SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:9 October 2009

Support Scheme for Rural Specialists, page 36:

The recent workshops provided a forum for surgeons to share the unique nature of rural medicine.

Have scalpel – will travel! Page 14:
Barry Hicks started his medical career in Ethiopia, working as a general surgeon.

Annual Scientific Congress (ASC) Page 22:
The 2010 Perth ASC is calling for abstracts.

Retired Fellows page 32:
A hobby has greater meaning in retirement, it's a reason to get up in the morning.

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

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What is the cost of a free ticket?

Bringing the profession into disrepute

Ian Gough
President

As President of the College I discuss issues of professionalism with many groups. This includes Fellows and Trainees, representatives of specialty societies and associations, other colleges, regulatory bodies and senior government officials. Medical practitioners are nostalgic for the "good old days" when autonomy and self-regulation were a given for the various professional groups, particularly for specialist medical practitioners. There was an expectation that the ethos and culture of being a medical practitioner would enable us to innately understand acceptable boundaries and principles of behaviour. It appears those days have gone.

There are, regrettably, numerous well documented examples of medical practitioner misconduct both overseas and locally. Patients have been harmed and the profession has been criticised for failure of self-regulation. Some of the criticism may be justified although the failure has routinely and dominantly involved failure of the regulatory bodies themselves. The predictable response from government, under pressure from citizens, has been greater regulatory control of the profession. This has been most notable in the UK, and the new national registration and accreditation processes in Australia will accelerate this here.

Another sinister aspect to erosion of professionalism is the progressive commercialisation of the practice of medicine and surgery – this can give the perception that patient care and the health of the community are not our foremost concern. The corporatisation of radiology and pathology is well established in both public and private sectors and other specialties are following at varying speeds. Pathologists in particular have been under severe pressure to remain efficient with no increase in government funded subsidy over 20 years while the community has the expectation that pathology services are provided "free" under Medicare at no personal cost. Government has an attitude that because it funds health care it owns health care. Pathologists now have a major challenge maintaining quality and unfortunately are perceived as part of corporatized business rather than as valued professional colleagues.

Surgeons can learn from these experiences. Working in partnerships and in teams is clearly desirable but there are dangers in some business models that could compromise professionalism and the doctor-patient relationship.

Another concern is the perception of interactions between Fellows and Trainees and the medical industry. Over the past 12 months the College has updated its Code of Conduct to include very clear guidelines on interactions with the medical industry. We are now finalising the sanctions policy to accompany this. In surgeons' interactions with the medical industry (including medicines and the medical technology industries) there are three important principles:

1. The best interest of the patient is paramount
2. Transparency
3. Acknowledgement of perception as an issue

There is no doubt that interactions with the medical industries have been enormously beneficial to patient care and have produced rapid development of various treatments and technologies. Medical industries have also appropriately supported educational activities that result in improved standards of clinical care.

However, surgeons receiving financial benefit from industry must realise that they are recipients of a gift even if it is labelled as an annuity or a consultancy, or travel and accommodation support. The gifts are offered because the industry believes that it will increase sales. No one who receives gifts can say that they do not then have a possible conflict of interest. The community sees self-interest and not best interest for the patient.

The College will always support the maintenance of high standards of clinical practice and ethics. Consequently when a number of newspapers started profiling stories of medical industry trying to influence doctors "Secret deals to woo doctors" (*The Age* September 7, 2009) the College was strong in its support of their investigative journalism.

Our standing as professionals is under challenge. It is important we look to ourselves and ensure that both the perception and the reality is that patient care always comes first. Doing otherwise brings the profession and the College into disrepute.

"There is no doubt that interactions with the medical industries have been enormously beneficial to patient care..."

Our Code of Conduct focuses on bringing these issues to the attention of all our Fellows and Trainees both as individuals and collectively to educate and then to ensure modification of any inappropriate behaviours. Any apparent breach of the code will require a signed undertaking to adhere to the Code in future. However, if inappropriate behaviour continues then the Fellow or Trainee will be asked to demonstrate why they should not have their Fellowship removed or be dismissed from training.

Professionalism is under attack. It is something that we rightly value. There is enormous importance to be attached to our autonomy and our capacity to self-regulate. The challenges of our modern society and the modern delivery of health care demand clear principles to be articulated, understood and adhered to.

Integrity and trust are fundamental to the primacy of the doctor-patient relationship in heath care and must be upheld.

"Meeting the Challenge"

How much of the increased funding has gone into front line clinical services?

Jean-Claude Theis
Chair, New Zealand National Board

This recent document released by the Minister of Health is the report by a Ministerial Review Group (MRG) on the New Zealand Health System and provides a good account of the current state of our publicly funded health services and its intrinsic deficiencies. It outlines the significant challenges we face as a result of a predicted slow-down in economic growth and an ever increasing demand on the public health system resulting from an ageing population and advances in medical technology. Despite substantial increases in funding over the last 10 years this has not been sufficient to keep up with demand and surgical services continue to struggle with long waiting lists for elective surgery and the ever increasing pressure on acute services. The New Zealand National Board supports the general tenor of the MRG report and many of its recommendations.

One wonders how much of the increased funding has gone into front line clinical services as compared to the 'back offices' of the growing health bureaucracy. It is pleasing to see that the MRG recognised this issue and called for a reduction of bureaucracy, waste and inefficiencies and the moving of resources to the front-line as health spending growth slows.

New Zealand has a population of four million people and 21 District Health Boards (DHB), which determine the priorities of health spending in their area. This has lead to duplication of many administrative processes, which could be managed more efficiently at a regional or national level. This has been recognised by the MRG. It recommends better resource utilisation through DHB's working together. This has the potential to reduce waste and increase public health services for the benefit of all New Zealanders. Centralised planning and funding of all truly national and regional services is recommended, leaving DHB's in charge of their local health services. This would certainly help the smaller centres who have difficulties attracting surgeons in certain specialities, so long as the regional service is in the true spirit of cooperation rather than big brother taking over and centralising services in the metropolitan areas.

"Considerable effort has already been devoted to improving the patient's overall journey through the health system by removing barriers, bottlenecks and overall inefficiencies."

In line with other recent reports, the MRG report has highlighted the failure of the changes in health management in the last two decades to deliver the anticipated benefits, to the detriment of clinical staff whose involvement in decision making has been eroded. The report strongly recommends that clinical leadership be strengthened across the public sector recognising that clinicians have the greatest knowledge of the requirements of the health service and that their day to day decisions have the most significant impact on costs.

In New Zealand PHARMAC, a central pharmaceutical purchasing authority, has been very successful at controlling drug costs. The MRG recommends a similar model be considered for high cost medical devices. This could lead to substantial savings which could be reinvested into clinical services. There is also a call for better evaluation of new technology and surgical procedures in a controlled environment prior to implementation across the health sector. Currently such decisions are often left to individual clinicians or hospitals without adequate consideration of cost benefit analysis covering, for example, operating theatre time, equipment cost and patient outcomes.

Considerable effort has already been devoted to improving the patient's overall journey through the health system by removing barriers, bottlenecks and overall inefficiencies. However a lot more work is required to reduce clinical waste and make health care safer. Reducing errors and complications will result in significant savings and improved quality of care. The MRG's call for the establishment of a National Quality and Safety Programme will assist this process.

Finally, the report highlights the waste of resources and opportunities through a failure to better use private hospital facilities. A stronger relationship between the private and public sector could boost the delivery of elective services and take the pressure off our chronically overstressed public hospitals. This could help public hospitals to manage their increasing acute load as well as continue to deliver the growing number of complex elective cases. This cooperation may also accelerate the establishment of surgical training posts in private hospitals. However, it would be important that any increased use of private hospitals does not reduce the availability of staff in the public system to manage the acute care.

It is clear that health expenditure growth in New Zealand, and probably in other countries, is not sustainable and in order that New Zealanders continue to have access to a strong and well funded public health system the Government needs to act now. The recommendations in this Ministerial Review Group document are clear and well founded based on a critical analysis of the current situation and the challenges ahead. Let's hope that there is the political will to engage with clinicians and give us a mandate to lead the change required to meet the challenges faced by the public health system currently and in the future.

Engaging the media

The College continues to bring attention to the great work done by the Fellows

Ian Dickinson
Vice President

An ongoing challenge facing the College is the need to raise its profile and identify opportunities by which it can influence public opinion and the policies of governments. A key means of achieving this objective is to generate media interest in the work of the College and its position on issues relating to surgery and, more broadly, issues of public health. We also work hard to generate media interest in the great work being done by individual Fellows.

You will not be surprised to hear that these essentially positive and proactive efforts are sometimes rudely interrupted by the need to react to negative media coverage.

Proactive Media

Recent examples of proactive media work include the publicity surrounding the development and formal launch of the Surgical Safety Checklist. The College worked hard to generate interest in this project, from the time we endorsed the World Health Organisation's prototype in January of this year to the formal launches, on both sides of the Tasman, of the Australian and New Zealand version of the checklist in August.

The regular conferences with which the College is associated are important opportunities to profile the work of Fellows. While the Annual Scientific Congress is the most prominent event of the year, sometimes giving rise to a dozen or more media releases, other conferences can catch the eye of media. The annual scientific conference of the Provincial Surgeons of Australia, recently held in Alice Springs, proved an effective means of raising awareness of the challenges facing rural surgery – not least the cessation of Commonwealth funding for the College's Rural Surgical Training Program.

The International Society for Surgery's International Surgical Week, held in Adelaide in early September, was the subject of four media releases, all of which resulted in media interviews.

Finally, the various regional scientific meetings have a proven capacity to generate media interest. Last year's Victorian meeting, for example, was covered by local media in and around the city of Traralgon where it was held. The 2008 Queensland meeting was notable for the considerable coverage it received in the Courier Mail.

"Recent examples of proactive media work include the publicity surrounding the development and formal launch of the Surgical Safety Checklist."

Reactive Media

But of course the best way to attract media interest is to err. Journalists are never more interested than when they detect a problem or, even better, sense scandal. At such times reality takes a back seat to perception, and the College must exercise more reactive media management skills.

Recent examples of such management include allegations that medical device companies had offered doctors inappropriate inducements to use, or consider using, their products. The College responded with a letter to the editor, signed by the President and published in the Melbourne Age, deploring such conduct and drawing attention to the College's code of conduct on this matter, which has been in place since February.

An article which appeared in Brisbane's Courier Mail in mid September revisited the tired and discredited argument that it is the specialist medical colleges which, by virtue of a closed shop mentality, are the great obstacle to producing more medical specialists. It went on to suggest that the training of specialists could be more effectively done at our universities.

We responded with a concise and persuasive letter from the President, published the following day, which pointed out that such an arrangement would involve considerable additional expense, given that Fellows currently provide training pro bono. We also drew attention to numerous studies, including one conducted by the Australian Competition and Consumer Commission (ACCC) into our College, which have found no evidence of anti-competitiveness on the part of the specialist medical colleges.

This story followed on the heels of a story which ran in the Courier Mail for several days. This concerned allegations that doctors in Queensland were working such long hours that serious mistakes were inevitably being made. We again responded, putting the College on the record regarding a story of obvious importance to all Fellows.

The Media – Always looking for a "good" story

There is perhaps no finer example of journalists looking for the most negative "angle" than the regular release of our audits of surgical mortality. These are examples of the College at its most transparent, quantifying and analysing incidents of mortality so as to improve the delivery of surgical care into the future. The media, of course, are less interested in the purpose of the audits – the proven enhancement of surgical care – than in the fact that patients have died.

The College will continue to do its utmost to ensure that the great work being done daily by its Fellows is brought to the attention of the public, however difficult that task can sometimes be made by the more sensationalist branches of the media.

Broadening skills and knowledge

The Murray and Unity Pheils Travel Fellowship has helped Dr Lam understand the potential of colorectal laparoscopic surgery

Sydney colorectal surgeon Dr Francis Lam used the funding attached to the Murray and Unity Pheils Travel Fellowship to work alongside surgeons at three of the largest centres of excellence in colorectal surgery in Hong Kong and China. From February to May last year, Dr Lam was a visiting Fellow at the Pamela Youde Nethersole Eastern Hospital in Hong Kong, the Prince of Wales Hospital in Hong Kong and the Chinese Academy of Medical Sciences and Peking Union Medical College Tumour Hospital in Beijing.

He described the experience of working alongside some of the most outstanding laparoscopic colorectal surgeons in the world as "tremendous" and said exposure to such skills had increased his own confidence and ability to undertake complex colorectal procedures using keyhole surgery.

He said the sheer size of the Chinese population and the concentration of tertiary referral hospitals, meant that surgeons there were leading the world in skills and technological development, undertaking many laparoscopic procedures which in other countries would still be done via open surgery.

"The Pamela Youde Nethersole Eastern Hospital (PYNEH) is one of only two major tertiary referral hospitals in Hong Kong Island with over 1600 acute in-patient beds. The Department of Colorectal Surgery there is world famous as a pioneer in laparoscopic colorectal surgery and is the largest laparoscopic colorectal unit in Asia," Dr Lam said.

"The unit performed the first laparoscopic colorectal resection in Hong Kong in conjunction with the Prince of Wales Hospital Hong Kong in 1992 and has since performed over 1000 laparoscopic colorectal resections."

Dr Lam said he was particularly fortunate to have had the opportunity to work alongside two of the most highly skilled and renowned colorectal surgeons in the world, Mr Michael Li, the Chief-of-staff at the PYNEH, and Mr Cliff Chung, the Head of Department and President of the Hong Kong Association of Coloproctology.

During his visit to Hong Kong, Dr Lam, who speaks Chinese, was involved in all aspects of the work conducted at the colorectal units including theatre work, ward rounds, outpatient and on-call duties and was given full access to the Minimal Access Surgery Training Centre (MASTC) attached to the PYNEH.

"It was simply amazing to witness the functions of such a large specialist hospital and to be part of their clinical activities."

"I was fortunate to have full access to the MASTC which is the first such centre established in Hong Kong to provide training in endoscopic-laparoscopic surgery with specialised courses for surgeons and trainees. This gave me the unique opportunity to apply and improve the skills I learnt from live surgery and further refine my laparoscopic techniques," he said.

After three months in Hong Kong, Dr Lam visited the tumour hospital in Beijing, which he described as an "incredible" experience.

"This hospital is one of the major referral centres for malignant disease in Beijing with more than 1200 beds. As a specialist cancer hospital with 22 operating theatres, it has some of the most advanced medical facilities in China," he said.

"It was simply amazing to witness the functions of such a large specialist hospital and to be part of their clinical activities. The operating theatres were so busy they had 'in-house' pathologists within the theatre complex to perform more than 60 frozen sections per day."

Dr Lam said he also had the opportunity while travelling to attend the annual Gastrointestinal Tumour Conference in Beijing and said some of the presentations, again based on the size of the population and the specialist skills gained via such an enormous volume of cases, were of great value.

"One speaker there presented a ten-year audit of the management of retroperitoneal tumour from his unit with over 1000 cases. That for us in Australia is amazing because most surgeons here would be lucky to see a handful of such cases throughout their careers," he said.

"Listening to these scientific presentations and working alongside some of the finest laparoscopic colorectal surgeons in the world, who are very aggressive, very advanced in their skills, has not only broadened my skills and my knowledge base but also my understanding of the potential of colorectal laparoscopic surgery."

