Jerusalem, Palestine. He went on to active service but no great surgical commitment in Greece, Crete and Tobruk.

One time, when he was in Syria with the Australian Forces, a notable clash took place with the Vichy French on the Rugby field. The French, as we well know, are good at Rugby, and at half time the Australians were losing. Weary was the Captain and gave the expected team talk resulting in the second half being a blood bath, which the Australians won. No doubt Weary packed plenty of the punches.

Prime Minister Curtin recalled the Australian forces to defend their homeland and Weary landed in Java in 1942 and was posted commander of No. 1 Allied General Hospital. After capitulation he elected to stay with his hospital and patients and became a prisoner of war.

He wrote comprehensive diaries, kept concealed throughout the war, on the Burma-Thailand Railway incorporating his meticulous observations of prison camp life. He became a hero and a legend amongst the Australian and Allied POWs, as did many other medical officers.

There were 22,000 Australians in captivity, more than 7,000 of whom died or were killed. This was a small number really considering all the other nations whose people suffered as well. By the time peace came in 1945, Weary carried with him a unique record of POW life. He returned to civilian life, married and continued surgical practice in Melbourne at an eminent level, building relationships with South-East Asia. He made the care of former POWs his life's mission.

At this point in the oration I elected to relate an expose of the society that produced a person such as Weary Dunlop. He was a fairly free ranging human being, a person of the Western liberal democratic tradition. More particularly he was a child of the "immigrant democratic diaspora" with roots in the immigrant countries all of us had come from somewhere and from where everybody's family, if we dug back enough, had a fairly good reason to leave.

In the beginning that diaspora was Western European and Anglo-Celt. Nonetheless, as the Australian song goes: "We are the World, we are Australian." Everybody has participated in

Ernest 'Weary' Dunlop, as he is remembered

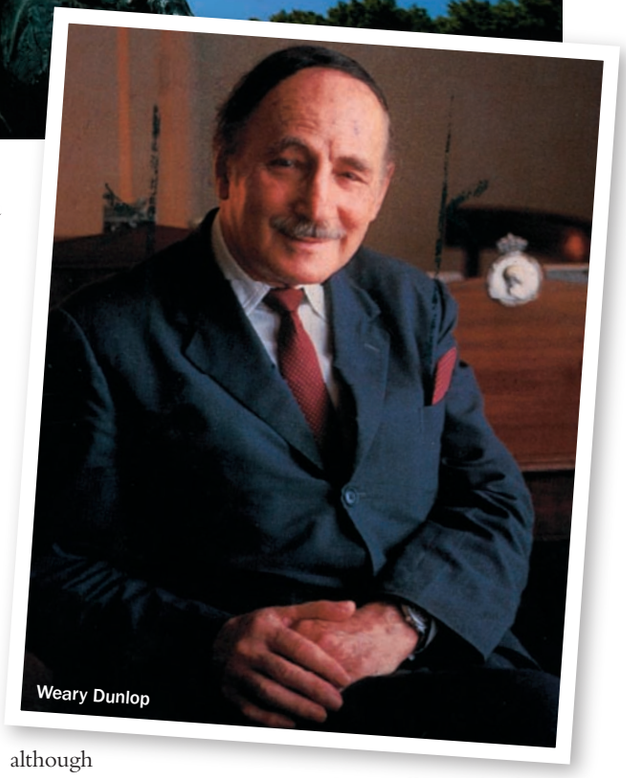
this movement.

The greatest highway was the ocean and London had access to the superhighway par excellence. So immigrants poured forth developing North America and many other parts of the world including Australia. As mentioned, digging down through the families of all who had immigrated we would probably find a really tough story, and Weary's was no exception: an independent minded people with a great sense of honour and justice and probably an unusual sense of humour.

North America was founded in many ways by the Puritans who sailed in the Mayflower because of their convictions. In 1788 the first fleet arrived in what is now Sydney Cove, people who had also mostly come because of their convictions. Same word, different convictions. Nonetheless, both people came from the fringes of the Old World from which they had chosen or been forced to leave. Therein the lies some of the seeds that have led to the Western liberal democratic tradition, which essentially puts me first, family second and community last. How does that compare to the East? The Ming Dynasty had huge ships – an armada and flotilla that travelled the world. They had access to the super highway and when they returned to China with their ideas the Ming Dynasty shut the ideas down, burnt the ships and closed the doors. A quirk of history. Confucianism had influence and in principle goes community first, family second and self last. It has been said (by Rudyard Kipling) that East is East and West is West and never the twain shall meet. However that is not true anymore, and certainly not a good thing.

Today it is possible to build a bridge between these two cultures, sharing communities, families and individual responsibilities in the reality of day to day life. As we communicate the practical aspects of what is right in daily life the bridges we build between us grow and draw us ever onward and together.

I then considered Weary as a prisoner of war. That is where his unique abilities came to the fore with his innovative surgery, his energy and his ability to stand up to his oppressors and be a beacon of leadership in an extraordinary difficult time.



