Surgical news

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THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Our largest paediatric team helps children in PNG PAGE 8

The College of Surgeons of Australia and New Zealand

2010 professional development workshops

The year is coming to an end but professional development opportunities go on! We'd like to invite you to attend the following workshops that support you to strengthen your abilities in arenas such as communication, business, leadership and management.

Surgical Teachers Course
21-23 October 2010, Adelaide

The Surgical Teachers Course, consisting of two and a half days of challenging and interactive activities, enhances the educational skills of surgeons responsible for the teaching and assessment of surgical trainees. Experienced faculty members employ a range of teaching techniques and presentations to deliver the curriculum including Adult Learning, Teaching Technical Skills, Feedback and Assessment and Change and Leadership.

From the Flight Deck: Improving Team Performance
29-30 October 2010, Melbourne

This two-day workshop is facilitated by an experienced doctor and pilot. It examines the lessons learned from the aviation industry and applies them to a medical environment. The program combines rigorous analysis of actual airline accidents and medical incident case studies with group discussions and an opportunity to use a full-motion airline training flight simulator. You will learn more about human error and how to improve individual and team performance. *Proudly supported by Kimberly-Clark Australia*

Polishing Presentation Skills
5 November 2010 Sydney

Want to develop an attention grabbing presentation to deliver your message more effectively? Whether you are a beginner or an experienced presenter, join this whole day workshop to advance your presentation skills. You will learn a step-by-step presentation planning process and practical tips for delivering your message. It is equally applicable to presentation sessions in hospitals, conferences and international meetings.
Proudly supported by Kimberly-Clark Australia

Process Communication Model (PCM)
29-31 October 2010, Sydney, 17-19 November 2010, Brisbane

Patient care is a team effort and a functioning team is based on effective communication. PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. PCM can also help to detect stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand. The College is investigating how PCM can assist surgeons to improve their communication skills. Two courses for rural Fellows, trainees and their supervisors are planned for later this year. *Proudly supported by the Dept of Health and Ageing*

Leadership in a Climate of Change
19-21 November 2010, Melbourne

This 2½ day workshop aims to develop your understanding of how to be an effective leader in the 21st century. It focuses on leadership styles, establishing and maintaining effective working relationships, managing the performance of others and managing issues effectively in a vibrant work environment. You will complete an online behavioural inventory called the DiSC profile that will generate a specialised report on your leadership attributes which is the basis for interactive debrief session. Behavioural preferences for a range of leadership styles are explored and you'll be offered challenging insights about your leadership attributes. *NB: This workshop is stand alone or one of three entry points for the Advanced Diploma of Management*

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.

professional development workshops

DATES: OCT – NOV 2010

NSW
29-31 October, Sydney
Process Communication Model
5 November, Sydney
Polishing Presentation Skills
19 November, Sydney
Occupational Medicine: Industry site visits
20 November, Sydney
Writing Reports for Court

QLD
17-19 November, Brisbane
Process Communication Model

SA
21-23 October, Adelaide
Surgical Teachers Course

VIC
29-30 October, Melbourne
From the Flight Deck, Melbourne
11 November, Melbourne
Supervisors and Trainers for SET (SAT SET)
12 November, Melbourne
Occupational Medicine: Industry site visits
13 November, Melbourne
Communication Skills for Cancer Clinicians
19-21 November, Melbourne
Leadership in a Climate of Change

WA
20 October, Perth
Supervisors and Trainers for SET (SAT SET)

19-21 November, Melbourne
LEADERSHIP IN A CLIMATE OF CHANGE
Change provides an ongoing challenge to surgical leaders. Understanding your own style of leadership and adapting it to the situation and personalities of others in the workplace is crucial in today's dynamic world. This workshop encourages a journey of self-discovery by undertaking a psychometric behavioural profiling exercise, indicating an individual's preferred leadership style. Group discussions identify alternative leadership styles, the value of emotional intelligence and a range of appropriate management styles that can enhance workplace relations.

Workforce planning – always at sea

There will certainly be a greater demand for health professionals

Ian Civil
President

In the health sector there appears to be no topic that creates more debate and outcry than issues of health workforce planning. What are the correct number of health professionals, how should they be educated and trained and where should they spend their professional careers are questions that fill newspapers and conferences. The theme creates position papers, policies and government departments to enact them. Depending on your perspective there can be too few health professionals creating shortages and waiting lists, too many health professionals creating excessive self generated demand, maldistribution creating subsidised training and bonded career paths or a 'glut' threatening restrictions in health insurance coverage or managed care. Yes, there will always be controversy.

Haunted by bad policies

However, there are a few facts that can be understood and are agreed. There is no doubt that the policies of the 1980s and the restriction on medical school intake have now created health systems very dependent on the importation of medical graduates trained in overseas countries. Australia and New Zealand are the two countries with the highest rate of imported overseas trained health professionals – both nurses and medical practitioners – to alleviate self induced shortages.

Into the future, there will certainly be a greater demand for health professionals. Two strong drivers of this are that fact that the aged population, particularly above 65 years, is increasing and this population requires interventions and advanced technologies to stay fitter for a longer period of time. 'Life saving surgery' is now almost commonplace and the surgical intervention in chronic diseases now routine and expected. In short, there is more work to do on a larger number of people.

President, Ian Civil presents wakarongoa (a vessel used to hold the healing plants of the Maori) to President of the College of Surgeons of Sri Lanka, Ranjith Ellawala.

Public Activities capped by budget controls

From a surgical perspective, another constant is the capped nature of surgical work that is undertaken in the publicly funded health sector. The nature of the clinical case load and the necessity for training the various healthcare groups also creates an environment in which organisational inefficiency is commonplace. Waiting lists are rarely due to a shortage of surgical expertise. They are due to constraints on access to operating theatres that occur in multiple ways. The challenge to obtaining access to routine surgical beds, intensive care beds, and staffed operating theatres at reasonable hours are folklore in the surgical community. Be it through overt budget cuts or capped budgets where surgical activity is seen as the most easily constrained service, the result is demonstrable public tension. The political excuses vary between Australia and New Zealand. In New Zealand where there is political acceptance of waiting lists, scoring systems are used to define those who fall below a threshold for treatment. In Australia, where waiting lists are less acceptable, there are many attempts to hide the numbers – either in the actual lists themselves or by refusing to accept people onto the waiting lists in the first place. Depriving people of access to surgeons in outpatient clinics or refusing to allow surgeons to place more than a certain number of patients on the waiting list appear two of the more common practices in the various states of Australia. ▶

“There is no doubt that the policies of the 1980s and the restriction on medical school intake has now created health systems very dependent on the importation of medical graduates trained in overseas countries”

No guarantees for the increased medical graduate numbers

In the meantime, the universities are now producing medical graduates in far greater numbers. So many that New South Wales can no longer guarantee intern positions to the graduates from universities in that state. And other states are not far behind. Six years of education going ‘up in smoke’ with often only debt left behind is an unconscionable position for our health system to find itself in. Surgeons often cannot obtain public hospital positions when they are establishing practices and move to full time practice in the private sector. The various departments of health in Australia seem unable to comprehend the requirements for not only continuity of clinical service, but for the critical task of establishing our younger surgeons in a career where they can contribute to education and research in the public sector, which is the lifeblood of ongoing education and training for all health professionals.

Multiple contradictions

What a contradictory pickle this is. The need for a growing surgical workforce in the future is self evident and the College and the various specialty societies need to respond to this. The training path from entry into medical school to the graduation of a surgeon can easily exceed 15 years. The requirements that we respond to for workforce planning have long lead-in times and do not align with the political imperatives of the next election or six second media grabs. Safe hours and limited increases in throughput in the public sector mean that there is little room to reduce this. Inefficiencies and frustrations in the public systems where we work can only increase the appeal and attraction of private sector careers.

Where to from here?

While there will always be debate on workforce numbers the overarching consideration at this time is workforce shortage. In that regard the role of the College is vital. Providing high quality surgical services to the community is the core of our activities.

Key to our immediate actions must be to engage the private sector, because of both the volume of surgical work being undertaken there and the scope of that workload. With this workload coming within the training umbrella, the future surgical workforce could be trained more flexibly and the potential for training could be significantly expanded.

Regardless of the nuances of workforce analysis, Australia and New Zealand both have an unsustainable reliance on International Medical Graduates. The World Health Organisation wants our governments to be signatories to documents which highlight the moral dilemmas of active recruitment of nurses and medical practitioners from other countries. Before we can do this we need to make positive progress locally on addressing our pressing workforce needs.

I look forward to your ongoing comments.

We live in interesting times

Keith Mutimer
Vice President

“Should the rebate come under threat the College will remind government and voters that Australian public hospitals, already hard pressed and under funded, will come under significantly greater pressure as hundreds of thousands of people desert private health funds and again rely on the public system.”

As I write this article a minority Australian Government is being sworn in, some 24 days after polling took place. An improbable ‘rainbow’ coalition of the ALP, Greens and independent MPs of conflicting ideologies are likely to find it difficult to agree on policy, let alone the fine detail of legislation. To complicate matters further, the government will have to negotiate with a Senate that will be controlled by a Family First senator until 30 June next year and thereafter by the Greens.