The Murray and Unit Pheils Travel Fellowship was established following a generous donation made by the late Professor Murray Pheils. It has a value of $10,000 and is awarded to either a Trainee or Fellow of the College to help cover the costs associated with travel undertaken to expand skills and training in colorectal surgery.

Dr Lam is now back in Australia and is a consultant colorectal surgeon attached to the Prince of Wales Hospital in Sydney.

"I feel very honoured and thankful for the invaluable support that the College provided. I am also particularly grateful to Professor Les Bokey in helping to organise my Travelling Fellowship and to Dr Michael Li and Dr Cliff Chung from Hong Kong as well as Professor Zhou Zhixiang from Beijing for their generosity in sharing their expertise," he said.

"Keep the bastards honest"

Why are we seen in such a derogative way?

I.M.A Newfellow

Mr. Nit Picker has a sense of humour. I know that this is hard to believe but he does. I admit that I was not there myself to hear it first-hand but a very reliable source tells me it is so. Apparently he was at the IMG (International Medical Graduates) interviews and Andrew Roberts, the part-time director of the IMG Program, was explaining the role of the Jurisdictional Representatives (JR's); Mr. Nit Picker likened it to the role that the Australian Democrats have seen as their role in Australian politics for many years.

No doubt you will recall that when the Australian Democrats were formed by the late Don Chipp in 1977 he vowed their purpose was to "keep the bastards honest". He was referring to the politicians, including his own former party, the Liberals. So Mr. Nit Picker apparently was suggesting that the role of the JR's was to "keep the bastards honest".

This all sounds somewhat offensive, particularly as the "bastards" referred to are us, the surgeons who serve without pay on various committees, boards and working parties. Why are we seen in such a derogative way? My teenage children have a very strong point of view on this matter that had better remain within the family. Is it that the public thinks that we charge too much for our services? Is it that we are seen as out of touch with the common man? Is it that we are seen as having a governance structure that is unfair to aspiring Trainees and is anti-competitive?

The late Don Chipp talking to a journalist in the Tally room

It is this latter point of view that caused the Australian Competition and Consumer Commission (ACCC) in their 2003 review to demand that the College open up the various critical boards and committees to representatives of the jurisdictions who were significantly affected by the decisions of the College.

This major change was undertaken, admittedly with some reluctance in some quarters. So we now have JR's sitting on the Surgical Education and Training Boards and other committees involved in the selection and training functions of the College. Initially some were viewed as spies, informers and "flies in the ointment". It was soon apparent that these persons from various health departments and government bodies had a lot to contribute in a constructive way to the functions of the College. They are often senior health administrators with a good knowledge of how hospitals and health functions in Australia.

It is interesting to note that although the ACCC authorisation has lapsed and we are no longer bound by its conditions many Boards have chosen to keep their JR's as members of their Board. Most JR's attend in their work time as a part of the salaried duties but some do travel from interstate.

The obvious question is "Are we bastards?" I have often asked the JR's with whom I have worked what they think of the College processes; invariably they express surprise at the openness of the processes and the fairness of the decisions. They also note that the decisions are not made to protect vested interests or to exclude competition, but are made in the best interest of surgical education and of the community.

So to all the JR's, past, present and future, thanks for your contributions and please do continue to "keep the bastards honest".

Cover photograph by Binh Nguyen

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Strategic direction for your business

If you have an established practice strategic planning is vital to avoid 'false starts'

Rob Atkinson
Chair, Professional Development

How do you decide on the future direction of your public and private practice? Successful preparation for the future begins with strategic planning. If you are just starting your practice, planning is vital to avoid the 'false starts' that can take years and be expensive to correct. If you have an established practice or are a senior manager in a hospital, a strategic plan forms a valuable part of your business plan and can lend stability and intentionality to the direction of your business.

If you would like to learn more about strategic planning, register for the 'Providing Strategic Direction' workshop on 13-15 November in Melbourne. It will focus on the skills and knowledge a surgeon needs to develop an organisational strategy through an effective planning process. You will also learn more about conducting an organisational/market analysis, sustaining a competitive advantage and developing strategic measurement systems.

'Providing Strategic Direction' is one of three face-to-face workshops that make up the Diploma. You can attend each of the workshops as a stand alone activity or use them as an entry point to enrol in the full academic program which culminates in successful candidates being awarded the Advanced Diploma of Management, a nationally recognised qualification under the Australian Qualifications Framework. This qualification is through UNE Partnerships, the education and training arm of the University of New England.

Clifford Hughes

The content has been customised in consultation with the College as well as industry representatives to ensure that learning outcomes address the issues faced by surgeons. Professor Clifford Hughes (CEO of the Clinical Excellence Commission), is a key member of the curriculum consultation panel and is so impressed with this course that he has registered to undertake the Diploma.

The other two workshops are 'Leadership in a Climate of Change' and 'Sustaining Your Business'. At the leadership workshop in June this year 15 surgeons, eight of whom were enrolled in the Diploma, went on a journey of self-discovery; exploring their preferred leadership style using a psychometric behavioural profile (DiSC). The profile helps participants to understand the key differences between individuals and provides them with a range of appropriate management styles to enhance workplace relations. The next leadership workshop will be in Melbourne on 18-20 June 2010.

'Sustaining Your Business' is being held in Sydney on 26-28 March 2010 and provides the foundation for developing business plans to sustain growth. It explores financial management; from the preparation and analysis of responsible budgetary plans, decision making, management and reporting, to the development of estimates and capital investment proposals.

Subject areas for further workshops in the series are currently being canvassed to provide ongoing options in relation to management and leadership.

Further Information

Please contact the Professional Development Department on +61 3 9249 1106, or PDactivities@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 +61 3 9249 1248.**

Alternatively, you could mail the gown to
The Conferences & Events Department,
Royal Australasian College of Surgeons,
College of Surgeons Gardens,
250-290 Spring Street, East Melbourne 3002.

The College would like to thank Mary Murdoch for the generous donation of her Court of Honour gown

College Conferences and Events Management

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

AUSTRAUMA 2010

Trauma, Critical Care and Emergency Surgery Conference

Sydney Convention & Exhibition Centre, Darling Harbour, Sydney.
11 – 13 February 2010

Conference Convener: **Dr Valerie Malka**

Conference Themes:

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- Neurotrauma
- Paediatric Injuries
- Trauma Radiology
- Animal Injuries
- Orthopaedic Emergencies
- Emergency General Surgery
- Damage Control
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perth '10

Annual Scientific Congress
Perth Convention & Exhibition Centre, Perth, Australia
4 –7 May 2010

Royal Australasian College of Surgeons

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

QLD REGIONAL COMMITTEE

ANNUAL STATE MEETING

Hyatt Regency Sanctuary Cove
Friday 30 October – Sunday 1 November 2009

Convener- **Dr Maurice Stevens**

Dual Theme:
Changing Surgical Culture in the Public Hospital Sector
Surgical Outreach and Retrieval Services

Program highlights:

- Deputy Premier and Minister for Health Mr Paul Lucas will be in attendance on Saturday morning of the conference
- Free welcome BBQ (pig on the spit along the beach front) on the Friday evening
- Neville Davis Prize presentations
- David Theile Lecture
- Honoured Guest – Mr Glen Merry and Saturday Gala dinner
- Trainee activities and presentations on the Friday program
- Outreach programs such as Deadly Ears and Operation Smile
- Panel discussions with the Deputy Premier and Minister For Health
- Panel discussions on topics including: Fatigue Risk Management (safe hours), Surgery Connect and Cultural and Leadership issues between hospital administration and departments of surgery.

Provisional program and registration forms will be available in the coming weeks, costs for the meeting will be:

REGISTRATION $AUD
Inc GST STANDARD EARLY REGISTRATION
By 15 September 2009

Fellows $260 $200

Trainees & IMGs $130 $100

Medical Students/Other Health Professionals $60 $40

Accommodation will be available at Sanctuary Cove for $235 per night, accommodation can only be booked through registration forms available from the College, please email qldasm@surgeons.org

Australian perspective on liability

Liability for negligence in Australian medical practice can be a complex matter

Michael Gorton
Partner, Russell Kennedy Solicitors

The practice of medicine is not perfect. Many patients suffer from disease or conditions for which there may be no, or no adequate, treatment. Nonetheless, patients have come to expect perfect results.

Patients may suffer "adverse medical outcomes". These, more often, are a natural outcome from the disease or condition which they suffer, the inherent risks and side-effects of a procedure or administration (i.e. drug) or some other systemic error, which is unrelated to the doctor's care and attention.

At law, doctors are only responsible for their own want of care, or the failure to apply the proper standard of skill and attention that might be expected in the circumstances.

Examples of obvious negligence are death or injury resulting from:

- administration of the wrong drug; or an excess of a normal drug being administered;
- administration of a drug in the wrong area of the body;
- the wrong limb being operated on;
- tourniquet remains too long with vascular complications;
- pressure areas or burns or other injuries to an anaesthetised patient;

Under Australian law (following the English common law system) liability can arise under different causes of action:

1 **Negligence**
In addition to a failure by the doctor to exercise proper care and attention, the doctor could also in some circumstances be negligent in failing to obtain informed consent (informing the patients of all material risks relevant to the procedure).

2 **Assault/Trespass**
If a doctor treats a patient without proper consent, the doctor is technically committing a trespass or assault on the patient.

3 **Breach of Fiduciary Duty**
In rare cases, the Courts have recognised a fiduciary duty arising from the "special relationship" between the patient and the doctor. Where a doctor fails to act in the best interests of the patient, and fails to disclose any conflict of interest, it is sometimes argued that this fiduciary duty is breached.

4 **Breach of Contract**
In common with a negligence claim, it is sometimes argued that the failure by the doctor to exercise due care is also a breach of the contract between the patient and the doctor.

In a negligence claim, the courts will usually assess three elements:

- the duty of the doctor to take reasonable care of the patient;
- whether there has been a breach of duty by the doctor; and
- whether the damage that the patient has suffered is a result of the doctor's failure of care.

The Duty

Doctors are generally asked to exercise the standard care expected of doctors of good quality and standing, and with the requisite degree of skill and experience in the relevant specialty of the doctor.

A specialist practitioner in a certain field is required to have that skill "of the ordinary skilled person exercising and professing to have that skill." The law recognises the variability of individual practitioner's skills and does not demand that doctors always perform at the highest standard of their peers. However, courts are now the final arbiter of negligence. Evidence of medical experts will have an important role in aiding the court to decide if a medical practitioner had been negligent.

Breach of Duty

The standard of care is that which a "reasonable person" would have taken in the circumstances. The courts will determine whether that standard has been met. Whilst the court may have regard to the practices and procedures of other doctors in similar circumstances, the court will determine whether the standard has been met, having regard to the skills of the doctor, general practices in the profession, the level of knowledge and research available and the other relevant factors.

Negligence can arise for positive conduct, but can also apply where the doctor has failed to undertake any action.

Damage Caused

Patients will be entitled to claim compensation for loss or damage which they suffer as a consequence of the negligence of the doctor.

The patient must show that the loss or damage would not otherwise have arisen if the doctor had not been negligent. This distinguishes between negligence and merely an "adverse outcome".

Trainees

Training or junior doctors like other professionals are required to exercise the skill "of the ordinary skilled person exercising and professing to have that skill". This test is satisfactory for patients who choose their physicians. But public hospital patients cannot choose their practitioners. A junior officer is only required to fulfil the skill required of their position. But this junior will be liable, if they negligently perform a duty outside their range of skill or fail to refer a question beyond their capabilities to another practitioner. (The hospital or supervising doctor may be liable if the junior doctor escapes liability by referring a situation to their superior and the negligent treatment is

not dealt with soon enough, or if the junior doctor has not been adequately supervised or instructed.)

The state of medical knowledge

Other factors may affect whether the requisite standard of care has been reached in diagnosis and treatment. A medical practitioner is only expected to have the knowledge of an "ordinary skilled" person in their field. If the state of medical knowledge means that a failure of equipment could not be predicted, preventative measures such as were required to prevent injury were not regularly taken at the relevant time, or the dangers of a type of treatment were unknown, there may not be a breach of duty.

The law accepts that, in order for medicine to progress, new techniques must be tested. However, if such techniques are used, there is a very high standard of disclosure required that demands patients be informed of alternative forms of treatment.

Failure to disclose risks/ informed consent

The law recognises that a doctor has a duty to warn a patient of a material risk which is inherent in any proposed procedure or treatment.

Failure to diagnose or follow up tests

One of the obvious areas for negligence is failure to diagnose accurately or properly the particular disease or condition of the patient.

It is now established that doctors have to ensure appropriate follow-up on tests ordered or reports requested. Doctors should have appropriate systems in place to ensure that, when tests are ordered or reports requested, there is a follow-up to ensure that any adverse outcomes are detected within time. Reports and test results can often go astray. Doctors cannot rely on patients contacting them again for follow up, and doctors must therefore have their own systems to ensure that follow-up occurs.

Doctors should also emphasise to patients, to a much greater extent, the need for the patient to call back to ascertain the results of tests, and should advise the patient of the implications of failing to follow up or failing to keep an appointment made, in detailed terms.

Vicarious liability

At law, an employer may be held responsible for the negligence of its employee, acting in the course of his or her employment. Accordingly, hospitals and other health institutions are responsible for and will be liable for the acts or omissions of their staff.

The staff member nonetheless remains liable for their own negligence.

Additionally, doctors will therefore be liable for the actions of their own employees (locums, administrative staff, office staff, etc.). These issues are important in considering whether an insurance policy maintained by the employer will cover particular staff members.

These issues highlight the need for medical practitioners to ensure that they have adequate and appropriate insurance for themselves, their practice, and for their employees (for whom they may be liable).

Risk management

To minimise legal risks, doctors should ensure that:

- appropriate insurance is maintained;
- relevant standards, protocols and guidelines are followed;
- detailed and appropriate communication is maintained with patients;
- they have good "informed consent" procedures;
- detailed notes and records are maintained;
- they respond to an adverse incident promptly;
- if in doubt, they consult their insurer or legal adviser.

Baby Quentin doing well

Baby Quentin was born in December 2008 just before Her Excellency, the Governor-General of Australia visited the clinic where she was born. The baby's parents immediately named her after the Governor-General. Baby Quentin was born with a one sided cleft lip.

In March 2009, baby Quentin Bryce had her cleft lip repaired by a team of Australian medical volunteers, as part of the College's Australia Timor Leste Program of Assistance for Specialist Services (ATLASS) program. The operation lasted 40 minutes and was successfully carried out by Dr Mark Moore and surgical trainee Dr Joao Ximenes.

Quentin before the operation

Quentin after the operation

Dr Mark Moore has been visiting Timor Leste since March 2000 and has operated on more than 400 cleft lips and palates. These visits are organised in collaboration with the Timorese Ministry of Health as part of the College's program.

Dr Ximenes has been a trainee of the AusAID funded programme and has started training in cleft lip surgery. This sort of capacity building is one of the most important aspects of the specialist teams program. Eugenio Gusmao and Abilio Quintao have been trained through the Institute of Health Sciences in Timor with the assistance of the program.

PROFESSIONAL DEVELOPMENT
WORKSHOPS 2009

In 2009 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities will assist you to strengthen your communication, business, leadership and management abilities.