Weary Dunlop

As a surgeon he was a non-combatant and did not carry arms, although this has changed today under the Geneva Convention.

The Japanese Bushido code, as with chivalry in most societies, had a highly developed sense of honour. Prisoners were deemed lowly, as they were considered to have failed to die honourably on the battlefield. Thus their treatment was deplorable and dishonourable. They were used as physical labour to build the strategic railway from Thailand to Burma as shipping was denied because of the United States submarine campaign. Weary's work in doing his best to keep the troops alive was heroic, and on a number of occasions he was threatened by the Japanese with a sword to his neck for imminent beheading.

The question I would put to you is, given he was a non-combatant and therefore not the same prisoner as an infantry officer, what honour would there have been in killing Weary? None at all, in fact quite the reverse. My strong view is that if Weary had been killed the chances of the railway being finished would have been pretty low. If the word went out that they had killed Weary then everybody else would have said "kill us too, we're not doing any more work." It was wise, or maybe pure luck, that they did not kill Weary.

What about this Japanese Imperial Army that treated combatants and non-combatants so badly! To note President Kennedy at the time of the Cuban crisis, he convinced his senior generals that Russians breathe the same air as Americans. Even the enemy is a human being and a bridge between us may prevent a worse crisis.

Continued next edition of Surgical News

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

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FOR THE FELLOWSHIP EXAMINATION

Applications from eligible Fellows willing to serve on the Court should be forwarded to the Examinations Department of the College no later than **Monday 1 December 2008.**

Fellows are asked to note the following vacancies on the Court:-

General Surgery
Australasia (2 vacancies)

Vascular Surgery
Australasia (2 vacancies)

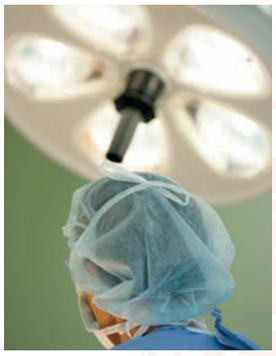
Urology
Australasia (4 vacancies)

Otolaryngology – Head & Neck Surgery
Australia (1 vacancy)

Plastic and Reconstructive Surgery
Australasia (1 vacancy)

Orthopaedic Surgery
Australia (2 vacancies)

- Please email application form and curriculum vitae to:
  examinations@surgeons.org
  or post
  Department of Examinations
  Royal Australasian College of Surgeons
  240 Spring Street
  MELBOURNE VIC 3000
- Application form is available for downloading via the College website
  www.surgeons.org
- The policy in respect to Appointments to the Court of Examiners can be found on the College website.
- For inquiries, please contact Carmen Davis on +61 3 9276 7471
  or email **carmen.davis@surgeons.org**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Letters to the Editor

What's in a name?

A call to keep our 'Royal' precede and a different system for managing acute care services

The College name change?

Regarding a recent article in *Surgical News* on the name of the College (Vol:9, No:5), I would like to give my opinion – physically remote although close in warmth and feelings. Besides the sound statement on historic grounds issued by the Irish College, to which I subscribe, I put forward other reasons in order to continue with the word "Royal".

First, whether a name is a sign or rather the expression of the being of an entity, I agree with two South American writers on the topic. Thus, the Colombian Gabriel García Marquez spoke in a free and personal interpretation of the need early man had to name whatever in creation came to his knowledge. From a different perspective, the Argentine Jorge Luis Borges emphasised, again a personal understanding, the relevance of a given name, writing that in the name of the rose lies the rose itself and that every river exists in the words "the Nile".

Upon this tropical basement, being a republican who lives in a republic, I am sure our College must keep its Royal prefix. It means, as a second argument, continuity in a place where discussion regarding both surgery as such and the practising of surgery should and must take place, as always, beneath a deep and proven entity whose essence is well represented by its full name as it is known today. Change in name is justified wherever accompanied by change in the above mentioned essence. Bizantium, Constantinople and Istambul: the same city with different names in altogether different times – truly eastern Roman, then Christian of two modalities and since 1453, Muslim. Therefore, she changed. Rome did not, nor did its name.

Please allow me to express my thinking and my wishes, both indeed full of gratitude: our association ought to maintain its strong, recognised-everywhere and tower-like name.

Prof. A A Campero MD, Mg. Chir, FRACS – Tucumán, Argentina

Acute Care Surgery Services

Phillip Truskett's article on Acute Care Surgery Services (Vol:9 No:6) is very timely and highlights the central role of surgeons in determining models of care. At Middlemore Hospital in South Auckland (serving a population of circa 460,000) General Surgery has had a dedicated acute care service for over five years known as a "Modular System" for the delivery of care Monday to Friday. We have moved away from the age-old concept of the admitting surgeon being responsible for the operative management of those under his care throughout their admission. The volume of cases particular in large units simply demands a collective approach to acute care. The growing significance of safe working hours can easily be accommodated by a modular approach.

Our system sees one surgeon taking the admissions under his or her name for the 24 hours, but that surgeon is not necessarily responsible for the physical delivery of acute surgery or assessment during the daytime "module". This allows the 24-hour call to be evenly distributed throughout the Department, but allows the 24-hour surgeon to go about "non-acute" activities until 5pm if that is what their normal schedule calls for.