What is the likely effect of this state of affairs on health policy generally and the delivery of surgery in particular? The Labor Government’s first term saw considerable attention paid to health policy and, while many of the reforms it initially promised were subsequently watered down, some significant changes and substantial investment have been promised. Given the likely difficulty in getting anything new through the parliament, I suspect this will be a period of consolidation in which the health reforms of the first term are implemented and bedded down. Having said that, there are likely to be two health-related issues on the new government’s agenda, one driven by the Greens, the other by the regional independents.

The Greens are on the record as having consistently opposed the private health insurance rebate, viewing it as a vote buying extravagance. So fundamental is their opposition to the rebate, the Greens may try to include it in the price of their ongoing support for a minority Labor Government. If not immediately, then down the track.

Labor, who know full well that the next election will be decided not in the regions, but in the outer suburbs of Australia’s major cities, will surely resist this push as doggedly as they will resist any push by the Greens to cut subsidies to, say, private schools. The Greens’ argument – that money saved by abolishing the rebate will be invested in the public system – will fail to convince middle class constituents struggling to pay health insurance premiums and justifiably sceptical of government’s capacity to deliver services efficiently.

Should the rebate come under threat the College will remind government and voters that Australian public hospitals, already hard pressed and under funded, will come under significantly greater pressure as hundreds of thousands of people desert private health funds and again rely on the public system. Any compromise arrangement, involving a lowering of the rebate, will be vigorously opposed.

The extraordinary deal-making that culminated in a minority Labor Government puts one thing beyond doubt: that public money will soon be flooding into regional Australia. This should see unprecedented funding for regional health services and represents an opportunity for the College to redouble its advocacy efforts on behalf of regional and rural surgeons.

We have a proud record of reminding government that it is in regional and rural Australia where surgical workforce numbers are approaching the point of crisis. A considerable portion of the College’s election manifesto sent to the major political parties during the campaign was devoted to this very issue. ▶

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SURGICAL RESEARCH SOCIETY ANNUAL MEETING

The Surgical Research Society

47th

Annual Scientific Meeting

will be held in Adelaide on Friday 19th November 2010 at the Basil Hetzel Institute, Queen Elizabeth Hospital

This meeting is open to all those involved in or interested in research, including surgeons, surgical or medical trainees, researchers and scientists.

JEPSON LECTURER:
Professor Michael Solomon
"Surgical RCTs: Past, Present and Future"

GUEST SPEAKER:
Professor Herb Chen, past President, Association for Academic Surgery
"Targeting Notch in Neuroendocrine Cancers: Bench to Bedside"

CALL FOR ABSTRACTS:
The call for Abstracts has now closed..

CONVENOR:
Professor Guy Maddern

PRESIDENT:
Professor John McCall

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Commonwealth funding for the College's Rural Surgical Training Program was terminated in 2009 and funding from a new Specialist Training Program commenced in 2010. The amount of money available to nurture the development of new rural surgical capacity under the STP is quite inadequate and it is imperative for people living outside our major cities that the Commonwealth Government support programs that bring new surgeons to the regions.

Our manifesto pointed out that support for the further development, career coaching and mentoring of International Medical Graduates working as surgeons in regional and rural Australia is essential if they are to be a sustainable resource. The Commonwealth should facilitate access by IMGs to educational up-skilling opportunities either through existing College training programs or specifically developed IMG education/up-skilling programs.

It was also noted in the election manifesto that there must be greater provision of services, such as nursing, anaesthetic, pathology and radiology in rural and regional areas. Some areas need to recruit resident radiologists, anaesthetists and pathologists in order to attract the interest of younger surgeons.

Where possible, increased resourcing of regional and rural hospitals should include personnel to recruit surgeons and help manage their transition into the hospital and their family's transition into the local community.

The accreditation of base hospitals as registrar training posts would have a beneficial effect on surgeon numbers in regional and rural areas. Experience suggests that surgeons trained in a regional or rural hospital are more likely to remain there once their training is complete.

Enhanced interaction with metropolitan hospitals, and in particular the adoption of hub and spoke arrangements, would facilitate the delivery of surgical care in regional and rural areas.

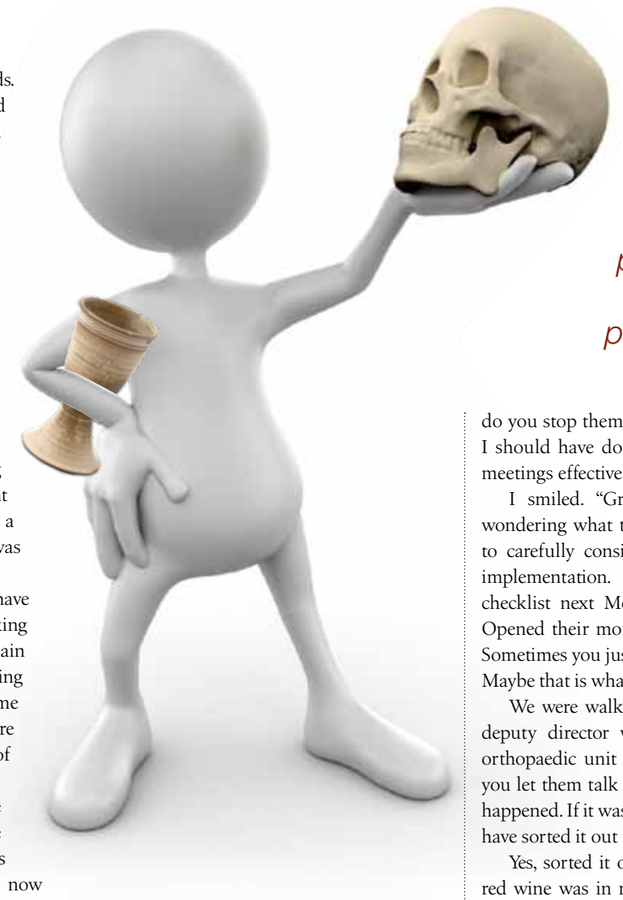
The provision of locum services to ensure leave relief must be encouraged. Hospital administrations should be given the latitude to fund more locally based initiatives, ensuring funding flexibility for local services during periods of peak demand.

When these points on rural and regional healthcare were made in the College's election manifesto in August, the government's response was courteous, but predictably pro forma. When we next raise these matters I suspect the government will be much more engaged.

Poison'd Chalice

Bit like herding those famous cats. Dangerous job, but someone needs to do it.

Professor U. R. Kidding



"How do you get the outcomes that you need and at the same time have people involved and actively participating?"

I gently rested my head in my hands. The meeting had been going on and on. It felt like forever. Again I reflected on my school studies of Hamlet and the long windedness of Polonius. Indeed the medical connection was strong. Freud had described him as "the old chatterbox" in his text Jokes and their Relation to the Unconscious.

He made famous the words, "Therefore, since brevity is the soul of wit. And tediousness the limbs and outward flourishes, I will be brief." (Hamlet Act 2, scene 2). Ah brevity, I would so appreciate it now. I lifted my head. Yes, it was another meeting of the Operating Theatre Management Committee. Who was it who said a committee of more than six members was incapable of making a decision?

Why should the Director of Surgery have to chair this committee I keep on asking myself. Why do anaesthetists need to explain things in such detail? Why do the nursing staff need to remind me how difficult some of my colleagues can really be? And we were really only discussing the introduction of the Surgical Safety Checklist.

It should have been simple. The checklist has been introduced around the world. It has been validated in numerous hospitals and health systems. There is now ample documentation in how it improves teamwork, decreases adverse events and can be locally adapted with advantage. However, it does need to be carefully implemented locally so the uptake will be successful. Engagement, that is the key. That is why we were discussing it at our regular committee meeting.

Committees should be so easy. I had always thought that, when I had attended my first few meetings. The occasional touch of wit; the clinical perspective that was so desperately needed to balance the bean counting approach of the management members. Easy, I thought. However, it was different 'in the hot seat'. Now, chairing a meeting is a different ball-game. I had always moaned when the Chair of various committees let people talk on and on and on. Mind you, I had given them a serve when they did not give time for that essential clinical input. Got to keep them on their toes you know.

How do you get the outcomes that you need and at the same time have people involved and actively participating? But how do you stop them talking...endlessly? I knew I should have done that course on running meetings effectively.

I smiled. "Great point", I said vaguely wondering what they had said. We will need to carefully consider that as we review the implementation. Now we are starting the checklist next Monday. They looked at me. Opened their mouths and then just nodded. Sometimes you just need to start doing things. Maybe that is what the leadership tag is about.

We were walking out of the meeting. My deputy director who was the head of the orthopaedic unit said, at long last. Why did you let them talk so long? It should just have happened. If it was just the surgeons we would have sorted it out in no time.

Yes, sorted it out in no time. The glass of red wine was in my hand that evening. Nice New Zealand shiraz again. I reflected on the meeting. Surgical Services bring together so many competing perspectives and views on issues. The joy of managing multidisciplinary groups – bit like herding those famous cats. Dangerous job, but someone needs to do it.

Maybe after I have done that "Managing Meetings Effectively" course, I can think about "Managing Diversity". That would shock them. Hmmm, for now another glass of red sounds the way to go. Maybe I should take a bottle to the next meeting?