SAT SET
24 October – Lorne (VIC AGSFM)
1 November – Sanctuary Cove (QLD ASM)
10 November – Melbourne
17 November – Wollongong
20 November – Auckland (NZAPS ASM)
25 November – Perth

This three hour course is aimed at enabling supervisors and trainers to effectively fulfil the responsibilities of their important roles. Supervisors and Trainers Surgical Education and Training Course (SAT SET) focuses on effective use of the workplace assessment tools that have been adopted as part of SET and explores strategies to improve the management of underperforming trainees and is also an excellent opportunity to gain insight into the College policies and processes, including legal requirements and the appeals process.

NEW Surgeons and Administrators: Working Together to Bridge the Divide
9 November – Sydney

This full day workshop focuses on a better understanding of the surgeon-medical administrator working relationship and development of more cooperative health service management. This workshop is offered in collaboration with the Royal Australian College of Medical Administrators. The key learning objectives are to:

- Have a greater understanding of the roles, responsibilities and priorities of surgeons and medical administrators
- Develop practical strategies for improving surgeon and medical administrator relationships

NEW Providing Strategic Driection
13-15 November – Melbourne

Want a solid understanding of the strategic planning process? Over 2½ days you can gain the skills and knowledge to produce and implement an organisational strategy. Focus will be on how to establish a strategic direction through an effective planning process. You will also learn more about conducting an organisational/market analysis, sustaining a competitive advantage and developing strategic measurement systems.

Communication Skills for Cancer Clinicians
14 November - Melbourne

In partnership with The Cancer Council Victoria, this four-hour workshop focuses on teaching you evidence-based, step-by-step communication skills that break down the challenge of delivering bad news to patients and their families.
A clinical psychologist will demonstrate the communication strategies and a role play exercise with an experienced actor enables you to practice your new skills in a safe environment.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES:
OCTOBER - NOVEMBER 2009

NSW

9 November	Surgeons and Administrators: Working Together to Bridge the Divide, Sydney
17 November	Supervisors and Trainers (SAT SET), Wollongong

QLD

28 October	Mastering Professional Interactions, Brisbane
30 October	Mastering Intercultural Interactions, Sanctuary Cove (QLD ASM)
1 November	Supervisors and Trainers (SAT SET), Sanctuary Cove (QLD ASM)
15 October	Supervisors and Trainers (SAT SET), Cairns

VIC

24 October	Supervisors and Trainers (SAT SET), Lorne (AGFSM)
10 November	Supervisors and Trainers (SAT SET), Melbourne
13-15 November	Providing Strategic Direction, Melbourne
14 November	Communication Skills for Cancer Clinicians, Melbourne

WA

25 November	Supervisors and Trainers (SAT SET), Perth

NZ

17-18 October	From the Flight Deck, Auckland
20 November	Supervisors and Trainers (SAT SET), Auckland (NZAPS)

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

Have Scalpel – Will Travel!


North Trip 2005


Scenery from a trip to Soddo

Barry Hicks has spent 16 years in several periods in Ethiopia, first going there in 1968

If the days of the general surgeon in the broadest meaning of the title are coming to an end in this age of sub-specialisation, then the era of the Christian missionary general surgeon may seem long past. Yet there is at least one Fellow of the College who not only embraces the latter description with both humility and pride but who, after decades working with the poor in Africa, continues to prove that the era is not yet history.

Mr Barry Hicks, general surgeon, first went to Ethiopia in 1968. He is about to return to determine if a teaching post offered him has the support and infrastructure to work. He has recently written a book describing his experiences that make first world medicine seem dull indeed.

Titled "Have Scalpel – Will Travel!", the autobiography describes his life from his early days then as a medical student in South Australia when he supplemented his scholarship with such jobs as driving trucks on the salt lakes in central South Australia, through his time as the only surgeon for more than two million people in a region of Ethiopia, to his later life as a teacher and mentor.

Arriving in Africa shortly after receiving his Fellowship in 1967, Mr Hicks began his life as a general surgeon in Shashemane working in impoverished hospital theatres sometimes with his medical text books opened on a violin stand beside him.

He was known by the local Ethiopians as the baby doctor, which he thought at first to be an acknowledgement of his rapidly increasing skills in obstetrics and gynaecology but which, in fact, turned out to be a disconcerting reference to his youth.

Over consequent decades he ran the gauntlet of village customs in which a bride-to-be must be presented with the severed penis of a stranger; paid the wages of hospital staff out of his own meagre salary so as to have assistance in theatre; took on corrupt officials and local witch doctors – and in between saved many lives.

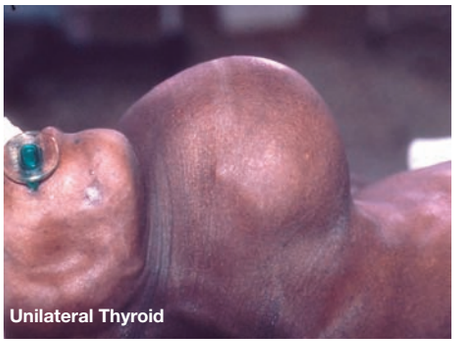
From sick children, to women in obstructed labour, to gun-shot and spear wounds to the most advanced pathology rarely seen in the west, Mr Hicks operated on the sick at times only by the light of candles, to do what he could for his patients.

"Sadly a lot of healthy babies died because, as a prophylactic measure, the custom was to cut off the uvula at the back of the throat with a long fingernail," he writes. "This was done to stop evil spirits grabbing hold of the uvula to drag themselves inside the child. If the child died, as they did, not infrequently, from tetanus or some other infection, it was proof, we were informed, that the procedures had not been done early enough. It was obviously one of the customs we strongly sought to eradicate."

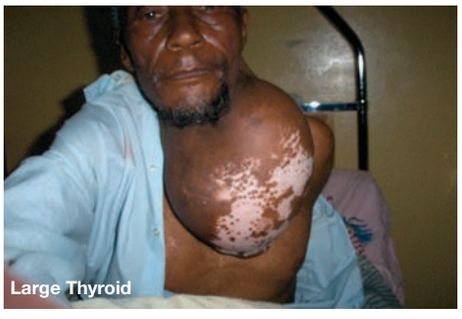
Forced to leave at various times through personal illness, political revolution and government decree, Mr Hicks could never stay away for long. With his wife Robin, a teacher, beside him, he raised his six natural and adopted children both in Africa and Australia working there in Soddo, Shashemane and Addis Ababa and here as Director of Surgery at Townsville Hospital.

Mr Hicks has witnessed the murder of a colleague, has seen the best and brightest young

"During the revolution our five mission hospitals were taken over at gun point"



Unilateral Thyroid



Large Thyroid

doctors leave Ethiopia for better pay and conditions elsewhere and has also seen, for decades, the sick turned away from medical care for lack of resources, yet still he cannot walk away.

Shortly he is to return to Ethiopia to investigate a teaching position offered him as Associate Professor of Surgery at the Jimma University 400km west of Addis Ababa. He will make a decision based on whether there is enough infrastructure available. There are certainly not enough surgeons to treat the available patients or to teach the under and post-graduate students.

"It has always been very easy for me to fall in love with the people of Ethiopia even though it can be very difficult to work within their system," he said.

"At least when working within the mission we could get the materials and supplies that we needed. At one stage, when at Shashemane, I was told by a senior government advisor that missions were doing 90 per cent of the medical work in Ethiopia with about 10 per cent of the personnel. During the revolution our five mission hospitals were taken over at gun point.

"I wrote this book to explain my experience over the years. Times have changed and most people have not experienced the world I have known. If some people are challenged by my Christian faith – that's good. We should be challenged by the need of these places. I became a surgeon and went overseas because of my faith. I don't apologise for that faith but I don't hit people over the head with the bible.

"I chose to focus on my time in Ethiopia, I suppose, particularly to give readers an idea of the breadth of surgery that we did there, particularly now that so much of western surgery is sub-specialist surgery.

"The biggest part of my surgical work there was obstetrics and gynaecology, but along with that I treated trauma injuries including burns and wounds and did a wide range of general and orthopaedic surgery and even some neuro and vascular surgery.

"I'm very glad to have lived when I lived because for better or worse it has been an interesting life. As a general surgeon I did what I could. I wonder about younger western general surgeons going there now because I imagine they'd be very hard-pressed because of the narrowness of their training and the paucity of investigations and afraid to do what they would need to do."

Mr Hicks has lived a life of tenacity and courage, according to Professor Ken Clezy, AM, OBE and the recipient of the College International Medal in 2002 for his work in PNG and Yemen. He writes in the foreword to the book: "Those who do best in the bush have pioneer qualities and accept truly unavoidable difficulties as routine challenges, but tend to tolerate colleagues' laziness, cussedness and downright malevolence even less easily than the rest of us do. Barry knows all about this, as I saw for myself... I fear I would have walked away beaten, but he kept popping up for more."

Indeed, the challenges of life in Africa seem only to have inspired him – from continuing to operate after being singed in an ether explosion, to convincing the sick to seek medical treatment over that offered by the witch doctors, to taking on the government.

"I have done some stupid things during my lifetime," Mr Hicks writes in the autobiography.

"I remember picking up a policeman by the scruff of his neck and the seat of his pants and forcing him out of my office when he tried to bribe me to change an accident victim's report to exonerate a rich driver.

"I remember refusing to release a prisoner with a fractured femur which was up in traction because I knew that he would be taken back to prison and left untreated.

"I guess I was foolish to be outspoken with the government when faced with such issues as them refusing to release imported equipment after we had paid duty. It cost me the ability to get a visa for some years.

"But I also did some audacious things. I did most of my own anaesthetics frequently monitoring them through the eyes and hands of an untrained person and I have treated people with disease pathology I had never seen and never thought to see.

"It was exciting and challenging; frustrating and satisfying; terrifying and rewarding. I have loved life and am only sorry that age takes away some of the energy and good health and made me slow down. In this next visit I will try and assess if, as an older man, I have enough strength to be of help still."

For a copy of the Mr Hicks' book, please visit the website at www.havescalpelwilltravel.com

Dermal Fillers

Patient information on permanent and semi-permanent dermal fillers

Guy Maddern
Surgical Director, ASERNIP-S

Dermal fillers are substances which may be injected into the skin of the face to treat patients with (1) age-related wrinkles, or (2) abnormal loss of fat in the face due to treatment for Human Immunodeficiency Virus (HIV). The Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) looked at the safety and effectiveness of long-lasting dermal fillers injected into the skin to give the face a fuller look, compared with more temporary dermal fillers.

The following information is a plain English summary of the full systematic review on injectable semi-permanent and permanent dermal fillers available at www.surgeons.org/asernip-s/publications.htm. The summary was prepared by a team of surgeons, consumers and researchers.

Main messages

From the small number of scientific studies available, ASERNIP-S found that for age-related wrinkles and for fat loss in the face from HIV medication:

- Long-lasting (semi-permanent and permanent) dermal fillers injected into the skin of the face appear at least as safe as temporary fillers in the short term. Many studies reported lumps in the face after treatment. Not enough scientific studies have been done to show that these products are safe for longer than five years.
- Injectable semi-permanent and permanent dermal fillers last longer than temporary fillers, and give patients high levels of satisfaction.

More high quality scientific studies on injectable semi-permanent and permanent dermal fillers are needed to collect information on outcomes for patients over a longer period of time.

This information is about the use of dermal fillers to treat:

Age-related wrinkles

As people get older they develop wrinkles on the face, and lines near their mouth and nose. The lips get thinner and the skin on the face begins to sag.

HIV-associated loss of fat in the face

Some of the medications given to people with HIV can result in abnormal fat loss from the cheeks, making a person's face look hollow. This can lead to the person being recognisable as having HIV and having a reduced quality of life. As a result, the patient may then decide to stop taking his or her medication.

Injectable dermal fillers

Injectable dermal fillers are substances which are injected into the skin of the face, to replace lost fat and restore the natural shape so that a person looks younger or healthier. Dermal fillers may be temporary or more long-lasting (semi-permanent or permanent).

- Temporary fillers are made of biological materials such as collagen, which can last up to 12 months before being absorbed back into the body. This means that patients need regular treatments to maintain the effect. Hence the patient can try out the treatment without it being permanent.
- Synthetic long-lasting fillers can maintain the cosmetic effect longer because they break down slowly (semi-permanent), or not at all (permanent). Some fillers can be injected into the skin to plump it up straight away. Other fillers can take a few months to work because they cause the skin to react and stimulate it to become thicker slowly.

The aim of the ASERNIP-S review was to look at the safety and effectiveness of injecting long-lasting dermal fillers into the skin of the face to treat patients with (1) age-related

wrinkles, or (2) abnormal loss of fat in the face due to treatment for HIV.

What is the evidence?

The number of scientific studies was low; however, the ASERNIP-S Review Group found that:

- **Safety:** In general, complications from the procedure were temporary and not serious, with most being a result of the injection itself and resolving within a matter of days. These complications included swelling, redness and bruising, with the most common complication being lumps under the skin. While many studies did not report what happened to these lumps, others reported that some lumps disappeared and some needed treatment. It was not possible to determine the long-term safety of the procedure because no scientific study looked at these products longer than five years.
- **Effectiveness:** For patients with age-related wrinkles or who have abnormal loss of fat in the face due to HIV treatment, permanent and semi-permanent dermal fillers injected into the skin can increase its thickness and improve the appearance of the patient's face; most patients were happy with the result of the procedure. The procedures appear to be effective over time, but more long-term studies are needed to see how the skin deals with these products over a long time period. (Review published in February 2009)

Glossary

HIV: HIV injectable dermal fillers: substances injected into the skin of the face to change facial appearance

literature review: ASERNIP-S conducts literature reviews on the safety and effectiveness of new surgical techniques before they are widely accepted into the health care system. Each review collects all relevant information, or evidence, on new and standard techniques used to treat a medical condition.

What is ASERNIP-S?

ASERNIP-S is a program of the College. ASERNIP-S conducts literature reviews on the safety and effectiveness of new surgical techniques before they are widely used. Each review collects all relevant information, or evidence, on new and standard techniques used to treat a medical condition. The quality of evidence is assessed. ASERNIP-S then makes recommendations on the safety and effectiveness of the procedures that are endorsed by the College, sent to hospitals and surgeons in Australia and overseas, and published on the website with summaries for consumers.

Acknowledgments

The glass sculpture image is provided courtesy of Mr Randall Sach, surgeon/artist.

Further information

For more information on ASERNIP-S, please contact:

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F: +61 8 8362 2077
E: asernipsconsumer@surgeons.org
W: http://www.surgeons.org/asernip-s

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

COURT OF EXAMINERS
FOR THE FELLOWSHIP EXAMINATION

Applications from eligible Fellows willing to serve on the Court should be forwarded to the Department of Examinations of the College no later than **Monday 1 December 2009.**

Fellows are asked to note the following vacancies on the Court, in the specialty of:

General Surgery
Cardiothoracic Surgery
Neurosurgery
Urology
Plastic and Reconstructive Surgery
Otolaryngology – Head & Neck Surgery
Orthopaedic Surgery

Should you wish to apply to be an Examiner/member of the Court of Examiners, please forward your application form with your curriculum vitae to:

examinations@surgeons.org
or post to
Department of Examinations
Royal Australasian College of Surgeons
250 - 290 Spring Street
EAST MELBOURNE VIC 3002

- Application forms are available for downloading via the College website www.surgeons.org
- The policy in respect to Appointments to the Court of Examiners and Conduct of the Fellowship Examination can be found on the College website.
- For inquiries, please email examinations@surgeons.org

Most uncomplicated elective surgery does not require red blood cell transfusion

True or False

Join the debate at www.theTransfusionquestion.com.au

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

Congratulations on your achievements

As an educator and master surgeon Doctor John Graham is a worthy recipient of the Rural Surgeons Award

Doctor John Campbell Graham -Rural Surgeons Award 2009

The Rural Surgeons Award was created by Council in 2002 to recognise conspicuous service to Rural Surgery as demonstrated by commitment to surgical excellence and education. John Graham is a worthy recipient as both a surgical leader and educator.