As with NSW, it is vital the Acute Surgeon has no commitments other than the smooth and efficient running of acute surgery. In addition to this basic tenet, the acute surgeon also works in a two surgeon team with fixed acute care days for each of our 5 teams between 8am and 5pm Monday –Friday. Surgeons take 24 hour call in turn, with all admissions coming under the 24-hour surgeon of the day. The roster has surgeon A covering the daytime one fixed day every second week, with surgeon B covering the daytime of the same day on alternate weeks. This has the advantage of "in house cover" with our philosophy being

> "We have moved away from the age-old concept of the admitting surgeon being responsible for the operative management of those under his care throughout their admission."

where possible to only have one member of the team on leave at a time. In addition, with two surgeons "free" each day, we have the ability to open a second General acute theatre if required. Timeliness of surgery has been dramatically improved.

A further advantage of splitting the day time from the evening/night roster is that Friday nights are simply rotated. One of our two-surgeon teams covers each Friday until 5pm, but as all the admissions are coming under "24 hour surgeon" who physically takes over at 5pm, the Friday day-surgeons have no more weekends affected than any other surgeon.

Clinical handover and collegiality are enhanced between teams. Furthermore, as many patients are admitted under one surgeon but operatively managed by another, "second opinions" are a matter of course. This has lead to a considerable increase in the consistency of care across the unit.

Day time acute surgery is now viewed simply as part of the normal working week for surgeons - as normal a part of the week as clinic or elective surgery. This modular approach has highlighted the importance of acute surgery as well as demonstrating to our trainees that acute care need not be onerous, nor is it something that requires a subspecialist. It is indeed very rare that an acute case

needs a "colorectal expert" or a "specialist upper GI surgeon" – we have learned off each other and hence we believe we are training a generation of surgeons to actually look forward with confidence to a day of acute surgery.

We have defended the policy of all members of the Department being on the acute roster and this modular system means that those approaching retirement can contribute greatly to acute surgery without having to participate in the more physically demanding 24-hour system.

We do not believe a General Surgeon, often fresh from Training, should claim to be "trained out" of acutes by the nature of their subspeciality. By applying a modular approach, and by having a two-surgeon team system, no surgeon should feel inadequately supported to do acute General Surgery. Surgeons can pursue their elective subspeciality whilst providing broad acute General Surgery. Those who do feel insecure early in their appointment can simply gain experience during the day-time module (when greater support is available) and then step up to the 24 hour roster. We have found this particularly effective in helping immediate-post-Fellowship colleagues make the "next step" to relative surgical independence.

For our Department, the modular system has been a tremendous success. We would not support the creation of Acute Care Surgery as a defined entity if this was to diminish the responsibility of all surgeons in our public hospitals to contribute their knowledge and skills to the care of our patients and the training of our junior colleagues in the art of acute surgery. We have made refinements over the last five years, but it has revolutionized and simplified acute care. We strongly recommend such an approach. We would welcome visits from any colleagues interested in seeing the system in action.

Andrew Connolly
Head of Department of General Surgery
Middlemore Hospital
Counties-Manuaku District Health Board
Auckland
New Zealand

Frank Stansfield

Thank you for reminding me of the late Frank Stansfield (Vol:9 No:7). There are a lot of Fellows of my vintage who owe him a great debt. Not only for his anatomy teaching but for his basic principle that most things can be made simple and a simple way to do something was usually the best.

His knowledge of railway timetables extended beyond the British Isles. A sure was to impress him at your first visit was to tell him correctly the name of the stations from Lithgow to Bourke – he knew them.

I have a copy of the famous monkey statue which I acquired on the Left Bank many years ago.

John B Walker
NSW, Australia

Photo courtesy of Kevin Connors

Old China hands

The Hong Kong CASC provided a perfect excuse for a post- conference cultural tour

Wyn Beasley

The College owes a great deal to Gordon and Rosie Low, whose concerns led to a system of exchanges that began as Project Guangzhou, then became Project China and after two decades had brought three countries together surgically to the point where the May 2008 programme, in Hong Kong and on the Chinese mainland, was an exercise in collaboration that was guaranteed to succeed.

It had always been my intention to register for the Hong Kong CASC meeting, but my wife, having visited Hong Kong more than once before, felt no need to come with me this time. Then an email from the Lows arrived, inviting us to join a group they were putting together, for a post-conference 'cultural tour' of China. Suddenly there was nothing my wife wanted more than to be part of the Hong Kong meeting! When we looked at 'cashing in' some air miles, we found we would need to arrive in Hong Kong almost a week ahead of the meeting, and our resourceful travel agent offered to put together a special little pre-conference tour for us, to Xian and Beijing, the two 'must-visit' places north of the Yangtze [and thus the perfect complement to the Lows' tour, which was to include a Yangtze cruise with visits to cities lying on or south of the river].