OPPOSITE PAGE:
1. Attendance was popular at the Mount Hagen General Hospital paediatric clinic.
THIS PAGE:
2-3. Patients recover after surgery.
4. A patient and his parents were very happy with the surgery (with Dr Cooper, left and Dr Shun).
5. Back Row , from L to R: Michael Cooper, Benjamin Yapo and Okti PoKi. Front Row (seated), from L to R: Jack Mulu, Albert Shun and Mclee Mathew

Paediatric team works in PNG

Fortnight in Papua New Guinea highlights needs of our nearest neighbour

Achieving a record number of surgeries and dinner with the Australian High Commissioner to Papua New Guinea (PNG) and the PNG Minister-Counsellor of the Australian Agency for International Development (AusAID) made for a memorable two-week visit for the latest paediatric team to visit PNG.

Headed by Dr Albert Shun of Sydney's Children's Hospital at Westmead, the team arrived at the Mount Hagen General Hospital on July 17 to conduct an initial consultation clinic after news of the visit was broadcast widely over the "tok save" radio.

The night before, however, violence erupted in the Emergency Department after a man was brought into hospital having been critically injured in a car accident, with the victim's family blaming a group of workers for his plight.

According to visiting team member, paediatric anaesthetist Dr Michael Cooper, the Emergency Department staff simply ducked and dodged the bullets from the shootout, regained a measure of calm and continued treating the patient.

"It can be a wild place the highlands of Papua New Guinea," Dr Cooper noted dryly.

"But the staff members up there are amazing. We walked in on the Sunday morning following and it was as if nothing much had happened."

The July PNG visit (funded by AusAID through the Health Education and Clinical Services (HECS) Program and the RACS) represented the largest paediatric surgical team ever assembled to treat some of the country's sickest children, many of whom had been specifically selected for treatment by the team not only for Dr Shun's expertise, but also for that of Dr Cooper.

With no specialist paediatric anaesthetist currently working in PNG, some children with congenital heart disease or those who had previously experienced anaesthetic-induced cardiac arrhythmias were selected as requiring his paediatric anaesthetic expertise.

Along with the two paediatric specialists from Sydney, the team comprised local paediatric surgeons Dr Mclee Mathew, Dr Ben Yapo, Dr Okti Poki and general surgeon and paediatric trainee Dr Jack Mulu.

Working out of Mount Hagen hospital first and later moving to Port Moresby, the team performed more major cases in one visit than had ever been achieved to date in the 10 years that Dr Shun and Dr Cooper have been visiting PNG.

Thirty-five children treated

Both hospitals opened their theatres to the team, at times allowing all five surgeons to be operating simultaneously while local staff worked long into the night and on a public holiday to provide assistance, allowing 35 children to be treated.

With more than 80 per cent of patients younger than five years of age, the surgeries were often extremely complex including Swenson's operations for Hirschsprung's disease, midgut malrotations with volvulus, the excision of a large abdominal teratoma, anorectoplasties and hypospadias and fistula repairs.

The invitation and opportunity for the team members to dine with His Excellency, Mr Ian Kemish, the recently-appointed Australian High Commissioner to PNG and Ms Stephanie Copus-Campbell, Minister-Counsellor of AusAID, came as a welcome respite from the arduous workload.

"It was a great honour to be asked to meet with the High Commissioner and the Minister-Counsellor of AusAID and it was a delightful evening," Dr Shun said.

"The High Commission residence in Port Moresby makes for a lovely setting for entertaining, looking over the harbour as it does, and we had an excellent, informative and stimulating evening."

Dr Shun said that while the post-operative death of one child had cast a shadow over the trip, he believed it remained in the best interests of the children and the local paediatric surgeons to allocate the visiting team the most difficult cases.

"The death of the child was upsetting but in some ways just illustrates the constant limitations affecting surgery in countries such as PNG," he said.

"The pathology was more complex than anticipated, which relates to the lack of diagnostic facilities there while there is no specialist paediatric ICU unit in the country for postoperative care.

"That means that no matter how good the surgery and anaesthetic support, you still confront limitations in infrastructure, skills and expertise that we take totally for granted in Australia.

"Yet still it is the job of such visiting teams to undertake the most complex cases not only because if we get it right the first time when operating on a child they have the opportunity of living a wonderfully normal life, but also because we can use the cases to train the local paediatric surgeons."

The needs are great

Dr Shun described seeing the increasing skills and expertise of the local surgeons as a highlight of the visit but said the country would only be self-sufficient in the surgical care of children when there were 15 such surgeons located across the country rather than the three now working there.

"There is such great need in PNG," he said.

"They need specialist paediatric nurses, specialist anaesthetists, specialist ICU facilities for babies and neonates, but I can't really see that happening probably until the PNG community at large fully appreciates the fact that babies and children have a right to be treated with equal although limited health resources.

Dr Shun said that as such, specialist team visits such as the July trip would continue to be required while Dr Cooper, also from the Children's Hospital at Westmead, is in the process of driving changes within the Australian and New Zealand College of Anaesthetists (ANZCA) to develop a more co-ordinated aid program for PNG.

He said this would include providing funding for two visits per year to upgrade and enhance the skills of Anaesthetic Scientific Officers and Registrars.

Dr Cooper is also in the process of arranging for a number of Boyles anaesthesia machines that are no longer being used in Australia to be donated to PNG with funding for transport provided by Rotary and other charities.

"The work done by the RACS through AusAID funding has had a major impact on the surgical services offered to the people of PNG, but that has not flowed through so much into anaesthetic support," he said.

"There are only nine specialist anaesthetists in the whole country, they have problems with the availability of reliable drugs and monitoring equipment, at times they run out of oxygen and the power can be less than reliable.

"Yet with all these limitations, the surgeons, nurses and anaesthetists do an amazing job in the care they provide and I would like to specially acknowledge the enthusiasm and hard work of Dr Rachel Paiva, the anaesthetic registrar from Port Moresby General Hospital, who worked closely with me during this visit.

"It is a privilege to work with such dedicated people and because PNG is our nearest neighbour with such close historical ties to Australia, we should train the specialists they require and provide the assistance that they need."

All will be revealed…

The first time we do something will always be the first time, but the last time may not always be the last time as we may decide to do it again

I.M.A Newfellow

And the winner is… Ivan Thompson, the WA Councillor. Now what competition has Ivan won? He was the first person to work out who I.M.A Newfellow really is. It must have been apparent for some time that Newfellow is not my real name. A quick look at the list of Councillors tells you that.

Now Ivan was pretty smart as he asked me point blank about three months after these articles started four years ago if I was Mr Newfellow. How did he work this out? I had hoped that it would have been from my incisive input, my clarity of expression or my knowledge of the College, but it was my sense of humour that gave me away.

This will be my second to last article as I am leaving Council next year. Now that is a clue as to who I am. I have given clues at various times, but they have gone un-gathered and ignored. Why have I written these articles in a rather impudent manner? I have been cheeky and possibly outlandish to get your attention. I have written these articles to try to transmit some understanding of the complex creature that is the College. Have I succeeded? I don't know.

Who are Mr Nit Picker and Professor Dead Certain and Mr Pot Stirrer? All will be revealed next month. Do I hear some Councillors stirring and wondering if one of these characters may be them – do I hear them calling their lawyers in case a defamation action is needed?

As I draw to the end of these articles it occurred to me that the end of eras in our lives is sometimes quite distinct and sometimes not quite so clear cut. All surgeons recall the first operation they ever did. Is the last operation as readily recalled? In my case – no. The first time we do something will always be the first time, but the last time may not always be the last time as we may decide to do it again. I hope the reader (and the censor) will allow a slightly risqué comment; I am reminded of the clever line in the film "Elizabeth" where Cate Blanchett as Elizabeth says to a bunch of startled and incredulous courtiers "I have decided to become a virgin". The last operation may be the last operation of that particular retirement and, like Dame Nellie Melba, there may be many other retirements ahead.

Rooster to feather duster

Surgeons are in a special situation in regard to retirement – they can 'wind down' rather than stop suddenly. Many employed positions are such that a date looms and retirement occurs – from top of the heap to another Old Age Pensioner; from surgeon to former surgeon; from rooster to feather duster. The College has held workshops for several years to assist in the end of professional life. It is interesting that they were once called "Winding down from Surgical Practice", but are now called "Building towards Retirement". I am not sure which name I prefer – they both transmit a useful concept of both decreasing the surgical work, but not leaving a vacuum.

Many surgeons in their years of busy practice do not have time for doing College things. The senior years does offer the opportunity to be involved in such activities as teaching in the College courses, serving on committees and boards, being involved in organising meetings, mentoring young trainees and even writing impudent articles for *Surgical News*.

At the Adelaide ASC in May 2011, the Senior Surgeons Group is holding several sessions, which I note has such topics as Prostatic Health, Changes to Superannuation and even a session called "Secret Men's' Business". I could not see anything about how to become a feather duster with dignity.

The administration team and trainees Mr Maoate worked with.

The conference in Vanuatu with the Pacific surgeons.

Surgeon optimistic about future

NZ paediatric surgeon Mr Kiki Maoate foresees a dramatic change in medical services in the Pacific Island nations

When NZ paediatric surgeon Mr Kiki Maoate speaks of the need for surgeons to take a higher profile in public health debates and the formulation of health policy, it is clear that his opinions are grounded in both action and experience.

As the son of the former Prime Minister of the Cook Islands, Sir Terepai Maoate, himself a doctor, the twin notions of the public good and public service infuse much of his work and world view.