John trained at Royal North Shore Hospital, Sydney and gained Fellowship in 1974. He then did further training in the United Kingdom, initially at the Cumberland Infirmary and then at Kings College as Research Fellow in Vascular Surgery. He returned to Australia in 1983 as Senior Registrar in Vascular Surgery at Flinders and then Concord Hospital Sydney.

In 1985 he was appointed to Royal North Shore Hospital as a Vascular and Transplant surgeon. He seemed set for a successful academic vascular practice and the city life.

This was not to be the case. John had always had a strong interest in rural practice. Much to the surprise of his colleagues he moved to Lismore in 1992 to establish a full-time vascular practice. This is perhaps the first time a vascular surgeon developed a solo vascular practice in a rural setting. He faced many challenges and overcame them. He demonstrated that such a specialist practice could be established in a rural setting which produced outcomes in major vascular surgery as good as any metropolitan teaching hospital. This was achieved by commitment to detail and demonstrated by audit and publication. This is an illustration of surgical excellence that is a shining example of what can be achieved in the rural setting.

John also demonstrated leadership in rural surgical politics. In 1997 he became Secretary then President of the Provincial Surgeons. From 2001 until 2006 he joined College Council as the representative of the Divisional Group of Rural Surgery. In 2006 he became an elected member of Council until 2008.

John was a strong contributor to College activities and worked as Chair of the Annual Scientific Congress Review Committee and Chair of the Fellowship Services Committee.

He has made a significant contribution to surgical education. John was one of the initial group who travelled to Nebraska in order to be involved in the initial provider course, then the instructor course, in Advanced Trauma Life Support (ATLS). This American College sponsored trauma course was adopted and adapted by the College to become the Early Management of Severe Trauma (EMST) course. John was a key player in the adaption, development and propagation of this course. The driving force for this energy for John was to provide an educational experience for surgeons in the rural setting who are often called upon to manage major trauma within an under resourced environment. John is credited with developing the "Dingo Creek" concept, which sets the scene of the course, demonstrating a methodology of management when under stress when reaching the limit of resources. He continues to instruct in this course 20 years on.

As an educator and a master surgeon, John Graham is a worthy recipient of the Rural Surgeons Award.

Citation kindly provided by Phil Truskett

Professor Stephen O'Leary - John Mitchell Crouch Fellow, 2009

Professor Stephen O'Leary graduated in Medicine at the University of Melbourne. He completed a PhD at the Department of Otolaryngology at the same university and then undertook a post-doctoral research fellowship at Oxford University in the UK. His surgical training commenced in the United Kingdom (UK) but he completed his specialist training in otolaryngology, head and neck surgery in New South Wales, becoming a Fellow of the College in 1998. In that same year, he also undertook a clinical and post-doctoral research fellowship in Otology at the Utrecht Medical Centre in the Netherlands.

In recent years Professor O'Leary has presented at a number of prestigious national and international meetings and is a member of several prestigious international medical societies including the Collegium Otorhinolaryngologicum Amiticiae Sacrum. He holds editorial positions for *Auditorial Neurotology* and *The Cochrane Collaboration: Ear nose and Throat Disorders Group* and reviews articles for a range of other journals.

Professor O'Leary has successfully integrated academic and clinical practice, having worked as an academic surgeon at the University of Melbourne and taking up the position of Chair of Otolaryngology last year, while also holding clinical positions at the Otology and Cochlear Implant Clinics at the Royal Victorian Eye and Ear Hospital (RVEEH) and the Royal Children's Hospital. He has a strong commitment to postgraduate surgical training, and supervises postgraduate research students and Fellows. Professor O'Leary is also an active member of the College and has been a member of the Board of Surgical Research since 2006.

Stephen is a surgeon who has made an outstanding contribution to the advancement of surgery, particularly through his internationally recognised research in cochlear implants and his leadership in academic surgery. He is a worthy recipient of the John Mitchell Crouch Fellowship for 2009.

Citation kindly provided by Julian Smith

Associate Professor Michael Besser AM - ESR Hughes Medal

Michael Besser obtained his Fellowship of the College in Neurosurgery and was appointed to the Department of Neurosurgery at Royal Prince Alfred Hospital (RPAH) and the Royal Alexandra Hospital for Children in 1979 following training in Australia and Canada. Under Professor Charles Drake, one of the giants of 20th century neurosurgery, Michael gained expertise in the treatment of intracranial vascular disorders as well as paediatric, skull base and oncological neurosurgery.

Michael was one of the first to bring to Australia the techniques of microscopic repair of vertebrobasilar aneurysms, the most demanding and difficult of neurosurgical conditions. His published outcomes for such cases were equal to those of the best surgeons internationally.

With his ear nose and throat colleague, David Pohl, Michael operated upon many hundreds of patients with acoustic neuromas and pituitary tumours with minimal morbidity. They consolidated the "team" approach to such challenging conditions. Michael was instrumental in the early establishment of interventional neuroradiological treatment of vascular disorders with his radiological colleagues at Royal Prince Alfred Hospital (RPAH).

Michael was appointed to the Melanoma Unit when it transferred to RPAH in the 1980s. With Professor John Thompson he published one of the largest management series of intracranial metastatic melanoma in the medical literature. His treatment outcomes for treating hundreds of patients with meningiomas and other demanding tumours of the brain were excellent.

His opinion and care has often been sought from colleagues who referred the most difficult cases from other teaching hospitals in Australia.

Michael's planning initiative and drive ensured the optimum provision of neurosurgical services with the early adoption of evolving technological adjuncts to neurosurgery at RPAH such as frameless stereotaxis, stereotaxic radiosurgery and Australia's first intraoperative Magnetic Resonance Imaging scanner.

He served many roles in the Neurosurgical Society of Australasia (NSA) culminating in the position of President. Within the College his activities have included those of Councillor and Examiner in Neurosurgery. In addition to convening several international neurosurgical meetings he has given 65 presentations at official scientific meetings and published 87 papers.

Michael was appointed a Clinical Associate Professor in Neurosurgery at the University of Sydney in 1996 and was the Area Director of Neurosciences of his Area Health Service from 1998 until his retirement. He was honoured with the Order of Australia (A.M.) in 2001 for services to medicine.

Involved in the development of a prescriptive curriculum of neurosurgical training, Michael oversaw the training of many neurosurgeons, becoming a valued mentor to all. Many of his former registrars have gone on to be leaders in neurosurgical subspecialty fields, academics and heads of their departments.

One of the most outstanding surgeons of his generation, Michael has been meticulously focused on his patients from both the clinical and humane perspectives and has been without exception totally prepared when he undertook their treatment. The example he has set to his registrars and colleagues in all aspects of neurosurgery from patient care and surgical prowess to teaching, audit and administration has made a most significant contribution to Australian surgery. Accordingly Clinical Associate Professor Michael Besser is a most deserving recipient of the ESR Hughes Medal.

Citation kindly provided by
Martin McGee-Collett

ACCOMMODATION FOR VISITING SCHOLARS – WE NEED YOUR HELP!

Through the RACS International Scholarships Program, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to 12 months.

Due to the short term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. If you have a spare room or suitable accommodation and are interested in helping, please send us your details. We are seeking people who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a resonable rental and eternal appreciation.

If you would like to help or require further information, please contact the International Scholarships Secretariat on the following details:

International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 – 290 Spring Street
East Melbourne Victoria 3002
Australia

Telephone: + 61 3 9249 1211
Fax: + 61 3 9276 7431
Email: international.scholarships@surgeons.org

Call for abstracts

For further information on the Perth ASC, click on www.asc.surgeons.org

Michael Levitt
Congress Convener
David Oliver
Congress Scientific Convener

The planning for the forthcoming and 79th Annual Scientific Congress in Perth is well advanced. The Perth conveners have drawn together an outstanding Faculty to present the most recent research and the most recent clinical material which will be of value in your everyday practice, whether a Fellow or a Trainee.

The Call for Abstracts form is included in this edition of *Surgical News* (please see next page), or it can be downloaded from the Congress website, 'asc.surgeons.org'. The closing date for research abstracts is 25 January 2010. The Provisional Program will be posted to all Fellows and Trainees in November.

Over the coming months we will highlight the scientific programs and the Visitors invited by the conveners.

Breast Surgery

The Breast surgery program is convened by Peter Willsher. Peter has invited as the RACS Visitor, Professor Henry Kuerer from the prestigious MD Anderson Cancer Centre in Houston. Professor Kuerer is a surgical oncologist with research and clinical interests in breast cancer and surgical education.

Peter has asked Professor Kuerer to provided updates on the areas of ductal carcinoma-in-situ, pre-operative chemotherapy and the ways in which the requirements for radiotherapy impact upon the timing of breast reconstruction. There will be two Masterclasses that should find broad interest for all delegates, whether Fellows or Trainees: 'Update on oncoplastic techniques' and 'Breast MRI – interpretation and application'.

Other sessions will address the medicolegal aspects and complications of breast surgery, new technologies in breast cancer, training and lifestyle issues for breast surgeons, and a session covering the particular problems faced by younger women with breast cancer. There will be a Trainee's Prize for the best abstract and presentation by a Trainee (certificate and $500). The Trainee's Prize is supported by Covidien.

The Breast surgery and Endocrine surgery sections will combine for their section dinners on Wednesday night, sponsored by Astra-Zeneca, Johnson and Johnson Medical and Novartis.

Colorectal Surgery

Professor Cameron Platell is convening the Colorectal surgery program. The College-funded Visitor is Professor Roger Motson, consultant surgeon at Colchester General Hospital, UK. He is an acknowledged expert in laparoscopic surgery, particularly in the field of colorectal surgery. Roger Motson is a past president of both the Association of Laparoscopic Surgeons and the Coloproctology Section of the Royal Society of Medicine.

Professor Motson will be presenting on the surgical management of Crohn's disease and the role of laparoscopic surgery in the management of rectal cancer. In addition to this, the program will include three sessions of audiovisual presentations on how surgeons perform a variety of laparoscopic and open surgical procedures. Three sessions have also been allocated to research paper presentations, including the prestigious Mark Killingback Prize for Younger Surgeons and Trainees. A further session will be devoted to showcasing a number of clinical trials in which members of the Colorectal section are involved. This will include Mr Peter Hewitt presenting the survival data for the ALCAss trial, a clinical study that compared open versus laparoscopic surgery for colon cancers.

The Colorectal section will offer two Masterclasses: the first (Wednesday) will be from Professor Michael Solomon discussing "Pelvic exenteration techniques including en bloc lateral pelvic side wall for recurrent pelvic cancers', in association with the Surgical Oncology section, and the second (Thursday) will address 'Colorectal misadventures'.

The Colorectal section dinner is on Wednesday night at 'Cocos'. This outstanding restaurant in South Perth overlooks the Swan River and offers spectacular view across the city skyline. The Colorectal dinner is sponsored by Johnson and Johnson Medical.

Associates Program

The Associates program has undergone a significant revamp. In Perth, all registered Associates are encouraged to attend the Senior Surgeons program and the Surgical History program, which are now officially incorporated in the Associates' program. Attendance is at no additional cost to Associates as is attendance at the Expand Your Horizons program.

The first Expand Your Horizons session will feature Dr Neville Marchant, from the internationally recognised Kings Park. He will deliver a presentation titled 'South West WA: an island of high plant diversity'. This will cover the evolution of the diversity of the flora and an overview of the gaining of knowledge of the plants since the visit of William Dampier in 1699. We have arranged a visit to the research facilities at Kings Park in the afternoon.

A retired Western Australian vascular surgeon, Bill Castleden has returned from France where he has been writing a book on the environment. Bill has a long history of involvement in environmental activism including anti-smoking and activism for compulsory seat belt legislation. Bill will talk on 'A surgical journey into environmental activism', an area in which he is very well qualified to speak.

President's Lecture

Due to unforseen circumstances Professor Barry Marshall will no longer be delivering the President's Lecture. Dr Kim Harry, the Western Australian Minister of Health has accepted the invitation to present.

We look forward to welcoming you to perfect Perth.

Call for Abstracts

perth '10

Annual Scientific Congress

Perth Convention & Exhibition Centre, Perth, Australia

4 – 7 May 2010

Royal Australasian College of Surgeons

PERTH CONVENTION BUREAU

Submission of abstracts for research and invited papers

Abstract submission will be entirely by electronic means. This is accessed from the Annual Scientific Congress website http://asc.surgeons.org clicking 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 1750 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.
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. 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 – Tom Reeve prize in Endocrine Surgery (best research paper from a Trainee); the Surgical Education prize (for best research paper) or the Bard prize (best research prize related to abdominal hernia management from a Trainee in the General Surgery program). Five hundred dollar prizes for the best abstract and presentation from a Trainee will also be offered in Breast surgery, Burn surgery, Colorectal surgery (in addition to the Mark Killingback Prize), General surgery, Hepatobiliary surgery, Plastic surgery (reconstructive prize and aesthetic prize) Trauma surgery, Upper GI surgery and Vascular surgery. Surgical Trainees must register their intention to apply for one of these prizes on the abstract submission site.
13. Authors must be registrants at the meeting for their abstract to appear in the publications, on the website or the Virtual Congress.

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 a confirmation email 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 to determine why a confirmatory has not been received (binh.nguyen@surgeons.org)

Important Information

TO SUBMIT AN ABSTRACT GO TO http://asc.surgeons.org AND CLICK ON 'ABSTRACT SUBMISSION'.

THE CLOSING DATE FOR SCIENTIFIC PAPER ABSTRACT SUBMISSION IS 25 JANUARY 2010.

THE CLOSING DATE FOR ABSTRACT SUBMISSION OF INVITED SPEAKERS IS 8 MARCH 2010.