Well, we relished our preliminary tour, which enabled us to see Xian with a cheerful guide who was justifiably proud of her city and its 'terrycotta' warriors [all our guides described this remarkable assembly as if it had been sculpted by Mrs Cotter's son Terence]. We then went on to Beijing, where our voluble guide sniffed at provincial towns like Xian, criticised the Western media for spreading lies about the peaceful assemblies in Tianenmen square, and generally showed evidence of what guides elsewhere laughingly assured us is the 'Beijing syndrome'. But we did get to see the 'Bird's nest', we did have a blue-sky day – our only one of the entire visit – and we did climb the Great Wall, and obtained a small brass tablet to confirm it!

Earlier issues of *Surgical News* have recorded the success of the Hong Kong meeting itself; and on the Monday morning afterwards twenty of us – the men all surgeons apart from one old soldier, the women mostly surgical wives – met up at Hong Kong airport, which seems [and is] highly efficient, and vast until you see the scale of the equally efficient new Beijing complex. We flew west to Kunming, which was [by China standards] quite close to the area of the previous week's earthquake. A relatively small city, of a mere four million people.

There was no evidence in Kunming of local earthquake damage, but plenty here of the explosive mixture of ethnic minorities that exists in China's south-west; and it was no great surprise to learn, just prior to the Olympics, of this boiling over into a couple of bus bombings. But our own visit was utterly peaceful, and we explored the splendid gardens of the 1999 Hort-Expo; the next day we paddled canoes on a river gorge, then made our way through a complex of limestone caves, and in the afternoon proceeded – by coach, then people-mover, finally on foot – across the Stone Forest: like everything we saw in China, it is on a larger-than-life scale. On our final morning in the Kunming area, we were shown round the Ethnic Minorities Villages, which are a riot of colour and costume but have somewhat the character of a human zoo.

By that evening we were in Wuhan, a big industrial city that has, amid all its bustle, the Yellow Crane Tower, which crowns a hillside and shows the elegance that traditional Chinese design can bring, if not compromised by political correctness.

At dusk our coach set out to take us the 300km west to Yichang, where we boarded our river steamer for our Yangtze cruise; on one of a network of expressways that seems to cover China [like a plate of noodles tipped over the map] we covered the distance in three hours! It is a great system, this road network, for bringing relief supplies in quick time to a disaster area, and could serve equally for bringing troops to an area of dissent.

The cruise itself was fascinating; the style and sophistication of Victoria Katarina was a match for the Rhine and Russian cruises we have undertaken in the past, with the exception that the evening entertainments turned on by the members of the crew were more accomplished than you could expect, even on stage ashore. And the river itself: the first prodigy was man-made – the Three Gorges power project. The dam is straight, not curved as ours commonly are; the ship locks which flank it were large enough to swallow our vessel along with half a dozen freighters.

Once upstream of the dam we slipped through a landscape of cliffs and haze, the cliffs gradually closing in on us. We learned all about the effects of raising the river level [it still has about 25 metres to go, but has already submerged the homes of a multitude of locals, who have been 'encouraged' to shift to housing at a higher level – geographically, that is; not really in the sense of quality.

Apart from the three gorges themselves, there are the three Lesser gorges, and finally the side-branches of the Lesser Lesser gorges: to explore them, we transhipped to vessels that resembled motorised pagodas, and finally to motorised sampans with a theatrical coxswain! I do not know when the sunny days of the tourist pictures occur; we did not see any unequivocal sunshine; but in the haze our version of the river had a Lord of the Rings quality in areas

"We ended our tour fascinated by all we had seen, better informed but still bewildered by the scale of the country and its 1.3 billion people."

that were not built up and, for the rest, a Step-toe quality, the river banks littered with ships being broken up, ships being built, and the general detritus of a vast country. And, as well as observing from the deck, we enjoyed a series of shore excursions.

Chongqing, where we disembarked, is a steep-built city at the junction of two rivers; a cheerful place which was the capital of the Chinese resistance during the Japanese invasion. It has a museum dedicated to Chennault's Flying Tigers, a group of airmen who fought for the Chinese before the US came into the Second War, and it was the terminus of the supply line from Burma once the US recovered from the shock of Pearl Harbor and threw its weight behind Chiang's resistance. It is still fashionable to deride Chiang, but hard to see how Mao could have persuaded the US to provide a tenth of what Chiang secured. And only now is there evidence of a comparable disillusion with Mao himself; until lately the excesses of the Cultural Revolution have been laid at the door of his wife and her three fellow-manipulators.

But the highlight of our Chongqing time would have to be our visit to the city's major military hospital, which caters for the needs of the local civilian population once the needs of the military have been met. It is a vast complex, and at the time of our visit it had the beds-in-corridors phenomenon that we have become familiar with: but here it was due to the arrival of 200 orthopaedic admissions from the earthquake area. Our guide was a female army subaltern whose bearing would gladden the heart of the most fastidious commanding officer.