Each year he makes up to 10 surgical and training visits to various countries in the Pacific while he is also an Advisor on Paediatric Surgery at the Fiji School of Medicine, acts as the College's paediatric specialty coordinator for the Pacific and is the President of the Pasifika Medical Association.

He says that while he has little interest in participating in the notoriously volatile politics of the Cook Islands, the politics of health equity and provision, particularly for Pacific Islander people, is a core passion.

"Absolutely, I was brought up to believe that those of us who have the opportunity, also have a responsibility to other people, to make a difference where and when we can," Mr Maoate says.

"Yet as I travel back and forth to various countries in the Pacific and get continual exposure to their way of life – the lack of money, the lack of facilities, even the lack of social opportunity – I get a bit frustrated when I come back to New Zealand and see how little we appreciate what we have.

"I don't think some people realise how easy it is in a first world country and how much money we have at our disposal, even though we always think it is never enough."

A healthy future

Yet while many Pacific Island nations continue to struggle to find the resources and the manpower needed to provide vital health services, Mr Maoate sees the future with optimism.

He claims that the surgeons working across the Pacific region now and the trainees coming through represent the best health workforce ever provided.

"The commitment, skills and maturity of the Pacific surgeons and trainees now coming through the system, compared to ten years ago, is absolutely fantastic to see," Mr Maoate says.

"We have a number of local surgical specialists now working throughout the region, all of whom have tremendous leadership skills and I believe over the next ten years that we will see a dramatic change in ownership of medical services provided.

"Now the choice of health services offered is predominantly driven by available resources and also the funders, Australia, New Zealand and the World Health Organisation to name a few.

"But I think the discussion is now starting from the people themselves about what they want, what they can do and what they can afford to do. That may still be a way off, but I can see it."

To help bring forward that day of greater self-determination, Mr Maoate, as president of the Pasifika Medical Association (PMA), has helped design and implement an education-based initiative known as the "Students are our Future Programme".

A New Zealand-wide initiative with the secondary schools and the Ministry of Health, the program aims to inspire Pacific Island students to pursue a health-related career. He also hopes to implement this program in the Pacific countries.

"We start with school kids from Year 10, to try and capture their imagination with a life in the health sciences and provide mentors to those already beginning their tertiary training," Mr Maoate says.

Kids often disadvantaged

"The kids from the Pacific are often disadvantaged and don't have the same opportunities to perform at the same level as others so we are actively working to bridge that divide while helping them to attain the skills that will in turn be of assistance to their own people.

"It's a long-term strategy aimed at solving some of the workforce issues confronting the Pacific Islands, but it is an exciting one.

"The role of the PMA is to bring people together and inspire them to work for the future of the Pacific Islands people."

When not focused on the future of the Pacific Islands, Mr Maoate works as a Paediatric Surgeon and Urologist at the Christchurch Public Hospital and Children's Specialist Centre and is a Senior Clinical Lecturer in Paediatric Surgery at the University of Otago, Christchurch.

Yet still he can't get the islands out of his blood for he also acts as an advisor to the Ministry of Health on Pacific Island issues.

He lists the major health issues confronting Islander people as diabetes and obesity, both of which raise the need for surgeons to participate vigorously in public health debates, given the chronic nature of the diseases.

"This is not just about arguing over money for health services, but about discussing wider issues such as how we live, what we eat, even how food is manufactured, costed or provided," he says.

Hon Viliami Tangi, Minister of Health, Deptuy PM, Tonga, Sir Terepai Maoate, Retired general surgeon, Cook Islands and Kiki Maoate at a WHO Regional meeting, Hong Kong 2009.

Public health advocacy

"That is why I am also such a strong believer in the role of the surgeon as a public health advocate and in some ways the surgeons now working in the Pacific are leading the way," he says.

"We understood some time ago that all our trainees needed to be aware of and able to manage issues relating to public health even if they are neurosurgeons, plastic or reconstructive surgeons.

"They need a strong voice in these countries to argue for the necessary funding, to determine and lobby for national health priorities and the School of Medicine in Fiji has established a curriculum to teach such leadership skills.

"I think New Zealand and Australian surgeons could learn from this, that our role is not one of just thinking about hospital systems or hospital funding, but engaging with the community about pivotal health issues.

"There have been some surgeons and others who have embraced this role of public advocate, but as a profession I don't believe we are there yet."

Having recently returned from the Vanuatu meeting of the Pacific Islands Surgical Association Meeting, Mr Maoate noted dryly that, given the tsunamis that have devastated some islands in recent years, disaster management courses were being held there during the meeting. At the same time, the September earthquake hit Christchurch.

He says the damage caused both to the central city and in outer regional areas had been extensive and that only the fact that it had occurred in the small hours of the morning limited the number of accidents and trauma.

"The damage on the ground is quite amazing, but in terms of accidents and injury it's all about timing because it happened in the middle of the night. If people had been driving on some of the buckled roadways there would have been multiple casualties."

Ian & Ruth Gough Surgical Education Scholarship 2011

Background:
The Ian and Ruth Gough Surgical Education Scholarship was established by Ian and Ruth Gough to encourage surgeons to become expert surgical educators.

Eligibility conditions:
Applications are open to Fellows and Surgical Trainees of the Royal Australasian College of Surgeons. Applicants must be a permanent resident of Australia or New Zealand.

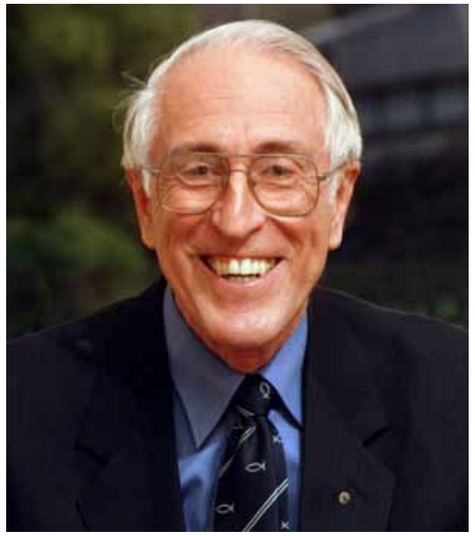
Applicants must provide:
> A Curriculum Vitae
> A Referee report
> An outline of a program proposal that includes documentation of your acceptance of visits to specialist centres or into courses that will enhance your ability to become an expert surgical educator. The Dean of Education is available to advise on suitable activities.
> Details of the approximate cost of your program
> A statement that summarises your personal experience in obtaining and delivering surgical education programs and the anticipated future contribution you will make to surgical education in Australia and/or New Zealand.

Value:
The duration of this scholarship is 12 months. The value of this scholarship is **$10,000.**

More information:
Applications are now open and close at 4.00pm on Tuesday 30th November 2010.

Please read the important general information and the scholarship conditions prior to applying, these are on the College website at www.surgeons.org. Please follow the prompts from the Research and Audit menu to Travel Scholarship Opportunities. Alternatively, contact our Scholarship Coordinator at scholarships@surgeons.org.

Please submit applications by 30th November 2010 to:
The Scholarship Coordinator
Royal Australasian College of Surgeons
PO Box 553, Stepney SA 5069
P: +61 8 8363 7513
F: +61 8 8363 3371



Work of a distinguished Fellow recognised again

The pioneer of the cochlear implant, Distinguished Professor Graeme Clark AC, has become only the third Australian to be awarded the Lister Medal, the world's foremost honour for surgical research.

Professor Clark, a Fellow of the College since 1966, did his research into the implant at the University of Melbourne during the 1970s. Since then more than 200,000 cochlear implants have been performed in over 100 countries.

He joins Howard Florey and Sir Peter Morris as the only Australians to have received the Lister Medal, named for English surgeon Joseph Lister (1827-1912) whose work on antiseptics was fundamental to the development of sterile surgery. The recipient of the award is determined by the Royal Society, The Royal College of Surgeons England, the University of Glasgow, The Royal College of Surgeons in Ireland and The Royal College of Surgeons in Edinburgh.

Professor Clark's work has been recognised by other distinguished bodies. In 2005 he received the International Speech Communication Association Medal for his contribution to speech science and technology. In 2007 he was awarded the Zulch Prize for his achievements in basic neurological research, and in 2009 the Otto Schmidt Award from the International Federation of Medical and Biological Engineering.

Celebrating his 75th birthday this year, Professor Clark is currently working on the next generation of cochlear implants and hopes that by 2020 all deaf people will enjoy the gift of hearing.

Representing the College at a dinner to celebrate Professor Clark's birthday, and at which the announcement of the award of the Lister Medal was made, Professor Julian Smith said Professor Clark's achievements were of historic proportions.

"His work has enabled the deaf to hear. Few others can make a claim of such significance. Some 200,000 people have had their lives changed for the better, and it is very appropriate that this be recognised – by events such as tonight's and by the awarding of the Lister Medal," Professor Smith said.

The virtues of examiners

The Court of Examiners represents a tightly-knit group of dedicated and committed surgeons

Spencer Beasley
Chair, Court of Examiners

Perhaps one of the most rewarding roles a Fellow can have in the College is as an examiner for the Fellowship examinations. For many, it is the ultimate achievement in their specialty, and the importance of the role is widely acknowledged throughout the College.