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, for assistance on +61 3 9249 1279 or email binh.nguyen@surgeons.org

Scientific Posters

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

Important Dates

Abstract Submission opens	2 October 2009
Closure of Abstracts	25 January 2010
Closure of Early Registration	15 March 2010

Executive Organising Committee

Convener	Mr Michael Levitt
Scientific Convener	Mr David Oliver
Executive Committee Member	Mr Harsha Chandraratna
Executive Committee Member	Mr Rupert Hodder
Executive Committee Member	Prof Christobel Saunders
ASC Scientific Co-ordinator	Mr Campbell Miles
ASC Manager	Ms Lindy Moffat
Regional Manager, Western Australia	Ms Penny Anderson
Executive Officer, Western Australia	Ms Angela d'Castro

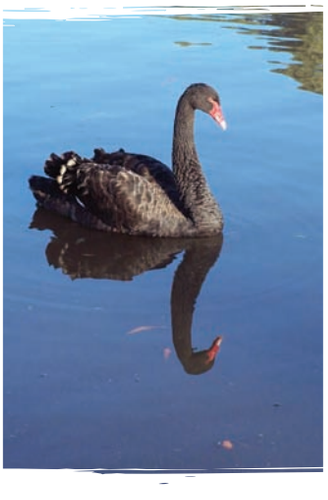
Perth ASC 2010 Program Overview

	Monday 3 May	Tuesday 4 May	Wednesday 5 May	Thursday 6 May	Friday 7 May
Breakfast session 7.00am – 8.20am		Masterclasses	Masterclasses	Masterclasses	Masterclasses
Session 1 8.30am – 10.00am	Professional Development Workshops 1. Polishing Presentation Skills 2 & 3. Supervisors and Trainers for SET (SAT SET) Workshops 1 and 2 4. Understand your patients better: Become culturally competent	Plenary	Scientific Sessions	Scientific Sessions	Scientific Sessions
10.00am – 10.30am		Morning Tea	Morning Tea	Morning Tea	Morning Tea
Session 2 10.30am – 12noon		Scientific Sessions	Plenary	Plenary	Plenary
12 noon – 12.30pm		Keynote Lectures	President's Lecture	Keynote Lectures	Keynote Lectures
12.30pm – 1.30pm		Lunch	Lunch	Lunch	Lunch
1.30pm – 2.00pm		Keynote Lectures	Keynote Lectures	Keynote Lectures	Keynote Lectures
Session 3 2.00pm – 3.30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
3.30pm – 4.00pm		Afternoon Tea	Afternoon Tea	Afternoon Tea	Afternoon Tea
Session 4 4.00pm – 5.30pm	4.30pm Convocation Ceremony	Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
7.00pm – 11.00pm	6.00pm Welcome Cocktail Reception	Sectional Dinners and Younger Fellows & Trainees Dinner	Sectional Dinners	Congress Dinner	Sectional Dinner

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 Surgery
- Colorectal Surgery
- Craniomaxillofacial Surgery
- Endocrine Surgery
- General Surgery
- Head & Neck Surgery
- Hepatobiliary Surgery
- International Forum
- Medico-Legal
- Military Surgery
- Paediatric Surgery
- Pain Medicine
- Plastic & Reconstructive Surgery
- Rural Surgery
- Senior Surgeons
- Surgical Education
- Surgical History
- Surgical Oncology
- Transplantation Surgery
- Trauma Surgery
- Upper GI Surgery
- Vascular Surgery
- Women in Surgery



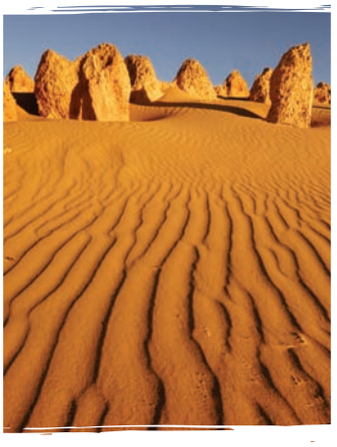
Keep abreast of program developments on the conference website **http://asc.surgeons.org**

perth '10
Annual Scientific Congress
Perth Convention & Exhibition Centre, Perth, Australia
4 –7 May 2010

Scientific Conveners

College & Industry Sponsored Visitors

Bariatric Surgery	Prof Jeff Hamdorf	Dr Paul Cirangle Prof Michel Gagner	USA USA
Breast Surgery	Dr Peter Willsher	Prof Mark Kuerer	USA
Burns Surgery	Professor Fiona Wood Dr Suzanne Rea	TBA	
Colorectal Surgery	Prof Cameron Platell	Prof Roger Motson	UK
Endocrine Surgery	Mr Dean Lisewski	Prof TWJ Lennard Dr Geoffrey Thompson	UK USA
General Surgery	Mr Jeremy Tan	Dr Frederick Moore Prof Karim Haouet	USA Tunisia
Head & Neck Surgery	Mr Richard Lewis	Prof Ashok Shaha Dr Subramania Iyer	USA India
Hepatobiliary Surgery	Mr Andrew Mitchell	Prof Jaques Pirenne	Belgium
International Forum	Prof David Wood	–	
Medico-Legal	Mr Max Baumwol Prof Alan Skirving	Prof Enrico Coiera Assoc Prof Peter Cosman	Australia Australia
Military Surgery	Mr David Read	Lt Col Todd Rasmussen	USA
Paediatric Ssurgery	Mr Colin Kikiros	Dr Rosslyn Walker	Australia
Pain Medicine	Dr David Holthouse	Dr Tony Van Havenbergh Dr Richard Bittar Dr James Hagen Dr Daniel Bennett	Belgium Australia USA USA
Plastic & Reconstructive Surgery	Mr Mark Lee	Prof Claes Lauritzen Dr David Fisher Dr Wayne Perron Dr Jerome Stevens	Sweden Canada Canada Netherlands
Rural Surgery	Mr Neill Kling	Dr David Borgstrom	USA
Senior Surgeons	Mr Gordon Baron-Hay	–	
Surgical Education	Dr Sue Taylor	Mrs Linda de Cossart Prof Clifford Hughes	UK Australia
Surgical History	Mr John Hanrahan	TBA	
Surgical Oncology	Prof Christobel Saunders	Prof Laura Esserman	USA
Trainees Association	Dr Mary Theophilus	–	
Transplantation Surgery	Prof Luc Delriviere	Prof Jacques Pirenne	Belgium
Trauma Surgery	Mr Sudhakar Rao	Dr Mark Bowyer	USA
Upper GI Surgery	Mr Krishna Epari	Assoc Prof Grant McArthur Mr Thomas Dehn (BJS) Prof Simon Law	Australia UK Hong Kong
Vascular Surgery	Mr Brendan Stanley	Assoc Prof Geoffrey White Dr Eric Verhoeven Dr Cherrie Abraham	Australia Netherlands Canada
Women in Surgery	Dr Katharine Drummond	–	
Younger Fellows	Mr Richard Martin	–	



NOTE: Information correct at time of printing. Information is subject to change.

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W: **www.surgeons.org**

PERTH CONVENTION BUREAU

Chalice – poison'd? Continued.....

I am now stranded between my "brothers in arms" and an administrative structure as firmly immoveable as ever

Professor U.R. Kidding

I often reminisce over my interview for the Director of Surgical Services. It was one of those life defining moments... like when you arrive home late one night and your wife says "I have packed your clothes, you can keep the car but I want the house!" (a lot of flowers and grovelling to remedy that situation I can tell you!)

"Life defining" means change of course but somewhere in the meaning are concepts like precipice, lambs and abattoirs and uncertainty. On reflection, the interview revealed that I had a split personality – one part of me said "I'm a successful surgeon, I don't need this, they can't intimidate me!" The other part of me wanted them to want me. The competitive instinct, inherent in all surgeons – as powerful as the survival instinct in all other species – kicked in. In reality, most of the interview was a blur, I was functioning as a reflex competitive being, brain in neutral, mouth in overdrive. I could feel the precipice approaching and I knew I wanted to jump!

They had smiled at me.... I had responded. Strategic plan, KPI's, developments for the health service and surgical services, handling difficult human resources issues, interests in education and research.... I even got them to laugh at some of my jokes. Always a good sign when the examiners, sorry the interview panel laugh with you, rather than at you.....

As management decisions go, my appointment was "faster than a speeding bullet"- maybe I impressed them but no-one ever commented on the depth of competition either.... The phone call to "come and have a chat about the contract" was the day after. It rang a few bells. I had never been impressed by the way that my clinical colleagues handled these sorts of things. We either live in a world of fee for service with interaction with individual patients or on a salary structure that seems to be settled by some remote union to government mutual slanging match. I didn't want to be labelled "money hungry" but I took the liberty of contacting that consulting friend of my anaesthetist.

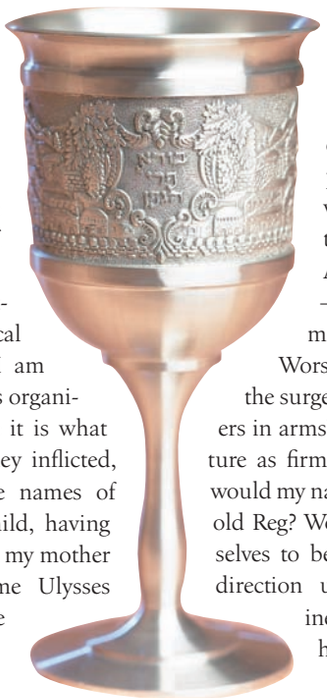
The options were mind-boggling. However, I was not going to be an equity partner and nor did I think share options or agreed percentages of dividends of an entity that could be technically bankrupt were a great way to increase the family's "net worth". However two messages should really have made an impression. The first message - get everything you want in writing before you sign the contract. It is so true; no one wants you more than the person who needs your signature. After that you are only another department head whinging for resources or after a salary review. The second - get them to agree to all the changes you may want to make and try and achieve them in the first 12 months. In the first 12 months they are emotionally committed to you. They appointed you – how could they have made a mistake!! After that you will be on your own and you become remarkably more dispensable. The honeymoon will be over.

I am now one of the whinging department heads – of course, and I think I have honeymoon cystitis! But if I ever apply for another one of these jobs I will try and make sure of myself on those two points.

However I did get a commitment to implementing a surgical structure, and I must admit I am increasingly a fan of making this organisational structure work. Maybe it is what my parents did to me when they inflicted, sorry, christened me, with the names of Ulysses and Reginald. As a child, having read Homers' epic poem, I asked my mother whether she chose to call me Ulysses because she thought I would be brave, determined, resourceful, an inspirational leader. "No" she replied "I just liked the name". Reginald was not a problem for me – I grew up in the time Reg Ansett and that entrepreneurial spirit in creating a great organisation. Always thought of myself as a "bit of a Reg" and getting structures in place in the hospital will take all of his ingenuity and no doubt consideration of the occasional Trojan horse.

So now I had joined the "dark side". It was confusing. Previously my life in healthcare had been clear – there was "us", clinicians trying to treat patients, and there was "them" – the enemy, administration and bureaucracy, trying to thwart each surgeon's inherent individual nobility. But now, who was the enemy? A disturbing thought began to dawn upon me – maybe I needed an enemy to provide a focus for my rationalisations?

Surgeons are trained to be great decision makers, technically dextrous as well as professionally wise. But now, the characteristic that I had previously valued and defended – individuality – threatened the management plans I had in mind. I soon came to recognise that this individuality produces fear and trepidation in the minds of hospital administrators and leads to poor progress in advancing surgical issues.



Suddenly I had 70 individual surgeons making complaints, suggestions or demands. Ramifications, previously a word not in my vocabulary, was instantly at the forefront of every thought. And then it dawned upon me – democracy was going to fail, majority rule was inappropriate. Worse, I was now stranded between the surgeons, who had been my "brothers in arms" and an administrative structure as firmly immoveable as ever. What would my namesakes do, Ulysses and good old Reg? Would they have allowed themselves to be pulled in every conceivable direction ultimately producing perfect inertia? I didn't think so. There had to be another way.

To be continued...

The Surgical Safety Checklist was launched in Australia and New Zealand in August

It is based on a prototype developed by the World Health Organisation (WHO) and was trialled at eight hospitals around the world representing a variety of economic circumstances and a diversity of patients. Results of the trial were published earlier this year in The New England Journal of Medicine.

The Australian launch was held at Parliament House, Canberra and was well attended by Members of Parliament representatives of the specialist medical colleges. The New Zealand launch was also well attended by the specialist medical colleges and Members of Parliament, it was held at Parliament Building, Wellington.

The Surgical Safety Checklist can be found on www.surgeons.org

1. Ian Civil, the Hon Tony Ryall, New Zealand Minister for Health & Alan Merry from the Australian & New Zealand College of Anaesthetists (ANZCA) **2.** Ian Civil & Damian McMahon **3.** Ian Gough, the Hon Nicola Roxon & Mukesh Haikerwal, ex President of the Australian Medical Association **4.** Spencer Beasely, John Quinn, the Hon Peter Dutton & Guy Maddern **5.** Ted Weaver, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Ian Dickinson & Hodo Haxhimolla **6.** Robyn Lawson, Australian College of Operative Room Nurses (ACORN), James Harrison, International Federation of Perioperative Nurses (IFPN), Margie Cowling, ANZCA & Patricia MacKay, ANZCA **7.** Cheryl Winter, President of ACORN, Ian Gough, Bruce Barraclough, Alan Merry & Robyn Lawson, ACORN **8.** The New Zealand launch

1

International Medical Development

The College is committed to improving international assistance

The design of protocols to allow Trainee surgeons a more effective role in international aid work and the need for more focussed surgical educational packages to be delivered by visiting surgical teams were the major recommendations to come out of the Colleges' second International Medical Development Symposium held in August.

First held in 2006, the symposium is designed to help the College constantly improve its ability to match the assistance provided with the various needs of host nations across the Pacific region.

The College is a major co-ordinator of millions of dollars in AusAid funding, has a strong and central ethos of providing voluntary medical assistance to countries in need. Programs co-ordinated through the College are dedicated to assist East Timor, Papua New Guinea (PNG), the Pacific Islands and Nusa Tenggara Timur.

This year, more than 180 delegates attended the symposium, including representatives from host nations, volunteer surgeons, nurses and allied health professionals. Aimed at building effective communication systems between host countries and the international aid providers, the symposium allowed host country representatives to explain the type of assistance they saw as most useful as well as providing a forum for volunteer Fellows to pass on the knowledge gained through their international aid work.

Speakers at the meeting included the Honourable Bob McMullan, the Australian Parliamentary Secretary for International Development, Professor Eddie McCaig, Associate Professor of Surgery at the Fiji School of Medicine, Dr Clement Malau, Secretary of Health, PNG and Sir Isi Kevau, Dean of the School of Medicine and Health Science, PNG.

Co-convenor of the meeting Mr Glenn Guest said that while the contribution of Fellows to international aid remained outstanding, constant social and economic shifts within the region meant that practical and effective communication systems remained vital.

"This symposium is very important because both sides involved in the provision of international medical development need to sit down together and listen to each other. It can be extremely difficult at times to meet the need of individual countries mainly because such needs are constantly evolving – from one nation wanting specialist teams to fly in to conduct specific surgeries to others seeking post-graduate educational assistance - while we have to constantly consider how best to stretch the development dollar as far we can.

"However, the strong turnout at the symposium suggested a great commitment from both sides of the equation to getting it right as often as possible. The meeting was a strong success given the wide variety of host nations represented, the diverse range of speakers sharing their experiences and the great enthusiasm of the surgeons, nurses, anaesthetists and other health professionals dedicated to providing this assistance."

Mr Guest said a central issue that arose from the meeting was the need for enhanced communication between the donors and recipients of medical equipment. He said there now existed at times a poor correlation between

what equipment donors wanted to give and what host nations could sensibly use.

"There have been cases where generous and well-meaning organisations have wanted to provide equipment such as a CT scanner for example to a hospital in the region that does not have the maintenance budget or the technical expertise to keep it running," Mr Guest said.

"Although a centralised catalogue and warehouse were suggested as an ideal solution, it was recognised that this was an extremely difficult undertaking beyond the scope of the College. However, a set of guidelines from the host nations is achievable and is a practical way of guiding the appropriateness of donated equipment."

Mr Guest said another central issue raised at the meeting was the strong desire by Australian and New Zealand Trainees to play a larger role in the provision of medical development. He said he would work over the next few months to devise a set of protocols to guide Trainees' involvement within the framework of the Colleges' international programs.