Our final city was Nanjing, another capital during the Sino-Japanese conflict, and one which suffered more than enough in the process. It has a museum that recalls the murder [with accompanying rape, fire and destruction] of 300,000 out of a population of a million; the displays are inspired in the skill with which they evoke the horrors of the Japanese massacre, even to the gradient of the floors as the record dips into the worst excesses. But it is also a city of happier commemoration, which offered us visits to the Sun-Yat-Sen mausoleum [he was a doctor, who led the 1911 revolution that got rid of the last emperor], to Chiang Kai-Shek's headquarters [he was Sun's brother-in-law, who led the Nationalist side in resistance to the Japanese] and to the home of Zhou Enlai [Chou En-Lai, who was Mao's offsider]. More than that, we were able to visit museums celebrating Zheng He, the eunuch admiral who explored much of the world – there is debate as to how much – and the Taiping rebellion, which dented the complacency of the imperial Chinese forces during the 19th century; and then to have our group photograph at Nanjing Museum.

We ended our tour fascinated by all we had seen, better informed but still bewildered by the scale of the country and its 1.3 billion people; we had appreciated the niceness of the people we had met, even as we were apprehensive of the background of 'comply or else' which overshadows their regime. We had received mixed signals, hints that the day of the one-party state may be numbered, along with evidence in the Chinese media that it is still not in order to question the official line. Whether China will become a more mellow single country at one extreme, or implode as the Soviet monolith did a couple of decades ago, or evolve into something quite unique and different again, is impossible to predict; whatever course China takes, it will produce reverberations even more widespread than the tremors that emanated from Chengdu in May [which some of us perceived in Hong Kong!]

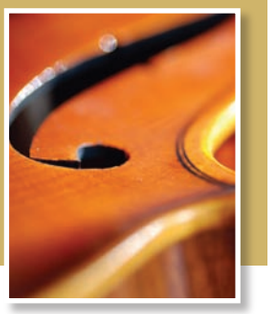
For China is a vast country, profoundly varied in its history, its ethnicity, its prosperity; and although we have only 'scratched the surface' we have, thanks to Gordon and Rosie and their cultural tour, enjoyed the scratching process. I hope, moreover, that we have gained from it.

Patrick Claessen and Dr Arun Mahajani running the City to Surf in the Northern Territory.

Living life to the fullest

Dr Arun Mahajani is proof that you are never too old to enjoy marathons. Dr Mahajani ran the City to Surf in the Northern Territory this year, it was a 13 km run. A few weeks later he also ran a half marathon of 21.1kms, he is a very fit Fellow.

Medicine & Art



My journey from surgery to history

Are you a medico-artist? As strange as it may sound, medicine and the arts are simply different forms of creativity

George Weisz

Born in Eastern Europe into an intellectual family, with classical and operatic music resounding within the walls of a small apartment, our happiness lasted until two subsequent totalitarian regimes destroyed the physical and spiritual health of the family. Music remained though a cultural basis for my humanistic approach in life, enriched only years later on in the West, by a literary and artistic self-education.

Medicine was the ideal of my life, considered a vocation and displacing everything to second level. Along 37 years, orthopaedic and spinal surgery preoccupied me entirely, music remaining a permanent stimulation and pleasure. It was only much later, once fairly stabilised in professional and family environment, that return to artistic activity could be entertained.

Indeed, aged 54, I enrolled in a History and European study course, achieving in three and a half years my first Art degree. It was an unexpected and extraordinary intellectual stimulation; my enthusiasm was greater than that of my younger colleagues. At the end, threatened by an intellectual vacuum, I found relief in a course on Italian Renaissance, leading within two years to another Art degree. The thesis, initially on "Renaissance Medicine" was reversed, rejecting the main concept of that period, namely the revival of antiquity. The classical medicine was considered unscientific and as a consequence, the final title of the thesis was changed instead to "Medicine in the Renaissance period".

It was at that time that I discovered the first instances of doctors turned to artistic creativity. During the coming ten years, many names were added to a long list of European, North American and Australian doctors – all involved in artistic creativity of various kinds. Many are surgeons, some presented in the lines of this magazine. This unique phenomenon amongst professions was presented on several occasions in academic circles and finally crystallised in an essay: the "Medico-Artistic Phenomenon".

My first presentation was at the History of Medicine Society meeting in 1988 on Erasmus' "Oration in praise of medicine". This was soon followed by a presentation at a meeting of the same Society, on three doctors turned artists, (Ficino, Servetus, Rabelais). The next move, in 1999, was a modest publication on "Healers at work", followed by publications on Friedrich Schiller, Carlo Levi and others.

The findings, by that stage concluded to be a "phenomenon", were presented in Byron Bay Conference "Take Heart" and at a conference on "Humanism in Medicine" in UWA, both in 2006. Enumerated were the many fields of medicine from which artists emerged, doctors being of all ages and at various stages in their career, some partially (A. Schnitzler) or totally (Maugham) abandoning medicine, others continuing to practice (Chekhov, Copernicus). They were creative in music (Borodin, Sinopoli, Kreisler), in painting (Banting, C. Levi), in theatre production (J. Miller) and in film production (G. Miller). The list of literary contributors in all aspects was impressive and covered history, theatre, novels, librettos, journalism, travel guides, and so on.