Each of the nine specialties has a special court of examiners responsible for the final assessment of its SET trainees at completion of their training before Fellowship of the College can be awarded; together they form the Court of Examiners.

In earlier years, examiners learnt their task on the job, mostly by osmosis. At their first examination they were often paired with a senior examiner (but not always so). As many components of the examination had a fairly unstructured format, it was assumed that all examiners intuitively 'knew' the required standard – and for that, it was expected that the candidates should demonstrate that they were capable of safe clinical practice, independent of supervision.

Now, the examination is a lot more structured, better aligned to the syllabus, and less subject to the vagaries of bias and personality. Advances in technology have enabled introduction of new assessment tools. Increasingly, the examination is based on defined standards and the demonstration of clinical competence. It focuses on clinical judgment and operative decision-making, rather than testing pure basic science. To this end, most specialties have removed, or are in the process of removing, the basic science components from their Fellowship examination and replacing them with components assessing the clinical application of this knowledge. Pure basic science is now tested as part of the generic and specialty-specific Surgical Science Examinations earlier in SET training.

Being an examiner now requires specific skills and expertise if the examination is to be conducted at a high level. It also carries with it certain responsibilities because the summative assessment provides the last opportunity to confirm that a trainee is ready to graduate from formal training.

The Court of Examiners has been concerned to ensure that the examination process can reliably and consistently demonstrate achievement of pre-determined standards, and that the whole process is fair and unbiased. To this end, the College is working towards providing greater support and training to examiners, and to develop the tools each specialty needs to provide feedback to its examiners on their performance.

Consequently, from 2011, all new examiners will undertake an examiners' training course and have the opportunity of being an observer for one examination before functioning as an examiner. This means that a Fellow who wishes to become an examiner can be confident that he/she will be provided with the necessary skills to function in this role at a high level.

Being an examiner has many attractions and rewards: it is intellectually stimulating and challenging, and facilitates the maintenance (and expansion) of one's own knowledge. The collegiality and camaraderie of the Court is legendary and highly valued by its members. While the Court of Examiners is not exactly a 'club', it does represent a tightly-knit group of dedicated and committed surgeons, genuinely interested in the teaching, assessment and the maintenance of surgical standards.

Being an examiner involves much hard work and commitment. Nevertheless, it is this sort of person that the College hopes to continue to attract so that the same high quality of examiners may be maintained into the future. If you, as a Fellow of the College, are interested in becoming an examiner, and contributing to your profession in this way, please contact Narelle Hardware, Manager, Examinations. Email narelle.hardware@surgeons.org or telephone +61 3 9276 7471.

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 Wednesday 1 December 2010 for appointment in 2011.

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

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

> 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

www.surgeons.org

Pacific Islands Surgeons meeting

August meeting in Vanuatu brought together representatives from across the region

John Kyngdon,
Chair, NZ National Board

This meeting brought together Pacific Islands' surgical leaders and trainees to discuss issues of surgery provision and to hear numerous scientific papers. Representatives were present from the Cook Islands, Fiji, Federated States of Micronesia, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, New Zealand, Australia and the host country, Vanuatu.

The first day of the meeting was devoted to younger surgeon training. This offered visitors such as myself a valuable insight into the knowledge and judgement of surgical trainees from the postgraduate programs at the Fiji and PNG Schools of Medicine. The trainees were at differing levels of experience and those nearing the end of their Masters training demonstrated knowledge, judgement and maturity comparable to that of similar level trainees in Australia or New Zealand. A Primary Trauma Care course for nurses and other paramedical staff was run concurrent with the first two days of this meeting.

At the opening ceremony, participants at the meeting were led to the venue by a ceremonial welcoming party. Delegates were welcomed by Professor Eddie McCaig, President of the Pacific Islands Surgeons Association and myself as Chair of the New Zealand National Board. Keynote addresses were provided by His Excellency Jeff Langley, New Zealand High Commissioner to Vanuatu, and Mr Mark Bebe, Director General, Vanuatu Ministry of Health. The meeting was formally opened by the Minister of Health, the Honourable Moses Kahu.

High demand for care

The region is vast with approximately 12 million inhabitants – more than six million of these live in Papua New Guinea, approximately one million in Fiji and the remainder are spread over a vast area in much smaller population groupings. This creates significant difficulty for the provision of health services and surgical services can be provided in only relatively larger centres.

The ratio of surgeons to population is extremely low by Western standards, but there is a high demand for surgical care reflecting injury, infection, the complications of diabetes (which is very prevalent within this region), neoplasia and degenerative conditions. Access to appropriate contemporary surgical advice and intervention is frequently delayed by transport difficulties and also the widespread reliance upon local healers as the first point of care. Consequently, there is a much higher morbidity and mortality within this region.

Professor Ikau Kevau, PNG School of Medicine, and Professor Eddie McCaig, Fiji School of Medicine, discussed developments in the Masters in Surgery courses. These two programs have resulted in a significant number of locally trained surgeons who contribute to the provision of surgical care in the region. Both programs are of four years duration and cater to doctors from throughout the Pacific. Despite this valuable educational development, serious workforce deficiencies remain and these cannot be addressed in the short-term. It was a concern to hear that some countries are needing to turn to places such as Cuba for undergraduate medical training (conducted in Spanish) to increase graduate numbers. Cuban and Chinese surgeons are employed in many Pacific countries. This does help the current workforce shortfall, but at times there are both language and cultural difficulties.

During the meeting a number of outstanding scientific papers were presented. These included

- Osteomyelitis *Dr Basharat Munshi* (Trainee Prize winner)
- Epidemiology of Lower Extremity Amputation *Dr Rajeev Patel*
- Blood Utilisation with Current Blood Ordering Practice at Vaiola Hospital, Tonga *Dr Saia Piukala*
- Congenital Diaphragmatic Hernia *Dr Colin Brook*
- Burnout in Fijian Surgeons *Dr Rajeev Patel* (Trainee Prize winner)

Professor Sitaleki Finau (from Auckland) gave a public health perspective to the development of health care in the South Pacific and participated enthusiastically in much of the discussion throughout the week. Dr Raj Singhal (a Rehabilitation Physician at Burwood Hospital) provided an excellent short paper on the conservative care of the patient with displaced cervical spinal injury. Dr Sammy Thomas' (PNG) paper highlighted the importance of neurosurgery in PNG.

Disaster management

One of the meeting's themes was disaster management. This appropriately reflected the recent tsunamis in Samoa and Tonga; and the importance of this was reinforced by the personal experiences of every participant in the 7.5 magnitude earthquake that struck Port Vila late on the Tuesday afternoon. Aftershocks continued throughout the week (and after all but the local participants had left Vanuatu) and were an ever-present reminder of the instability of much of this region.

This was an outstanding meeting of immense value to all participants, both those from Pacific Islands and those from New Zealand and Australia. The strong collegiality, support and leadership demonstrated within this group of surgeons and trainees will undoubtedly play a significant part in the further development of health services within this region.

The meeting was made possible through the significant financial assistance of NZAID and the Pasifika Medical Association (PMA), supported with assistance from AusAID (through the PIP and the HECS programs) and sponsorship from Braune. The meeting was extremely well-organised by Dr Richard Leona who was assisted by the Vanuatu Ministry of Health staff, in particular Mr John Tesserei, and by Mr Kiki Maoate (Paediatric Surgeon in Christchurch and President of PMA) and staff from the College's NZ Office.

The next Pacific Islands Surgeons Meeting is to be held in 2012 in either Tonga or Fiji.

LEFT: The Minister of Health, Hon Moses Kahu, at the official opening of the Meeting. ABOVE: Professor Eddie McCaig (2nd from left) with surgical trainees from Fiji School of Medicine post graduate program.

Snakes and Ladders (or Mentors and Role Models)

Difficulty is, all surgeons I meet are usually my direct supervisors

Dr Ina Training

Training is like a game of Snakes and Ladders. You throw the dice, get a lucky number and whoosh - up the ladder to start your surgical training pathway. And then you throw another good role, and next thing you know you're up the next small set of ladder rungs, past the primaries. At least, that's sometimes what it feels like. There are also times when you fail at something and before you know it, you're down a snake and have to start a whole section all over again. Drat!

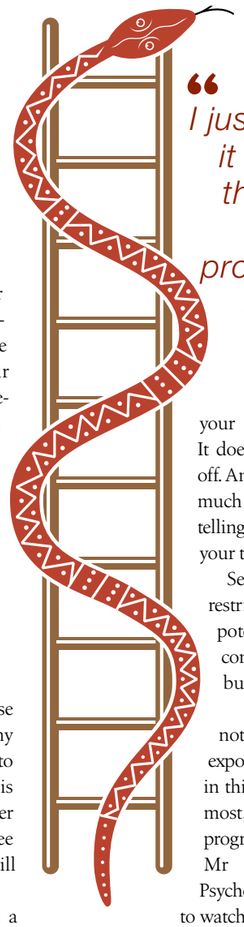
I was pondering over a nice glass of sauv blanc and a solo dinner (yet again!) all those snakes and ladders. Actually, I was really thinking about the professional interactions we have and how they impact our training careers. In particular, of the many supervisors I have had. Sometimes a Snake, sometimes a Ladder, but from everyone of those experiences I have learnt something that I believe will make me a better surgeon.

Pander me, for a moment. This is going somewhere.