"Often Trainees are not given the opportunity to become involved in some of the outreach work provided through the College because host nations frequently want visits by specialists but the trainees are the specialists of tomorrow. We want to catch them when they are young, when they are enthusiastic and before the responsibilities of private practice make it more difficult for them to take time out to travel yet we have to design a system whereby their involvement does not impact on the training of local surgical trainees," Mr Guest said.

Mr Guest said highlights of the meeting included the strong involvement and enthusiasm of nurses, the presentation and on-going involvement in international development by Professor David Scott, the Medical Director for the Colleges' East Timor Program, and the contribution made by Professor David Watters, the Medical Director of the Pacific Island Project.

Fellow convenor Associate Professor Hamish Ewing, who has visited East Timor every year since 2002, said the need to measure the benefit of assistance and to better co-ordinate educational packages had also been central themes of the meeting.

"While there is absolutely no doubt that the voluntary contribution made by Fellows and allied health professionals continues to be outstanding, we are now perhaps at a time where we can and should devise systems so that we know at a glance that we are providing what each host nation wants us to provide while also proving to ourselves and others that what we do is as good as we think it is," Associate Professor Ewing said.

"I think it is time that we designed a process that can measure the impact of our assistance, that can co-ordinate follow-up research and that can also ensure that the educational component of each team visit is as practical and useful in each particular situation and country as we can make it. For that to work we need to make sure there is effective communication between each host country and each program. We need to collect and analyse data and we need to tailor educational packages.

"A suggestion was made at the symposium that one way to achieve this was for the establishment of an educationalist within the College to design such packages, to co-ordinate the data and to act as a focus between host countries and volunteer surgeons.

"Yet this a complex issue because as with all international aid matters, it comes down to decisions on how the aid dollar is best spent."

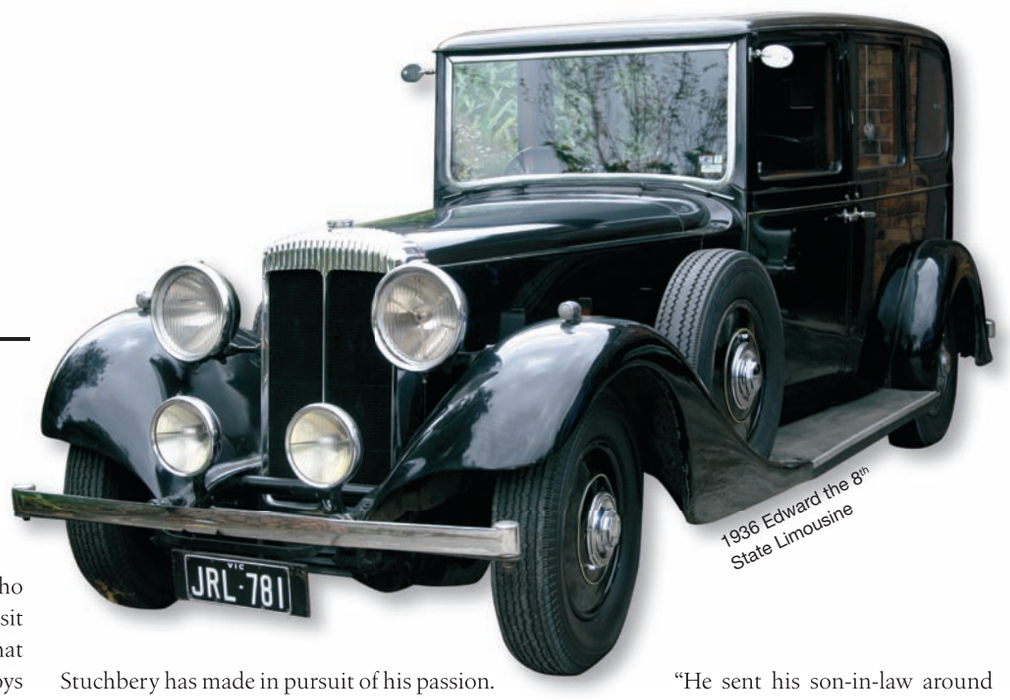
Associate Professor Ewing said, however, that despite the challenges, the symposium demonstrated the on-going enthusiasm of Australian and New Zealand health professionals to provide assistance to those nations in need.

"All the feedback we received suggested that people found the meeting to be rewarding and useful in that it was very interactive, very honest and positive and allowed people to establish useful relationships across professions, specialties and nationalities."

1. Isi Kevau, Clement Malau, Greg Fernandez, Don Marshall, Ian Gough & Glenn Guest **2.** Rowan Nicks & Gordon Low **3.** Valerie Remedios & Ruben David **4.** Neil Wetzig & Michael Henderson **5.** Richard Rawson & Jambi Garap **6.** Vince Cousins, Perry Burstin & Malcom Baxter

The romance of vintage cars

We all know that surgeons who don't have interests outside work when they retire, die too soon



1936 Edward the 8th State Limousine

When describing his attitude towards his fine collection of vintage cars, retired vascular surgeon Mr Ken Stuchbery uses the metaphor of patios. There are those who like to build patios and those who like to sit on them, he says, and he is of the group that likes to build, which is to say that he enjoys working on his cars more than tootling around in them.

And after almost 50 years of rebuilding and restoring some of the most glamorous automobiles ever produced, he should know. Now parked in garages spread around Melbourne, Mr Stuchbery has an early-1930s Daimler limousine, a 1928 Straight-Eight Stutz, a 1929 Stutz Six Coupe, two Austin 7s, a 1951 Morris Minor convertible, an MGB, a Rolls Royce Silver Shadow and lastly, his most recent purchase, a 1950 Riley.

When he lists them all he laughs and says it may sound a little excessive, like a hobby that has got out of control, yet with a life-long love of engineering and with most of the cars in the "basket-case" category upon purchase, he says that each one represented an irresistible challenge.

"The appeal to me is in the engineering, in the mechanics of restoration. Some people can think of such vintage cars as having an air of romance about them but believe me, the romance is all in the appearance, not in the driving. Some of the big cars handle like a ten-tonne truck and I injured my shoulder at one stage driving the Stutz and had to have a shoulder reconstruction," he says.

But that is just one of many sacrifices Mr Stuchbery has made in pursuit of his passion. Some decades ago he also spent hours of his precious free time racing off to night school after his hospital hours were over to learn the fine arts of panel beating and car body building.

"I had an interest in mechanics growing up in the country and worked on my own cars as I went through university, and later joined the Armoured Corps during my national service. Sometimes upon reflection I wonder if I should have pursued a career in engineering but still there are strong similarities with surgery, it's still the same interest in working on a machine and putting things together and getting it right," he says.

Mr Stuchbery says he first became interested in vintage cars when studying surgery in England in the 1960s. A friend who had decided to pursue his study in America left him the Daimler and asked him to sell it.

"I came back from holidays and he'd left a note under the windscreen asking me to sell it but I couldn't even get it started," he laughs.

"I was a registrar then and I was looking after a patient by the name of Mr Harold Welham who was a mechanic who also restored, maintained and sourced veteran cars, particularly for the British film industry and maintained the cars for the film *Genevieve*.

"He sent his son-in-law around to help me get it started but the first time I took it out, at the first set of traffic lights I went straight through because the breaks didn't work. Clearly I couldn't sell it and no-one much wanted it particularly because it used enormous amounts of petrol and the best I could get was 25 pounds from the wreckers.

"So my friend gave it to me instead which was a gift I needed like a hole in the head but then Mr Welham came around to look at it and said he thought it was a royal car which came as a great surprise."

Before shipping it to Melbourne, however, a strange co-incidence occurred. A film-maker working on a documentary on the abdication of Edward VIII needed a Daimler for fill-in shots and Welham suggested using the one owned by Mr Stuchbery. When they drove it into the grounds of Windsor Castle, one of the staff who looked after the cars was asked his opinion as to whether it once belonged to the royal family.

"This man said he could soon prove it," explains Mr Stuchbery.

"He put his hand behind the back seat and found an inflatable cushion, which I knew was there, and claimed they were always put into royal cars because Queen Mary had suffered from a bad back and it had become a tradition

1. Ken in the 1928 Stutz 8 speedstar **2.** A 1950 Riley **3.** A 1964 MGB **4.** A 1928 Austin 7

to fit an inflatable cushion for her."

It was not until Stuchbery brought the car back to Australia that he learnt that the Daimler was, in fact, the state limousine used by Edward VIII before his abdication in 1936 to marry the notorious Wallis Simpson which is a twist that Mr Stuchbery still finds fascinating.

"Out of all the Daimlers then still in England the film-maker unknowingly chose Edward's own car which I think is extraordinary," he says.

Perhaps that was the magic moment that kicked off the life-time interest. Later, back in Melbourne, he bought the two Stutzs, working on their restoration in the nights with a friend who was a car body builder. Indeed, many of his cars have been almost entirely rebuilt, with Mr Stuchbery calling on a range of friends in a range of fields to help him manufacture parts and source rare components.

"At one stage my wife said she was sick of the monster cars and wanted something smaller so I went about collecting bits and pieces of an Austin 7 but the parts were in such disorder and disarray that in desperation I bought an intact Austin 7 which was itself a basket-case but was at least complete so I could see how it should be put together."

While some of the cars, or what remained of the cars, were worth at purchase only paltry sums, now some of the gracious automobiles that comprise Mr Stuchbery's fleet are worth quite a lot, with the Daimler still making film appearances, most recently in a TV production based on Robert Menzies trip to London in 1940.

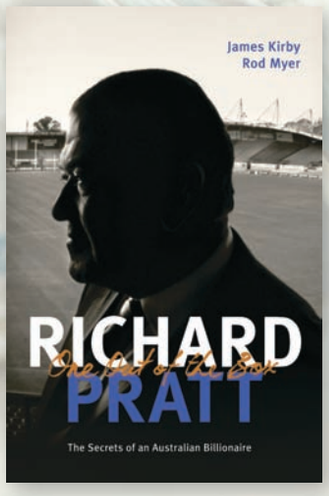
Yet still Mr Stuchbery says that while he keeps all the batteries charged so he can take each car out if the whim takes him, his interest remains in their upkeep and maintenance.

"I have a few convertibles which are quite pleasant to take out for a spin on a good day but there is a bit of a show-off factor about that I suppose, whereas I would just rather work on them. In some ways they have greater meaning for me now in retirement, as a reason to get up in the morning, because we all know that surgeons who don't have interests outside work when they retire, die too soon," he says.

The Surgeons' Bookclub

Welcome to The Surgeon's Book Club

Highlighted in this months issue are recent and new titles from across the spectrum of books available from John Wiley & Son.



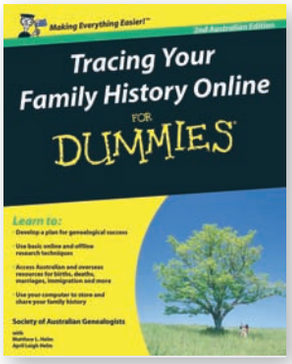
Book of the Month
20% Discount

New

Richard Pratt: One Out of the Box: The Secrets of an Australian Billionaire
James Kirby and Rod Myer
9781742169606 | Sept 2009 Pbk
~~AU$34.95~~ / **AU$27.96**

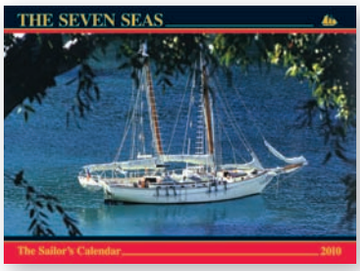
Richard Pratt was one of Australia's most successful, formidable and charismatic businessmen. Yet for all this he was unfailingly human, his life playing out like a drama even after the final act.
Self-made billionaire, family man, generous philanthropist, patron of the arts and Carlton Football Club saviour were just a few of Pratt's many guises, and in this compelling biography the truth behind the headlines is revealed. The twists and turns of Pratt's life are chronicled with candour – from humble beginnings in Poland to the heights of global business success tainted by the humiliating price-fixing scandal that earned Visy the largest corporate fine in Australia's history. Pratt's many achievements and controversies polarised public opinion but made him one of Australia's most enigmatic public figures. Though his legacy is debatable, no-one can deny that Richard Pratt was ... *one out of the box.*

Other Titles at 15%



Tracing Your Family History Online For Dummies, 2nd Australian Edition
Society of Australian Genealogists with Matthew L. Helm, April Leigh Helm
9780731409099 | Paperback | 344 pages | July 2009
~~AU$39.95~~ / **AU$33.96**

Millions of genealogical resources and records are available online, allowing you to become a successful family historian from the comfort of your home. This fully updated and practical guide shows you where to start, how to find and use the best websites and how to swap information with others – helping you to become a smart, discriminating researcher. Lots of great information to help you orgainise your research, get started, create websites and form research groups, and lots more, inc Bonus CD of genealogical software tools.



The Seven Seas Calendar 2010
Ferenc Máté
9780920256640 | August 2009 | Pbk
~~AU$24.95~~ / **AU$21.21**

It's never too late to dream of running away to sea. And it's never too soon to go.
Few phrases stir our imagination like the centuries-old "ran away to sea." It was used most often in reference to young men turning their backs on the security of land and hearth and striking out for adventure, the unknown, and a new life.
This calendar takes you on a journey to the most mesmerizing places on earth.

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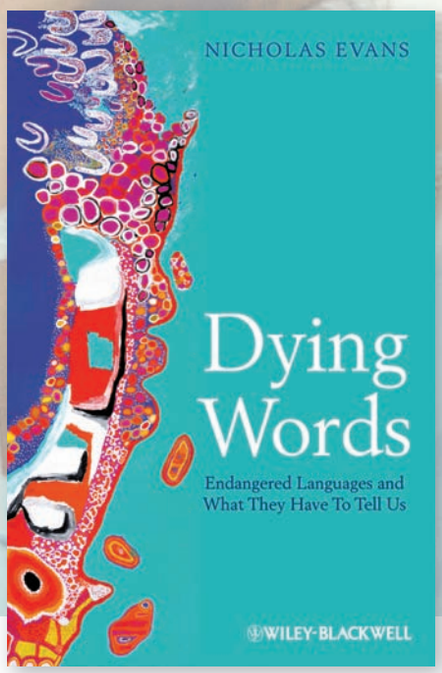
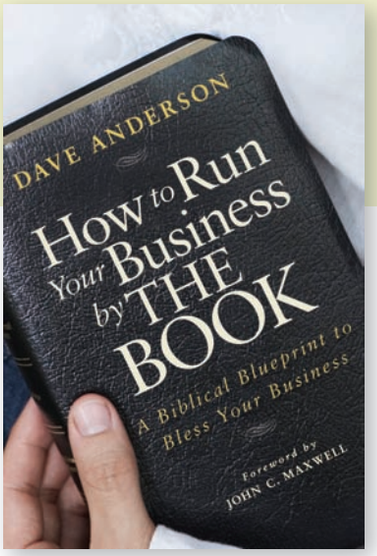


Dying Words: Endangered Languages and What They Have to Tell Us
Nicholas Evans | 9780631233060
April 2009 | Pbk
~~AU$49.95~~ / **AU$39.96**

The next century will see more than half of the world's 6,000 languages become extinct, and most of these will disappear without being adequately recorded. Written by one of the leading figures in language documentation, this fascinating book explores what humanity stands to lose as a result.