A particularly rich contribution came from the Australian continent. Contributions were in theatre, in writing fiction or

"It is my conviction that this humanistic study enhanced the compassion and understating of doctors toward the sick."

history, archaeology, many presented in medical or surgical journals. The contributions to visual arts came from individual artists or members of one of the five active medical art societies, with yearly exhibitions, workshops and courses where doctors carve in wood, sculpt, paint landscapes and portraits, work in oil, in batik, draw in carbon or paint on glass.

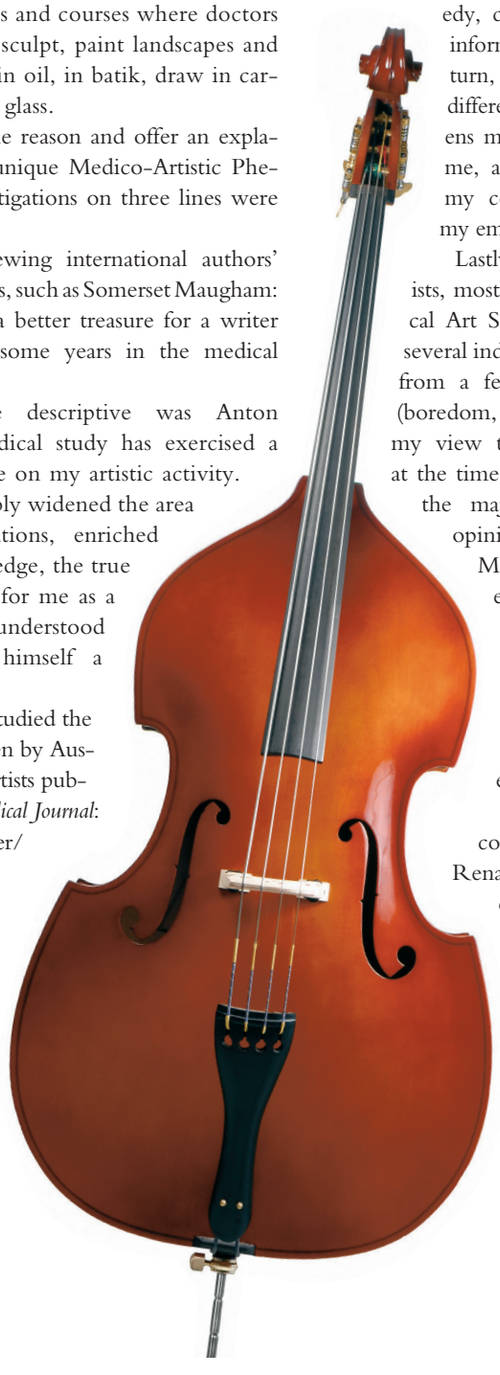
To detect the reason and offer an explanation for this unique Medico-Artistic Phenomenon, investigations on three lines were undertaken:

Firstly, reviewing international authors' own explanations, such as Somerset Maugham: "I don't know a better treasure for a writer than to spend some years in the medical profession."

Even more descriptive was Anton Chekhov: "Medical study has exercised a serious influence on my artistic activity. It has considerably widened the area of my observations, enriched me with knowledge, the true value of which for me as a writer can be understood only by one himself a physician".

Secondly, I studied the explanations given by Australian medico-artists published in the *Medical Journal*: such as the painter/GP: "'Painting energises me, my love and practice of art has helped me become aware of the broader social picture of Medicine. Medicine and art, my two passions, have always intertwined, shaping my life" (S. Blyth).

A paediatrician/painter wrote: "The practice of medicine, so laden with pathos, grief, love, regret, sadness, joy, struggle, tragedy, courage and humility, has informed me as an artist. ... In turn, creativity fosters new and different ways of seeing, broadens my understanding, nurtures me, assuages my soul, deepens my compassion and heightens my empathy" (L.C. Ades).



Lastly, I interviewed 27 artists, mostly members of the Medical Art Society of NSW and also several independent surgeons. Apart from a few negative explanations (boredom, routine, and alike – in my view the result of immaturity at the time of opting for medicine), the majority were of positive opinions, repeatedly stating: Medicine and Arts are different forms of "creativity". Terms such as "art as a need for intellectual activity", "intellectual stimulation" and "instinct of creativity" were repeated expressions.

My own views: I discovered at start that the Renaissance humanistic education ("uomo universalis"), has connected the two forms of art. Along the centuries, a particular relationship between the two forms was maintained, when writers dealt with medical topics in many of their writings (Rabelais, Schiller, Cronin, Schnitzler, Williams, Faure). The connection became prominent in the 19th and more so in the 20th century, when medical schools have introduced basic humanity studies in their curriculum (just like in US).

It is my conviction that this humanistic study enhanced the compassion and understating of doctors toward the sick. For me, medicine and art are two forms of the same art, the shift being but a continuation of an instinct of creativity, complementary, rather than contradictory.