Mr Eccentric, Mr Old-fashioned, Mr Younger Fellow (who is up-to-date with the latest published data on their area of expertise and many others), Mr Family Man, Mr Unlucky, Mr Practical, Mr Sexy-but-doesn't-seem-to-know-it (he may also be Mr Younger Fellow), Mr Re-assuring, Mr Controlling-Manipulative-Psychopath, Mr Grumpy (but really a Teddy Bear), Ms Forthright, Mr Cheeky, Mr Gentle, Mr Unpredictable, Mr Grandpa, Mr Ladies-Man, Mr Manic, Ms Got something to Prove and The Prof.

I cannot give their real names, but these surgeons exist and have made a huge impact on my training. These role models have been mostly positive, with behaviours I have tried to emulate. Occasionally, the lessons have been habits to try to avoid. They have been very strong role-models. You may wonder, "Which one am I?"

But please note that I have stated here that they are role models, who model being a surgeon in ways that make me want to be a good, or better, surgeon. However, I do not feel that my relationship with any one of them is close enough that I could actually admit to them my hopes, dreams, desires or fears. I tell them what I think they want to know, or what they need to know. I listen attentively to their operative discourses and management plans, take notes and ruminate intently over the evidence for their preferences. Any career advice I receive, however, I take with a grain of salt. There is always a concern that what they tell me is partially for their own (or someone else's) gain. I have very little trust that the advice I receive is really for my benefit. Except maybe that of Ms Forthright, who just says it like it is, and calls the spade a ..... shovel.



Yet to find a mentor

The College has tried to formalise the Mentor processes, with many specialities and programs trying to match the trainees to a mentor. This has not worked for me, and after seven years involvement as a trainee of some description or another, I still find myself mentorless. Why is this?

For me, the difference between a role model and a mentor is vast. First and primarily, a mentor needs to understand me as a human being and a person; what my background is, where I'm at, and where I'm going. And I need to have a reciprocal understanding of them. They would need to be a friend and confidante. Someone you have met and trust implicitly. Where you can have a conversation about what you really think, and there is no concern that what you say could ever be brought against you. Unfortunately, as a trainee, this is very difficult to find as all the surgeons you meet and have exposure to are usually your direct supervisors at one stage or another. Therefore, they have some (or much) direct input into your assessment, and hence some (or much) say into your progression through training. It does not pay to piss these people off. And I strongly doubt that there is much (or anything) to be achieved by telling them what you really think of your training.

> *"I just don't consider it appropriate that those responsible for your career progression should also be those to give you career advice."*

Secondly, there is a huge restriction on interaction with potential mentors due to time constraints. Either they are too busy working, or you are.

Hence, I am mentorless. This is not to say that the people I have had exposure to do not wish to function in this capacity. I am convinced that most, if not all, would like to see you progress and prosper (except maybe Mr Controlling-Manipulative-Psychopath whose only pleasure is to watch others suffer). It's a Catch-22, a conflict of interest. I just do not consider it appropriate that those who are responsible for your career progression should also be those to give you career advice. Particularly when your career aspirations can be so far off-stream to their own; "Are you crazy? Why be a generalist? You should specialise. Why would you want to go rural? There's no future in it." (This was actually once said to me. Nice guy, no idea.)

Which brings me back to Snakes and Ladders. Some of these role models are snakes, some are ladders, but a mentor would give you a good overview of the board and where the snakes and ladders lie. And sometimes you just have to hit a snake that takes you down, but will set you up for the ladder that brings you home.

The 2010 Hamilton Russell Memorial lecture

"In Praise of Surgery"

Continuation from September Surgical News of the lecture delivered by Allan Skirving at the 79th Annual Scientific Congress, Perth

Allan Skirving

I'll move onto neurosurgery. It is, I think, fair to say that, as in many other surgical specialties, progress has largely resulted from new technology which has expanded the horizon and refined the precision of almost all neurosurgical procedures leading to improved outcomes and reduced morbidity.

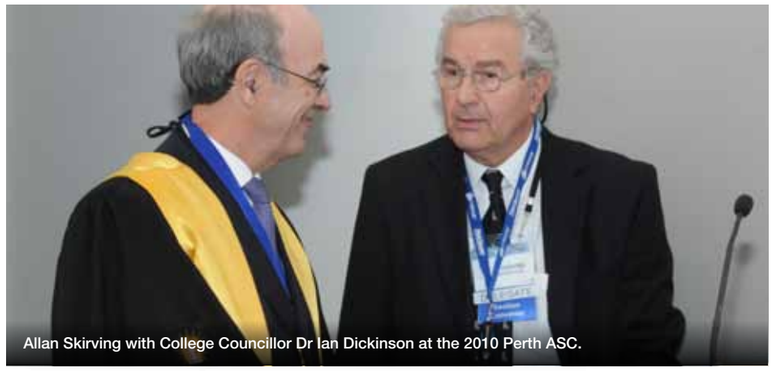
These advances include frameless stereotactic surgery, interventional imaging, with MRI becoming the preferred modality and Gamma knife surgery.

Frameless stereotactic surgery relies on fiducial markers, which are taped to the scalp before the brain is imaged. In the operating room, the orientation of these markers is used to register the computer containing the brain images. Once registration is completed, a digitising camera senses the position of the surgeon's instruments in space and indicates the position of the instrument on the image displayed on the computer monitor in real time, as the operation proceeds.

Gamma knife surgery enables patients to undergo non-invasive brain surgery using multiple beams of gamma radiation to focus precisely on the targeted lesion with markedly reduced surgical risks and faster rehabilitation. The procedure is applicable to many forms of benign tumours such as acoustic neuromas and pituitary tumours; also for some metastatic and primary intracerebral tumours as well as vascular malformations.

Although these extraordinary technological advances have allowed improvement in almost all forms of neurosurgery it is in the management of movement disorders and, in particular the management of intractable temporal lobe epilepsy which is, perhaps, most impressive.

Pre-operatively, patients with intractable temporal lobe epilepsy typically are at the end of the road, taking multiple medications, often suffering severe side-effects, unable to work, unable to drive, socially isolated and desperate.



Allan Skirving with College Councillor Dr Ian Dickinson at the 2010 Perth ASC.

In one study, one-year post-surgery using stereotactic techniques and interventional MRI scanning resulted in 85 to 90 per cent of patients being either free or having significantly reduced frequency of disabling seizures. In every respect, there was a marked improvement in the patient's quality of life especially in terms of their social and occupational functioning. Morbidity from the surgery was minimal and the procedure is very cost-effective.

What an extraordinary achievement!

Transplantation surgery

In this field, I have a personal reason for choosing renal transplants. In 1950, my elder sister, Avril, died of renal failure, having developed post-streptococcal glomerulo-nephritis and nephrotic syndrome. My father, who was not a doctor, tried to persuade her treating doctors to consider a renal transplant with himself as the donor. It was, of course, declined but I remember very clearly a few years later my father, in tears, telling me that, on December 23, 1954 in the Peter Bent Brigham Hospital in Boston, John Merrill and his team performed the first successful renal transplantation from one healthy identical twin to his twin brother who was dying of renal disease.

Of course, it was understood that the success of this operation was due to the absence of host rejection but, enormously encouraged by the technical success of the surgical procedure, attention became focused on the immunosuppression required for transplants from an unrelated donor or a living family donor. There was a brief flirtation with total body irradiation which achieved the desired immunosuppression, but at a cost of profound marrow aplasia and overwhelming infections.

In 1963, the introduction of azathioprine and steroid combination therapy became the mainstay of immunosuppression until 1983 when one of the most pivotal events in the history of organ transplantation occurred with the introduction of cyclosporine followed by anti-T cell antibodies as well as other maintenance immunosuppressants.

Renal transplant is now vastly superior to dialysis and is the treatment of choice for most patients with end stage renal disease and, currently, three year patient and graft survival rates exceed 90 per cent in most transplant centres. It has also become clear that those patients who receive a transplant early in the course of end-stage renal disease experience the best outcomes.

The cost benefit of kidney transplantation compared to dialysis over a period of ten years, which is the median transplant survival time, is approximately $500,000, which is approximately $50,000 per year for each year that the patient has a functioning transplanted kidney.

Dr Thomas Starzl back in the 1960s, said that what is required in transplantation surgery is 'the courage to fail' and progress since then suggests and I quote 'looking back, the failures seem almost totally eclipsed by the successes'.

Perhaps you should include that in your next application for ethics approval.

Orthopaedic Surgery

Of course, eventually I have to come to orthopaedic surgery and you would have to concede the great difficulty I have in making just one selection from the many, which would easily fulfill most of my criteria. My task has been made easy because the selection has already been performed by others. In *The Lancet* in 2007, Total Hip Replacement was described as 'the operation of the century', admittedly by three orthopaedic surgeons. The impact of this surgical solution to hip arthritis of various aetiologies is undisputed, but it reaches even greater status when it is appreciated that so much can be attributed to one man – Sir John Charnley

Charnley made three major contributions to the evolution of total hip replacement. Firstly, he introduced the concept of low frictional torque arthroplasty which he considered the basis of total hip arthroplasty design. There is a well known anecdote that this epiphany resulted from a serendipitous event when a patient whose left femoral head had been replaced with an acrylic Judet prosthesis reported that his left hip squeaked every time he bent forward. Charnley recognised the importance of low frictional resistance at the articular interface and the requirement to reduce the torque transmitted from the metal femoral head to the socket to reduce the risk of loosening. He achieved this by reducing the diameter of the femoral head component to 22.2 mm in diameter.