- Explores the unique philosophy, knowledge, and cultural assumptions of languages, and their impact on our collective intellectual heritage
- Questions why such linguistic diversity exists in the first place, and how can we can best respond to the challenge of recording and documenting these fragile oral traditions while they are still with us
- Written by one of the leading figures in language documentation, and draws on a wealth of vivid examples from his own field experience
- Brings conceptual issues vividly to life by weaving in portraits of individual 'last speakers' and anecdotes about linguists and their discoveries



How to Run Your Business by The Book: A Biblical Blueprint to Bless Your Business
Dave Anderson
9780470496428
July 2009 | Hbk
~~AU$42.95~~ / **AU$36.51**

The book is a refreshing return to commonsense business, based on leadership lessons peppered throughout the Bible. Best of all, you don't need to be familiar with the Bible to profit from these timeless principles. The book teaches what the Bible has to say about hiring and training people, managing money, creating a leadership vision, work-life balance, and achieving business goals.

Diabetic foot management

Outback workshops have provided new insights into caring holistically

Ollapallil (Jacob) Jacob
SSRS Project leader

This year the College was again successful in obtaining funding through the Department of Health and Ageing's Support Scheme for Rural Specialists (SSRS). The SSRS provides financial support for Continuing Professional Development (CPD) projects for medical specialists working in regional, rural and remote Australia. The projects provide an opportunity for surgeons, Trainees and International Medical Graduates (IMGs) to engage with peers who share an appreciation of the unique nature of rural medicine in Australia.

The project aimed to deliver a series of workshops demonstrating how to effectively recognise, assess and treat diabetic patients with 'high risk' foot complications.

The first workshop targeted the clinical team in and around Alice Springs. It brought together specialists from endocrinology, vascular and orthopaedic surgery, radiology, podiatry and nutrition to provide participants with a multi-disciplinary and holistic approach to high risk diabetic foot management. The 21 participants included surgeons, Trainees and IMGs in addition to health care workers. During the morning participants were given an overview of the epidemiology and theoretical perspectives of effective diabetic foot management. This was followed by a series of hands-on workstations including casting techniques, vascular assessment and podiatric approaches to good foot care.

The second workshop was also held in Alice Springs on Wednesday 29 July, in conjunction with the Provincial Surgeons of Australia (PSA) Conference. The workshop sought to address the many factors which influence the management of high risk diabetic foot and the steps that can be taken to avoid surgical intervention, including amputation, in at-risk patients. Over 70 surgeons, Trainees and allied health professionals attended the workshop with the feedback received indicating that the meeting was highly educational and enjoyable for all involved.

An important element in the success of the workshop was the focus on utilising a multi-disciplinary approach to the management of diabetic patients. The workshop presentations reflected this approach as they were delivered by experts from a variety of specialities including orthopaedic and vascular surgeons as well as podiatrists, a renal specialist, an endocrinologist and an infectious diseases specialist. Several topics critical to the diabetic foot management were addressed including clinical assessment, peri-operative management, neuropathic pain, radiological assessment, management of foot sepsis/osteomylitis, revascularisation of the ischaemic diabetic foot, management of complex wounds, management of charcot arthoropathy and salvage surgical procedures.

My thanks go to the project advisory group and all presenters involved in the workshop; Robert Fitridge, Linda Ferris, David Armstrong, Neil Cohen, Ben Beamond, Sajiv Cherian, Mark Hamilton, Christian Holmes, Sara Jones, Ruben Sebben and Morgyn Warner.

The Eric Bishop scholarship

The scholarship has given Dr Newell a chance to concentrate on research without wage worries

Brad Newell

The 2008 recipient of the Eric Bishop scholarship, Dr Bradley Newell, is using the scholarship to concentrate on laboratory research into understanding of the role of protein CD151 in the behaviour of prostate cancer. Dr Newell said the research was specifically aimed at understanding the role of CD151 as a mediator of cell motility and cell migration.

"We are trying to determine if tumours with up-regulation of CD151 are more likely to metastasise than tumours with less CD151 expression. Not a lot is known about CD151 which is part of the tetraspanin family of proteins of which less than 30 have been identified in human cells," he said.

"We do know that they modulate cell function and that they bind to other proteins on the surface of the cell but we are entering new research territory with this project because no-one has looked at their role in prostate cancer before, even though it is now the most prevalent solid organ cancer affecting men."

Taking on the research as part of his PhD, Dr Newell is based at the Austin Hospital and is working in collaboration with scientists at the Monash Institute of Medical Research in Melbourne and Bernard O'Brien Institute at St Vincent's Hospital. He is working under the supervision of Associate Professor Damien Bolton, Head of Urology at Austin Health, and Professor Albert Frauman, Director of Clinical Pharmacology and Drug Therapeutics at Austin Health.

Dr Newell said that a better understanding of CD151 could lead to better prognostic information in patient workup and potentially targeted treatment for some prostate cancers.

"The problem with prostate cancer is that we know that well-differentiated tumours tend to behave indolently while the undifferentiated tumours tend to behave aggressively but the intermediate grade tumours can be very difficult to predict," Dr Newell said.

"That means that it can be quite difficult to manage such patients clinically in terms of knowing whether to offer aggressive treatment or not. We are hoping, then, that by understanding CD151 we may be able to use it as a prognostic marker giving surgeons information into which way particular prostate tumours might behave. Already we have found that prostate cancers with increased amounts of CD151 tend to have increased cell motility and a poorer prognosis."

The Eric Bishop scholarship has been made possible due to a generous donation from the late Eric Bishop. The scholarship is intended to support applicants who wish to take time away from clinical positions to undertake a full-time research project and comes with a stipend of $55,000 with $5000 in departmental maintenance.

Dr Newell, a Trainee, said he took on the research as an opportunity to explore areas of medicine outside surgery, became fascinated by it and is finding it difficult to put it aside and go back to his training.

"You get started in research and it can be a slow and arduous process to begin with but the more you know the more you want to know. You end up fascinated to find out what happens next and it can be very hard to put the tools down for someone else to pick up later," he said.

"Yet at the end of the day it's incredibly fulfilling to feel that you are contributing to a body of knowledge that could be of great value to surgeons and patients in the future."

He said he was honoured and grateful to have received such support from the College.

"This scholarship and others like it offered through the College are very generous and profoundly important," he said.

"They mean that young surgeons like myself can step away from clinical practice for a while to simply concentrate on adding to scientific and medical knowledge and to be given the chance to do that without having to worry about taking on extra shifts to pay the mortgage or put food on the table means that we can concentrate on producing effective, meaningful, useful research."

A medical milestone

Having conducted 10,000 successful operations means the hospital has a great database of information

An orthopaedic surgeon who contributed to the revolution in arthroscopic knee ligament reconstructive surgery, Dr Leo Pinczewski, last month reached a rare medical milestone when he conducted his 10,000th such operation at the Mater Hospital in Sydney. In 1993, Dr Pinczewski developed a new technique to repair the anterior cruciate ligament by replacing the use of the patellar tendon with a hamstring tendon autograft and interference screw fixation.

Designed to enhance knee strength, limit pain and morbidity from the donor site and reduce the possibility of future osteoarthritis, his technique has become a mainstream procedure adopted by the rest of the world.

Dr Pinczewski has travelled through the US and Europe teaching the technique, has won multiple awards for his research and has been invited to present the 15-year follow-up results of his surgical method to the prestigious American Academy of Orthopaedic Surgeons next year. Speaking of his contribution to surgical science and innovation, Dr Pinczewski said he had been fortunate to have graduated at a time of rapid technological advance.

"When I first began doing this work, knee reconstruction was an open surgery with perhaps an arthroscope used to have an initial look. That procedure required patients to spend up to a week in hospital and up to six months in plaster and on crutches with many people unable to straighten the leg fully for another six months, if ever," he said.

"Then when we began using the arthroscope to operate and using the patellar tendon, that hospital time was reduced to two days but many patients were experiencing pain from the donor site which in effect fixed one problem while giving them another. We knew that using the hamstring tendon could possibly solve that problem but they were not as stable as the patella tendon so the break-through came when we decided to use a screw."

Yet while that seemed like a classic eureka moment, Dr Pinczewski said he could find no appropriate screw already designed and no medical device company willing to make one. Instead, he sat down with an engineering acquaintance and designed it himself.

"Then we had to find someone, some company to make them for us and we approached the Small Arms Factory in Lithgow which had originally been established to manufacture military weapons but which had since been virtually closed down. They said they would, they began hiring people again for the first time in years and at one stage we were exporting the device to 17 countries. Now the surgery is conducted in less than an hour and on a walk-in-walk-out basis."

Dr Pinczewski has spent the vast majority of his working life at the Mater Private Hospital helping to establish its strong reputation for orthopaedic surgery and is a clinical director of the North Sydney Orthopaedic and Sports Medicine Centre.

He was been awarded the Evelyn Hamilton Trust Memorial Prize for Best Paper at the Australian Orthopaedic Association Annual General Meeting three times, has won the Research Excellence Award for his new technique from the Australian Conference of Science and Medicine in Sport and has won a number of travelling Fellowships to advance his research.

Dr Pinczewski said his 10,000th ACL had been conducted to repair the knee of a 15-year-old elite netballer via the use of her mother's hamstring tendon.

"Girls that age tend to have tiny tendons while at the same time we are not sure how important the hamstrings are in preventing further injuries in young people," he said.

"So her mother very kindly offered to donate her tendons. This was the second set of tendons she had given because the year before her son, who was about to break into elite soccer in England, had ruptured his cruciate ligament requiring the same reconstruction surgery. However, the family had been so pleased with his recovery that she was prepared to do the same for her daughter."

"Any advances that I have made have all been done in small steps and with the support of my co-workers."

Dr Pinczewski has not stopped thinking, designing and improving methods of knee repair surgery since his first leap forward. A few years ago, while cycling across the Nullarbor from Sydney to Perth with all that time to think, he devised a set of instrumentation to dynamically balance the ligaments during partial knee replacement surgery. He has also designed cement removal blades for the revision of cemented total hip replacements and an interlocking hip prosthesis for revision total hip replacement with proximal femoral bone deficiency.

Yet despite the recent surgical milestone and the career-long interest in innovation and development, Dr Pinczewski said his greatest satisfaction came from limiting patient's pain and morbidity.

"Most importantly, having conducted 10,000 such operations now means that we have a great database of information and from that we can say that patients who have the hamstring and screw reconstruction surgery don't seem to be developing osteoarthritis to anywhere near the severity or consistency they did with the older methods," he said.

"That is hugely satisfying because one of the driving goals of my research was to reduce morbidity and the possible need for future joint replacement – both to benefit the individual patient and the health system in terms of reducing future costs.

"Any advances that I have made have all been done in small steps and with the support of my co-workers. One does not set out to do 10,000 of anything, but the struggle to achieve the perfect result and understand how that is accomplished leads one on and on."

Expression of Interest!

Are you interested?

The Academy of Surgical Educators is now being formed. It will have a Board including members from the College Council as well as two specialty society and association representatives, two representatives from academic surgeons and two non-surgeon experts in medical education.

The Advisory Committee to the Board will have broader representation. There will be one member from each of the thirteen specialty societies and associations, two Fellows with a demonstrated interest in surgical education, two academic surgeons, two members of the current Surgeons as Educators committee and trainee representation.

If you have enthusiasm, experience and expertise in education and particularly education of surgeons, then please consider involvement at the advisory committee or board level. Board members ideally should also have governance experience.

Please contact your specialty group or other representative group or directly to the College through the Dean of Education at bruce.barraclough@surgeons.org or +61 3 9247 1206.

Deadline for nominations is Monday 26 October 2009

the John Corboy Medal

Dr John Corboy (1969-2007) was elected chair of the Royal Australasian College of Surgeons Trainees' Association in 2007. He was a great leader and a selfless representative of Trainees of the Royal Australasian College of Surgeons. He gave generously to his peers his time and wisdom. His energetic service to the profession and his tenacious passion for surgery despite personal adversity was remarkable.

This distinguished award for surgical Trainees commemorates Dr John Corboy's achievements and recognises exceptional service by other Trainees. The John Corboy Medal is awarded annually to a Trainee who demonstrates the characteristics for which John was admired.

The award is made to a candidate who shows some or all of the following qualities in the performance of his/her duties, in service to the surgical community, in the manner and approach to the fulfilment of their surgical training or by their commitment to and involvement with the community of surgical Trainees:

- Outstanding leadership
- Selfless service
- Tenacity
- Service to Trainees of the College

Please download nomination form from www.surgeons.org or email fiona.bull@surgeons.org

Deadline is close of business Friday 30 October 2009

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

Peter John Batchelor VIC
Bimalendu Biswas SA
James Morrison Ellis NSW
Michael Gallagher QLD
John Mackinnon Grant, VIC
Ahmed M Hanieh SA
Paul Ng Kit Ling Hong Kong
Graham Neil Lewis SA
Ivan Lichter AUCKLAND NZ
Heather Thomasina Mackintosh NEW PLYMOUTH NZ
William Dudley Refshauge ACT
William Copland Shirer NZ
Harold Frederick Story VIC
Robert (Bob) Vance Sutherland Thompson
Raymond Che-Wai Wong Hong Kong

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 www.surgeons.org go to the Fellows page and click on In Memoriam.

Informing the College

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

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

Promoting a nationally consistent approach to clinical breast cancer data collection

NBOCC has launched the *Breast cancer specific data items for clinical cancer registration*, aimed at improving the quality of data collected.

The National Health Data Dictionary recommends a core set of generic data items for clinical cancer registration however these often lack the detail required by groups interested in specific tumours.

In response, NBOCC has developed breast cancer specific data items for clinical cancer registration to facilitate comparative analysis, and where appropriate, data pooling.

The data items and data definitions were developed through a multidisciplinary working group, in consultation with key stakeholders, including the Royal Australasian College of Surgeons. Where possible, these items and data definitions have been aligned with those already in use across Australia including the Royal Australasian College of Surgeons National Breast Cancer Audit.

NBOCC is committed to working in collaboration with key stakeholders to promote the adoption of the clinical minimum dataset for breast cancer to help ensure a nationally consistent approach to data collection and reporting of breast cancer data.

Breast cancer specific data items for clinical cancer registration is available to download at www.nbocc.org.au/resources. Hard copies can be ordered by phoning 1800 624 973.

For information on the development of *Breast cancer specific data items for clinical cancer registration*, please contact Trenna Rowe at trenna.rowe@nbocc.org.au or phone 02 9357 9439.

Faces of Melbourne

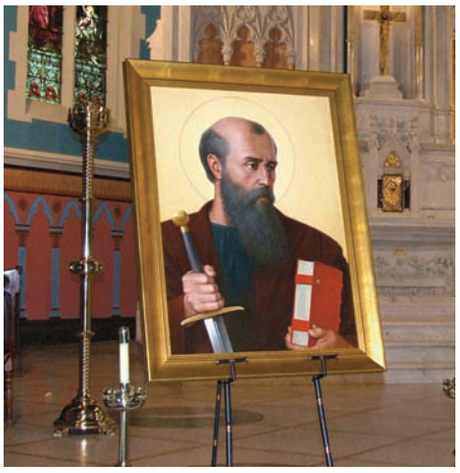
The first in a series for the Foundation for Surgery, this exhibition opens on November 12

Bruce Barraclough
Chair, Foundation for Surgery

Faces of Melbourne, the forthcoming boutique exhibition at the Victorian Artists' Society — only walking distance from the Melbourne College (430 Albert Street East Melbourne) — explores a selection of the personalities and places which define the Victorian capital city.