From creativity in spinal surgery, each case being a new creation, (based initially on a textbook, but eventually different) and converted to the art of Medical History, it seems an expression of creativity in another form. It is by no means an abandonment of medicine, neither idealistically, or practically.

At present, forced by age and circumstances to restrict medicine to consultancy, my activities are oriented toward two different lines of research: The "Medical history written in Renaissance painting", discovering a long list of anomalies painted and sculptured hundreds of years ago, a treasure of medical history.

The other line of research, much less attractive, but necessary, is the review of "The darkest page in the history of medicine: Nazi Medicine", presented as a poster exhibition in Sydney (March-July 2008), scheduled at UNE Armidale, (in August), at UNSW (September) and in Melbourne, (November)

Most of my publications were in accord with the principle that the best medical history is written by two persons: one doctor and one historian. The author of this principle is my research collaborator: Emeritus Professor at UNSW, Randall. W. Albury.

It remains to others to answer my perennial question: "Am I a medico-artist?"

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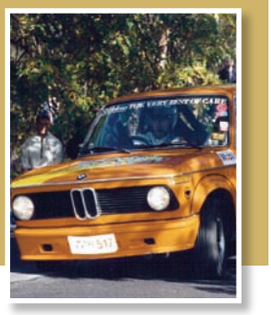

Driving force

Car racing at first seems an unusual hobby for a surgeon but there are similarities – reassembling and a desire to make it work better

Paying his way through university by working weekends at a service station in Hobart, plastic and reconstructive surgeon Mr Simon Thomson found that he liked working with his hands. So it was that he chose to become a surgeon and so it also was that he developed a lifelong passion for cars; building cars, fixing cars and racing cars.

Now a father of three and working out of the Royal Hobart and Calvary Private Hospitals, Mr Thomson rebuilt his own beloved 1969 BMW 2002 from scratch which he both drives and races.

"Coming into work with hands that look like they belong to a mechanic has raised a few eyebrows in the past. But I think everyone needs to find something they love to do away from work, something that allows you to take your mind off it and concentrate on something else and that something else for me is working on cars," he laughs.

Though it seems at first blush to be an unusual hobby for a surgeon it's not hard to think of comparisons – understanding the components; taking apart and reassembling; a desire to make the machinery work better.

"I think working on cars and even car racing have close links to surgery. Car racing in particular requires planning and preparation so that risks are minimised and if you approach it seriously and intelligently it can be extremely rewarding," Mr Thomson says.

"There are some people who dislike car racing intensely and think it sets a bad example for young people but I would argue the reverse. You have to obey the rules, most events have a zero tolerance for alcohol and it reinforces the need for driver skills and education, that it's not just about getting behind the wheel and putting your foot down.

"More people end up in A&E from football, rugby, and netball than from rally driving and far more people die annually skiing than from motor sport."

Rallying is a family affair, Simon & his brother Peter on the prologue stage of Targa

"Often members of the public don't think of surgeons as ordinary human beings yet car racing is a favourite hobby of many Australians."

Since taking up rally car driving in 1998, Mr Thomson says he has suffered no injuries and has often raced with his son and daughter as co-driver and navigator.

In particular, his favourite event is the Targa Tasmania, a five-day tarmac race through the picturesque back roads of the island state. The race was invented in 1906 with the most famous being the Targa Florio held on the mountainous roads of Sicily with the name "targa" simply meaning the plate given as the original prize to those that survived the rigours of Sicilian roads.

Mr Thomson has so far received a plate at each of the five races he has entered.

"Tasmania is great for this sort of racing. We have good quality roads that are easy to close off and the scenery is fantastic," he says.

"Over the five days of the race there are 43 stages which the driver has to negotiate. A competitive stage is a section of the road chosen for the challenges that it offers so that particular stages are typically windy, twisty, have varying turns and curves and conditions may be uphill or downhill. Each crew is given a basic set of instructions describing the stages including special care and warnings. Many of us prefer to run with our own pace or safety notes which are much more detailed, often rating every corner of the event.

"At the same time, absolute speed is not necessarily seen as a desirable element of any competitive stage and there has always been a push to slow the event down. If there are accidents then it is often about trying to do so much, not planning adequately and not leaving enough in reserve when you might need it."

Mr Thomson says thousands of people come out to see the drivers tackle the challenges while up to 3000 volunteers each year man the road closure signs, staff checkpoints and keep spectators at a safe distance.

"This unique Tasmanian commitment to the Targa is one of the things that sets this race apart from those held elsewhere because this level of community support is unprecedented. I've even had patients turn up to take a look

Simon & his daughter Katrina as navigator at Targa, 2005

and at one stage of one particular race I saw one of my patients holding up a sign that read 'Go Doc!'," Mr Thomson says.

"Even though the race ignites passions on both sides of the fence, I think it's hard to argue against an event that brings so much pleasure to so many people."

Not having competed in a race for the last few years, Mr Thomson is getting now ready to rev up his engines for next year. He says that tarmac racing has become increasingly popular in recent years with various events now being held across Australia, and he's missed it.