Secondly, after a disastrous trial of polytetrafluoroethylene or Teflon in 1962, he inserted the first high molecular weight polyethylene acetabulum and the qualities of this material, its excellent wear resistance, low friction and high impact strength have stood the test of time.

His next major requirement was to determine the means of securing these foreign materials to living bone. Methylmethacrylate cement was borrowed from the dental community and in 1960, he produced a momentous publication entitled 'The anchorage of the femoral head prosthesis to the shaft of the femur' in which he demonstrated the bone cement acted as a grout and not as a glue so that the fixation was achieved by interlocking and not by adhesion.

Charnley's contribution, however, extended far beyond what I have so far described: his preoperative assessment and clinical and radiological outcome measurements were meticulous. He recognised the value of laminar flow clean air enclosures in operating theatres. His operation was reduced to 149 well-described and illustrated specific steps and for many years orthopaedic surgeons were not allowed to insert a Charnley hip arthroplasty unless they had visited and observed the operation being performed at the Whittington Hospital. There are many times when I wish that these strict criteria were insisted upon today.

One further point I think illustrates the stature of the man is that he had many instruments named after him, but he patented none of them and nor did he patent his low friction arthroplasty.

He was a special man and he deserved a Nobel Prize.

Impressive though it is I would concede that perhaps my three orthopaedic colleagues might have been a little more humble and described total hip arthroplasty as being 'The orthopaedic operation of the century' but, as you know, we orthopaedic surgeons don't do humble too well.

What about Plastic surgery?

It is, I know, unnecessary to describe to you the devastating physical, psychological and socio-economic impact of a deforming birth defect on the well-being of a child and this is equally true for children in the developed world as in the developing world. The great difference, of course, is that our children have access to effective surgical solutions, which have the potential to be life-transforming. For this reason successful cleft lip and cleft palate surgery has for many years been one of the surgical procedures I most admire.

Over the past 30 years, there have been technical improvements in this surgery but unlike the advances in most other subspecialties, these improvements are not based on technological progress, but have resulted from meticulous thought and study of the embryology and pathology of the deformity followed by the development of appropriate corrective surgical technique. Suffice to say that these technical advances, linked to an interdisciplinary team that includes orthodontic surgeons and speech therapists, have led to realistic goals of normal appearance and normal function.

I know you are aware of the effort and commitment of many doctors and nurses in many organisations from this country and around the world who are also committed to the challenge of providing these life transforming surgical corrections of these deformities to children in the developing world. I know if you could see these children, I would not for one moment insult you by posing the question as to whether the procedure is cost-effective.

I believe our medical community, perhaps this College should resolve that no child in our region be denied access to this form of corrective surgery.

Regrettably, at least for me, I have to draw to a close. Had I had time, and I assure you I prepared the material, I would like to have presented my selections from all the other surgical specialties and I apologise for not being able to do so.

I have described just a little of the extraordinary progress which has been made in the past half century or so and we can take, perhaps, some vicarious satisfaction from these achievements, but there is still a long way to go and, although some of this progress will be made by seismic contributions from special individuals, maybe from one or two or three delegates attending this meeting, there is no doubt much of the progress will be Darwinian, that is, slow and incremental.

Some of you will make the appropriate observations, conduct the appropriate trials and experiments or perform the rigorous scrutiny of clinical outcomes research. Many of you will simply inspire your younger colleagues and students. No matter your role, your contribution will ensure that the recent decades of innovation and progress will continue for the benefit of our patients and society.

80th Annual Scientific Congress

Adelaide Conference Centre Monday 2 May to Friday 6 May, 2011
asc.surgeons.org

Campbell Miles,
Annual Scientific Congress Co-ordinator

The theme for the 2011 Annual Scientific Congress is extremely appropriate – Unity Through Diversity: Diversity as exemplified by the nine disciplines and the numerous special interest groups that work together under the unity of the Royal Australasian College of Surgeons. The year 2011 marks an important milestone for the College – the 80th ASC. Many western world surgical colleges no longer convene a multi-disciplinary scientific conference, an exception being our sister College, the American College of Surgeons, the College that had a significant influence on the founding Fathers of our College.

Convocation & Welcome reception

The Convocation will be held at the Adelaide Convention Centre at 4.30pm on Monday 2 May. All delegates and associates are invited to attend. Any Fellow who has received their Fellowship in the past five years, and who has not previously convocated, is invited to register to attend the ASC as a convocating Fellow. Convocating Fellows receive complimentary registration for the conference and their family members are welcome to attend the conferral of Fellowship. Further details regarding convocating and College gown hire are available from the ASC Executive Officer Katie Fagan at 'Katie.Fagan@surgeons.org'.

The Honourable Alexander Downer has accepted the College's invitation to present the George Adlington Syme oration during the Convocation. After a long career as a Federal politician and the long-serving Minister for Foreign Affairs and Trade, Mr Downer is now an ambassador with the United Nations with special responsibility for Cyprus. Mr Downer has an outstanding reputation as an erudite, entertaining public speaker. He follows in the footsteps of other political leaders who have delivered 'The Syme'.

The Convocation is followed by the President's Welcome Reception at 5.30pm to which all delegates and the families of convocating Fellows are invited.

Adelaide conference centre

Scientific and Plenary program

Since June 2009 and only weeks after the conclusion of the Brisbane ASC, members of the Adelaide convening group have applied themselves to planning the 2011 conference. Suren Krishnan, Congress Convener, and Tom Wilson, Congress Scientific Convener, have led an outstanding group of Adelaide surgeons and the Rural Surgery Convener Matthias Wichmann from Mt Gambier, and an excellent program has resulted. The scientific program will be held from Tuesday 3 May to Friday 6 May 2011.

The plenary program is a keystone of the Congress. The content cannot be replicated in strictly sectional programs, which is a reflection of the breadth of interests represented at the ASC.

The plenary topics all address vital surgical matters related to training, politics & standards.

Tuesday: The interface between surgery and government – for better or for worse.
Wednesday: Commercialisation of the surgical profession – ownership, ethics and the law.
Thursday: Training the tsunami of new medical graduates and training in the private sector.
Friday: Quality improvement in surgical practice – how are we doing as a profession?

Tuesday's plenary will open the Congress. The first presentation will be the British Journal of Surgery Society Visitor, Lord Ara Darzi whose lecture is titled 'Innovation and the interface between surgery and government'. Lord Darzi has been a Minister in the Health portfolio, a Minister in the House of Lords and is Professor of Surgery at Imperial College, London.

Congress faculty

The entire program will benefit from an outstanding invited faculty of 40 surgical leaders from Australia, New Zealand and from around the world – the US and UK, Canada, Europe and Turkey. This impressive faculty of Congress Visitors is made possible by funding to participating sections from the College's own Visitor Funding program and from our industry partners. The College visitor funding is sourced from Fellows' annual subscription fees, and not from the College Foundation, as it was until 2002. Funding from industry is now used to enhance the scientific program of particular sections rather than funding individual speakers to a program.

Call for abstracts

This issue of *Surgical News* contains the Call for Abstracts form – it is stapled in the centre pages as a pull-out section. The Adelaide program conveners have scheduled copious time for research presentations, an important feature of the ASC. The Trainee Research Prize program has been expanded to 16 sections. Winning the prize is not just about the money, but the accolade in the winner's CV. Full details regarding the Trainee Research Prize program are on the Call for Abstracts form and on the abstract submission site: asc.surgeons.org.

Suren Krishnan and Tom Wilson look forward to seeing you in Adelaide for the 80th.

ANNUAL SCIENTIFIC CONGRESS

ADELAIDE CONVENTION CENTRE, ADELAIDE, AUSTRALIA

2 – 6 MAY 2011

http://asc.surgeons.org

UNITY THROUGH DIVERSITY
80 Years of the ASC

Royal Australasian
College of Surgeons

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. Authors must be registrants at the meeting for their abstract to appear in the publications, on the website or the Virtual Congress.
13. Please ensure that you indicate on the Abstract Submission site whether you wish to be considered for:

Section	Prize	Sponsor
Bariatric Surgery	$500	Johnson & Johnson Medical
Breast Surgery	$500	Covidien
Burns Surgery	$500	
Craniomaxillofacial Surgery	$500	Johnson & Johnson Medical
Colorectal Surgery (Mark Killingback for Young Fellows & Trainees)	$500	Covidien
Endocrine Surgery (Tom Reeve prize)	$500	Covidien
General Surgery	$500	Covidien
Head & Neck Surgery	$500	Johnson & Johnson Medical
Hepatobiliary Surgery	$500	Covidien
Neurosurgery	$500	College
Surgical Education (Not exclusively for Trainees)	$500	Section
Surgical History	$500	College
Surgical Oncology	$500	Novartis Oncology
Trauma Surgery	$500	Johnson & Johnson Medical
Upper GI Surgery	$500	Covidien
Vascular Surgery	$500	Atrium

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 email 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 ALL SCIENTIFIC PAPER ABSTRACT SUBMISSION IS 25 JANUARY 2011.