It is hoped the faces and facades that will appear on the walls of the charming ground-floor Cato Gallery will provoke both philosophy and philanthropy as the aim is to raise funds for the Foundation for Surgery. This will be the first of a series of annual exhibitions in aid of the Foundation.

Hazel Westbury, Director of DMT Arts International and the sponsoring body, will open the show on Thursday 12 November. This is perfect timing to buy that special gift for Christmas or do as Professor John Collins did — commission a portrait. Professor Collins' recently completed portrait was shown at the College just prior to his leaving for Oxford.



One of Vladimir Sobolev's potraits

Vladimir Sobolev, the Russian Master who painted the portrait, will be one of the exhibitors in the November show. Born in Moscow, Vladimir was awarded his first international art prize at the age of 12 and over the past 40 years has travelled extensively, exhibiting and carrying out commissions in many corners of the world. A former Professor of Fine Art at the Moscow College of Fine Art and currently visiting Professor he remains a truly Russian painter, with realist painting as his basis.

The portrait takes a special role in Vladimir Sobolev's creative work. Being one of the most difficult genres of painting, it attracts the artist not only because it provides the possibility to demonstrate an impeccable technique and the ability to convey precisely a portrait likeness, but also to reveal the inner world of the sitter. Vladimir's official portraits hang in Treasury Place, The Royal Society Victoria, The Sporting Hall of Fame and St Mary's Star of the Sea.

Another view of Melbourne is taken by Tasmanian photographer Ilona Schneider. Trained in Europe, with global experience in portraiture, Ilona has picked the urban landscape, with which she has a great affinity, as her topic and interpretation of Faces of Melbourne.

Lastly, Hazel Westbury will exhibit her own contribution to the city landscape. A former resident of Collins Street, she fell in love with the 170-year-old boulevard, described as having "status as the grandest street of one of the great cities of the Victorian Age, an urban landscape upon which many masters have worked and continue to work today. Its fine 19th century heritage is still strongly evident, adding depth and richness to that of the twentieth and twenty first centuries."

Surgeons, family and friends are all invited to attend the opening on Thursday, November 12 at 6.00 pm, in the Cato Gallery at Victorian Artists' Society Albert Street – just across the road from the Melbourne College.

Enquiries and RSVP to Hazel Westbury +61 422 166 284.

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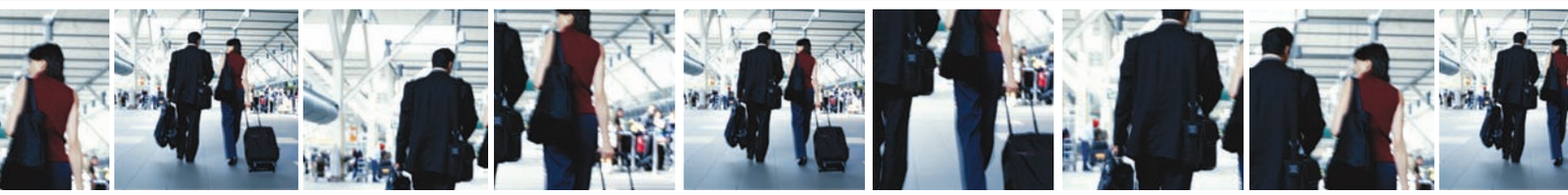

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AMA 'Difficult Cases' Workshops

Case-based discussion will aid exploration of difficult assessments in a series of legal workshops across Australia

Neil Berry
Chair, Medico Legal Committee

The Medico Legal Section Executive is offering a series of new workshops which will focus on the application of AMA impairment guidelines in practice using case-based discussion to explore difficult assessments.

The workshops will be piloted in Melbourne, Brisbane and Sydney in 2010. If successful, further workshops will be held in other capital cities. Each will run for approximately two to three hours in the evening and cost $75, which includes a light supper.

The proposed dates for medico legal workshops are:

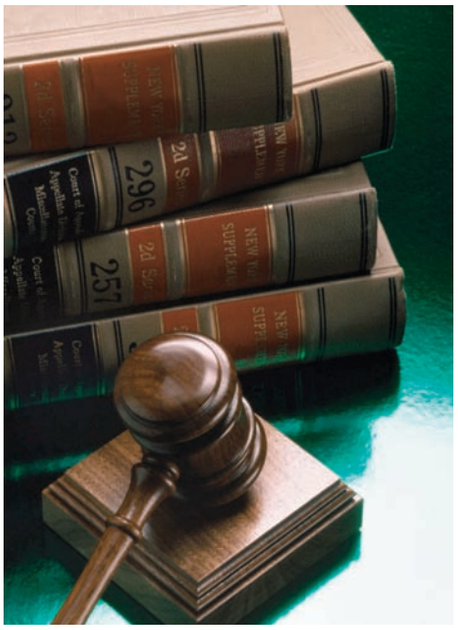
- AMA 4 'Difficult Cases': Melbourne
  Thursday 11th February 2010
- AMA 5 'Difficult Cases': Sydney
  Thursday 19th August 2010
- AMA 5 'Difficult Cases': Brisbane
  Tuesday 9th November 2010
- Writing Reports for Court: Sydney
  Saturday 20th November 2010

Venues and dates will be confirmed early in the New Year.

Continuing Professional Development (CPD) – Medico Legal Requirements

The 2007-2009 Continuing Professional Development triennium is coming to a close with the 2010-2012 triennium commencing on 1st January 2010.

The 2009 CPD recertification data form will be issued to Fellows in January 2010. If you require any assistance in regards to your Medico Legal CPD requirements, please contact the Recertification Officer, Department of Professional Standards on +61 3 9249 1282.



Accrual of Medico Legal CPD points is not limited to the activities offered by the College, and we encourage all Fellows who know of or have participated in relevant educational activities to contact the provider of the workshop and request they submit an application for CPD approval. Staff members in the Professional Standards department are always happy to assist any Fellow or education provider through the process.

Occupational Medicine: Factory Visits

The first factory visit for Occupational Medicine Surgical Bridging Course 'Getting Your Patients Back to Work' took place on Wednesday 14 October 2009 at the Ford Assembly Plant in Broadmeadows, Victoria. The visit offered surgeons the opportunity to meet with the company doctor, injury management personnel, production and safety staff as well as several factory workers

The site visit enabled surgeons to gain a greater understanding of what type of reports are required to support a successful return-to-work. Direct access to the workplace can enable surgeons to develop a better understanding of the workplace environment including what functions post-surgical patients are able to perform, how injuries may occur and potentially how injuries can be avoided.

A future visit at a mining facility in New South Wales is currently being investigated for the 2010 program. For details regarding occupational medicine, factory visits or for any other Medico Legal enquiries please contact the Medico Legal Secretariat on +61 3 9276 7473.

Australian Orthopaedic Association (AOA)/ College Annual Meeting, 13-15 November 2009

The AOA/College combined Medical Legal meeting, themed 'The Medical Assessment Of Musculoskeletal Injuries', will begin at the College, Melbourne on Friday 13 November and continue on Saturday 14 and Sunday 15 November at the Royal Automobile Club of Victoria (RACV), Bourke Street, Melbourne.

Registration fees for the meeting are:
Early Fee (If paid prior to 31st October, 2009) $385.00
Normal Fee $440.00

The conference dinner will be held in the clubrooms of the RACV on Saturday 14 November at a cost of $88.00 per person.

Accommodation is available at the RACV Club at special rates for the meeting, reference number 1834244. Please contact Alison direct on +61 3 9944 8842 and quote the reference number.

More details regarding the conference can be found at www.medleg.com or you can contact the Secretariat, Mr Kevin Wickham, at kevin@wickhams.com.au

Interested in becoming a member of the Medico Legal Section?

If you are interested in becoming a member of the Medico Legal Section please contact the Medico Legal Secretariat for more information on +61 3 9276 7473 or rebecca.clancy@surgeons.org

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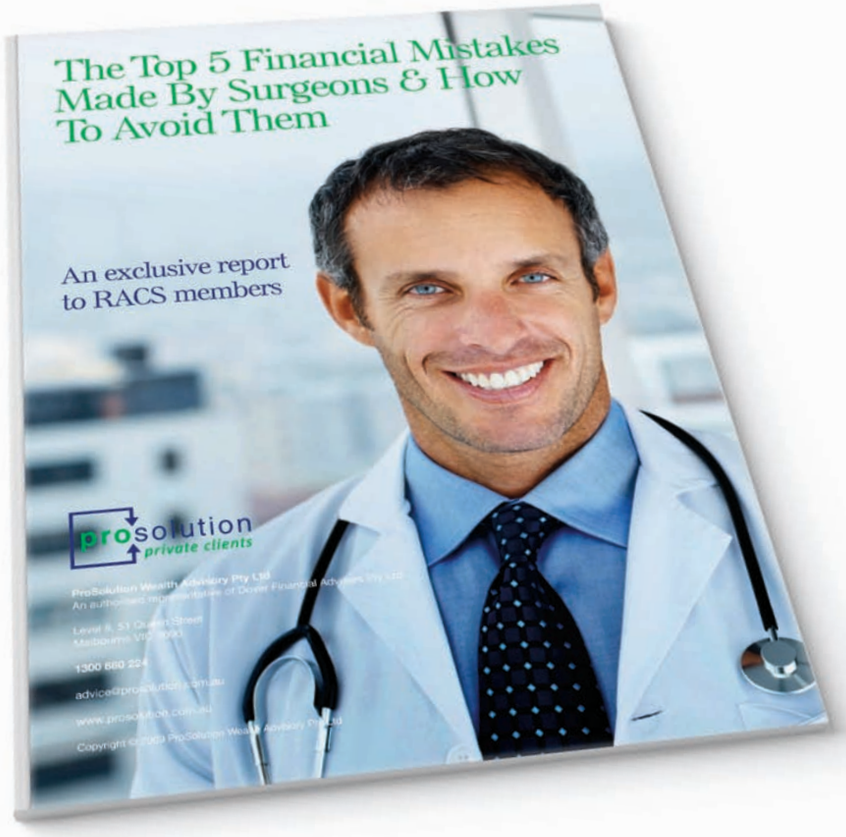

For a limited time, **ProSolution Private Clients** is offering RACS members a free copy of its new report called "The Top 5 Financial Mistakes Made By Surgeons & How To Avoid Them."

This report provides a 'no holds barred' assessment of what we have identified as the top 5 mistakes that surgeons make which dramatically destroy wealth. Visit the website address below for a brief introduction to the 5 mistakes.

To take advantage of this limited time offer, go to **www.prosolution.com.au/RACS** to download your personal copy today.

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Who was Bransby Blake Cooper?

A renowned surgeon's nephew operated on battlegrounds and found plenty in his career to make him a success in his own right

Keith Mutimer
Honorary Treasurer

PHOTOGRAPHS COURTESY OF THE WELLCOME LIBRARY, LONDON

Pictured left: The Cooper's Adz versus the Lancet, 1828, possibly after Thomas Wakely, coloured etching by Dickey Fubs **Above:** Bransby Blake Cooper, 1842, photogravure of mezzotint by WH Summers after EU Eddis

Surgeon to royalty, anatomist and influential teacher, the name of the 19th Century surgeon, Sir Astley Paston Cooper is well-known. But who was Bransby Blake Cooper? The letter transcribed above is another of the treasures in the College's Archive – written by Astley Cooper in 1819, it recommends his nephew Bransby to an unknown recipient.

My dear Sir

I was at Windsor last night and am just returned. I have therefore sent my relation Mr Bransby Cooper who has been surgeon in the army with the Duke of Wellington in the Peninsula and has seen an immense field of practice and who you will find excellently informed in his profession.

I am yours very truly
Astley Cooper
June 25th 1819

Bransby Cooper was Astley Cooper's pupil at the United Borough Hospitals in 1811 and prompted by his uncle, found himself in the army the following year.

The 'immense field of practice' attributed to Bransby in 1819 was his work as an assistant surgeon in the Ordnance Medical Department during the Peninsula War. As we have no specific accounts, Bransby Cooper's experiences in the Peninsula War are the subject of speculation. However, his initial experiences must have been something of a shock – from walking the ordered wards of a hospital and performing minor surgical tasks to struggling with inadequate supplies and dealing with overwhelming numbers of wounded men. Assistant surgeons like Bransby provided a supporting role supplying water, dressings, drugs and field tourniquets.

The work of medical teams after each battle was harrowing, and an eye-witness account by a Lieutenant Grattan of the 88th Connaught Rangers describes the chaos attending the battle of Fuentas d'Onoro in 1811:

[He]*...found the surgeons at their improvised tables. Stripped to the waist and bloody, they worked on men placed on doors wrenched off their hinges and laid over barrels. The arms and legs they had removed earlier lay in heaps about the courtyard and the ground around the tables was dyed red.*

The sheer numbers of the wounded overwhelmed the medical services in the Peninsula Wars; many died for want of timely treatment. As Chatrian says in his *Histoire d'un Paysan*:

The soldier's greatest foe was not famine nor pestilence, or the wandering and starving forest dog, nor the forest wolf, nor even the camp follower so vividly described in Victor Hugo's Les Misérables, *it was the putrescence of wounds.*

Chatrian's brief account omits mention of a far more formidable enemy of large armies: diseases such as typhus, malaria and dysentery were rife in the military campaigns of the Peninsula War. On its withdrawal from Badajoz in1811 for example, Wellington's army camped in a notorious malarial area and the resulting epidemic brought 500 deaths.

Returning from the Peninsula War, Bransby Cooper resumed his surgical studies and, in 1825, was appointed a surgeon at Guy's Hospital. His position may well have owed more to his uncle's patronage then his being excellently informed as a surgeon! For in 1828, *Lancet* editor Thomas Wakely, when describing Bransby's ill-fated lithotomy operation on Stephen Pollard – the operation took nearly an hour and the patient subsequently died – questioned both his surgical abilities and the role of patronage in securing his position. Significantly, Astley Cooper sued Wakely on his nephew's behalf but only received notional recompense for his trouble.

Despite such slurs on his professional practice and the dubious advantage of having such a famous uncle, Bransby Cooper does seem to have had a successful surgical career. He continued as surgeon at Guy's hospital until his death in 1853, became a Fellow of the College and was Aris and Gale Lecturer at the College in the 1840s.

Elizabeth Milford College Archivist

An evening with Donald Simpson

The College is very fortunate to have received a collection of historic instruments from the Neurosurgical Society of Australasia. Donald Simpson has been the Honorary Curator of this Collection for many years and has produced a comprehensive catalogue of it.

To celebrate the transfer of the Collection to the College on long-term loan the Heritage & Archives Committee will be holding a presentation on Wednesday 28 October 2009, beginning at 5:30pm in the Hughes Room.

Donald will come from Adelaide for the evening and will talk about the Collection. A selection of the instruments will be on display. Not only is Donald one of Australia's most prominent neurosurgeons he was also the first Chair of the History Section of the College.

The Committee welcomes anyone with an interest in surgical history and / or neurosurgery to attend what promises to be a most interesting evening.

RSVP to Ms Megan Sproule +61 3 9249 1220 or megan.sproule@surgeons.org by Monday 12 October. Please indicate the names of the people attending.

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