"I think the best analogy is that driving on a testing road with various curves and drops and bends is very much like downhill skiing because it requires rhythm, planning, patience, technique and if it comes together this can be utterly exhilarating," he says.

"I don't feel at all at risk participating in such races as the Targa because we are usually very well prepared and like most crews in the event we usually drive well within our own and our car's capabilities, and I think professionally it works too.

"Often members of the public don't think of surgeons as ordinary human beings yet car racing is a favourite hobby of many Australians and I think it helps build rapport between me as a surgeon and the community within which I work."

Dr Peter Arnold BSc, MBBCh (Witwatersrand 1961) BA (UNE), formerly Deputy President of the NSW Medical Board and Chairman of the Federal Council of the Australian Medical Association, assisted by a sociologist and a statistician, is undertaking a study of the migration of South African medical graduates to Australia.

He is attempting to contact, by e-mail, all 2,000 who have migrated to Australia, as well as the surviving spouses or children of those who have died since migrating. He asks that any South African medical graduates reading this notice write to him: **parnold@ozemail.com.au**

PATHOLOGY GUIDELINE FOR THE REPORTING OF BREAST CANCER REVISED

The new, revised version of *The pathology reporting of breast cancer – a guide for pathologists, surgeons, radiologists and oncologists (3rd edition)* is now available.

The guide, first published in 1997 and revised in 2000, has been updated to reflect the latest evidence and expert consensus opinion. The revisions were undertaken by a multidisciplinary working group convened by National Breast and Ovarian Cancer Centre and Australian Cancer Network.

The guide includes recommendations on the handling, examination and reporting of invasive carcinoma and ductal carcinoma in situ. It also includes new and updated sections on sentinel node biopsy, tissue banking, hormone receptor and HER2 assays and lobular neoplasia.

One of the key recommendations of the guide is the use of synoptic reporting to ensure better communication between clinicians, with less likelihood of misinterpretation of findings. The guide contains an updated version of the synoptic report that provides a systematic method of ensuring all relevant pathology information is included in a way that is easily interpreted by the clinical team. The synoptic report can either be used as the definitive pathology report or as a summary provided in addition to a more traditional descriptive report.

A copy of the guide will be sent to all fellows of the Royal College of Pathologists of Australasia and members of the Section of Breast Surgery, Royal Australasian College of Surgeons.

The pathology reporting of breast cancer – a guide for pathologists, surgeons, radiologists and oncologists (3rd edition) can be downloaded or ordered online at www.nbocc.org.au/resources or by calling 1800 624 973.

Michael Grigg ,Chair, Professional Standards Committee

Surgical Competence and Performance Guide

The Surgical Competence and Performance Guide was mailed to all Fellows of the College in mid September 2008.

In many ways, this is a remarkable and possibly unique document. I hope you will spend a few minutes looking through it. It is designed as a tool for self-assessment and self-reflection. It can provide some useful insights into both you and your colleagues and how others might see you. It aims to address how we understand and improve our performance in all areas of surgery, including the key competencies of communication, collaboration, teamwork and management.

The Surgical Competence and Performance Working Party developed the guide over the past two years, with the oversight of the Professional Development and Standards Board. A review of the world literature showed little in the way of practical examples that would allow self-reflection to identify appropriate levels of performance – hence the need to develop our own document.

If you have any questions or comments regarding the guide, please contact Dr John Quinn, Executive Director of Surgical Affairs, Australia at email john.quinn@surgeons.org.

If you require additional copies of the guide, please contact Kylie Mahoney, Manager Professional Standards at email kylie.mahoney@surgeons.org. The guide is also available on the College website at www.surgeons.org under 'Guidelines and Positions Papers'.

Continuing Professional Development Program

All active Fellows of the College are required to participate in the Continuing Professional Development (CPD) Program. The program aims to advance the individual surgeon's surgical knowledge and skills for the benefit of patients and provide tangible evidence of participation in and compliance with the program by the award of a certificate.

To date eighty-three percent of Fellows have participated to date for the 2007 program – very encouraging but not perfect.

We encourage all surgeons to participate in the CPD Program and particularly encourage those Fellows who have outstanding returns for 2007 to make contact with the Professional Standards Department. It is important that surgeons show their ongoing commitment to professional advancement by recording the fact that they are participating in a recognised CPD Program.

The Professional Standards Department would welcome suggestions to improve the CPD Program.

2007 CPD recertification data forms overdue

Fellows are reminded that the 2007 CPD Program recertification data forms are now overdue. Fellows who are yet to make a return for 2007 received a third reminder letter in mid September. Please contact Maria Lynch, Department of Professional Standards, on +61 3 9249 1282 or email at cpd.college@surgeons.org if you require assistance completing your data form or require another copy.

'Surgical Snips' – A College News Scanning Service

Would you like to start receiving the latest editions of Surgical Snips? Surgical Snips is a news scanning service issued via email to College Councillors, Presidents of Speciality Societies, Trauma and Rural groups as well as other interested College Fellows and staff.

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