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	13 October 2010
Closure of Abstracts	25 January 2011
Closure of Early Registration	15 March 2011

Adelaide ASC 2011 Program Overview (indicative only)

	Monday 2 May	Tuesday 3 May	Wednesday 4 May	Thursday 5 May	Friday 6 May
Breakfast session 7.00am – 8.20am		Masterclasses	Masterclasses	Masterclasses	Masterclasses
Session 1 8.30am – 10.00am	Pre-Congress Workshop Program	Plenary	Scientific Sessions	Scientific Sessions	Scientific Sessions
10.00am – 10.30am		Morning Tea	Morning Tea	Morning Tea	Morning Tea
Session 2 10.30am – 12 noon		Scientific Sessions	Plenary	Plenary	Plenary
12 noon – 12.30pm		Keynote Lectures	Edward 'Weary' Dunlop Memorial Lecture Keynote Lectures	President's Lecture	Keynote Lectures
12.30pm – 1.30pm		Lunch	Lunch	Lunch	Lunch
1.30pm – 2.00pm		Keynote Lectures	American College of Surgeons Lecture Keynote Lectures	Hamilton Russell Memorial Lecture Keynote Lectures	Rupert Downes Memorial Lecture 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 6.00pm Welcome Cocktail Reception	Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
7.00pm – 11.00pm		Sectional Dinners and Younger Fellows & Trainees Dinner	Sectional Dinners	Congress Dinner	

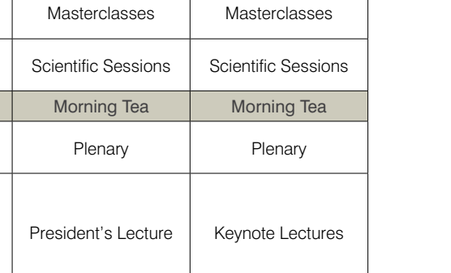
Research Paper Specialties

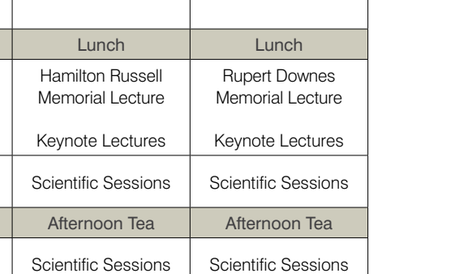
Authors of research papers and posters are invited to submit abstracts for consideration and inclusion in the Scientific Program in the following areas:

Bariatric Surgery
Breast Surgery
Burns Surgery
Colorectal Surgery
Craniomaxillofacial (CMF)
Endocrine Surgery
General Surgery
Head & Neck Surgery
Hepatobiliary Surgery
International Forum
Medico-Legal
Military Surgery
Neurosurgery
Pain Medicine
Rural Surgery
Senior Surgeons Group
Surgical Education
Surgical History
Surgical Oncology
Transplantation Surgery
Trauma Surgery
Upper GI Surgery
Vascular Surgery
Women in Surgery

Executive Organising Committee

Convener:	Mr Suren Krishnan
Scientific Convener:	Mr Tom Wilson
Member of Executive:	Dr Michelle Lodge
Member of Executive:	Mr Greg Bain
ASC Co-ordinator:	Mr Campbell Miles
ASC Manager:	Ms Lindy Moffat
ASC Executive Officer:	Ms Katie Fagan
SA Regional Manager:	Ms Daniela Ciccarello





Scientific Conveners

		College & Industry Sponsored Visitors	
Bariatric Surgery	Dr Lilian Kow	Assoc Prof Daniel J. Scott Dr Helmuth Billy	USA USA
Breast Surgery	Mr David Walters	Ms Fiona MacNeill Prof J M Dixon	UK UK
Burns Surgery	Mr John Greenwood	Mr Ken W Dunn Mr Peter Davenport	UK UK
Colon & Rectal Surgery	Mr Andrew Hunter	Prof Ronan O'Connell Prof Frank Frizelle Prof Robin Phillips	Ireland NZ UK
Craniomaxillofacial (CMF)	Assoc Prof Peter Anderson	Prof David David Dr Michael Buckley	Australia Australia
Endocrine Surgery	Mr James Kollias	Dr Fiemu Nwariaku Dr Herbert Chen	USA USA
General Surgery	Mr Trevor Collinson	Prof Michael Bailey Prof Mehran Anvari Dr Lee Swanstrom	UK Canada USA
Head & Neck Surgery	Mr Darcy Economos	Dr Marshall Strome Dr Nicholas McIvor	USA NZ
Hepatobiliary Surgery	Dr Mark Brooke-Smith	Mr Rowan W Parks	UK
International Forum	Mr Mark Moore	–	–
Medico-Legal	Mr Erik Eriksen	Assoc Prof Leigh Atkinson Mr Anthony Morris	Australia Australia
Military Surgery	Mr Craig Jurisevic Dr Robert Baird	Mr David McLeod Prof Grant Niemann	Australia Australia
Neurosurgery	Dr Stephen Santoreneos	Prof Peter Wormald Prof Takeshi Kawase	Australia Japan
Pain Medicine	Assoc Prof Andrew Zacest	Prof Kim J Burchiel Prof Yucel Kanpolat	USA Turkey
Rural Surgery	Assoc Prof Matthias Wichmann	Dr Nadine Caron Dr Lloyd Einsiedel Dr Christian Mueller	Canada Australia Australia
Senior Surgeons Group	Mr Glenn McCulloch	–	–
Surgical Education	Assoc Prof Mellick Chehade Mr Adrian Anthony	Prof Richard Reznick	Canada
Surgical History	Assoc Prof Susan Neuhaus	Ms Libby Stewart	Australia
Surgical Oncology	Dr Brendon Coventry	Dr Clifford Ko	USA
Transplantation Surgery	Dr Christine Russell Mr John Chen	Prof Peter G. Stock	USA
Trauma Surgery	Assoc Prof Robert Atkinson	Dr Karim Brohi Prof Keith Willett	UK UK
Upper GI Surgery	Dr Harsh Kanhere	Prof Michael Griffin	UK
Vascular Surgery	Prof Robert Fitridge	Prof Stephen Cheng Prof Mario Lachat Prof Matt Thompson	Hong Kong Switzerland UK
Women in Surgery	Dr Melissa Bochner	–	–

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Pre-anaesthesia consultations

High quality pre-anaesthesia assessment practice benefits patients and assists surgeons

Dr Andrew Mulcahy,
Vice-President, Australian Society of Anaesthetists

Studies have repeatedly demonstrated the importance of high quality pre-anaesthesia consultations in ensuring good outcomes from surgery and anaesthesia as well as the converse – inadequate pre-anaesthesia assessment of patients leads to poor patient outcomes. In fact inadequate pre-anaesthesia assessment has been identified as a major contributing factor in adverse outcomes in every triennial report into anaesthetic mortality published by the Australian and New Zealand College of Anaesthetists (ANZCA) since these studies have begun.

Why are anaesthetists concerned?

Providing a good pre-anaesthetic consult is proving a challenge because of:

1> increasing day surgery (>60 per cent of all surgical procedures)
2> day-of-surgery-admissions (another 20 per cent)
3> the intervals between booking for surgery and admission to hospital is decreasing
4> the time between admission to hospital and arrival in the operating suite is decreasing
5> staggered admission times for patients
6> inadequate physical facilities for pre-anaesthetic assessment.

What is happening now?

Anaesthetists are anxious not to interrupt the efficient flow of an operating list. They therefore have to rush to the pre-op area or day-surgery unit to conduct the pre-anaesthesia consultation in what are often unsatisfactory conditions; they may have to consider leaving an incompletely recovered patient in the recovery area.

Of course, should the anaesthetist discover unexpected acute or chronic medical conditions (often unrelated to the surgical procedure) this will lead to a last-minute cancellation of the surgery. (Australian data reveal this occurs in up to 1 per cent of day cases.)

What can be done?

There is no question that ideal pre-anaesthesia assessment practice benefits patients, but it is important to emphasise the fact that ideal anaesthesia practice also assists surgeons in their efforts to provide best possible patient care.

The solutions to this emerging problem will be multiple and often location-specific, partially determined by the practice at individual institutions. However, a key component in solving this dilemma will be good communication between surgeons and anaesthetists.

Improving communication will allow anticipation of problems in advance and provide time for anaesthetists to invoke alternative pre-anaesthesia assessments where required. Health questionnaires used by either hospitals or referring surgeons to screen patients for health problems should be made available to anaesthetists well ahead of the operating list. The increasing utilisation of pre-hospital pre-anaesthesia consultations will minimise late cancellations, facilitate day-of-surgery admissions for major surgical procedures and provide improved patient satisfaction. Telephone consultations in advance of admission can also be used as both a screening tool and a means to address areas of concern for patients prior to the day of surgery.

Staggered admission times?

Whilst administratively appealing, staggered admission times necessarily create a situation of either an inadequate pre-anaesthetic assessment or theatre list inefficiencies. Patients need to be informed why they are being brought in early and anaesthetists need to see them.

To facilitate the most appropriate pre-anaesthetic treatment for patients, anaesthetists require the ongoing and continued support of their surgeon colleagues. Opening the channels of communication, particularly in healthcare institutions will enable both the surgeon and the anaesthetist to provide the highest level of quality care for the patient.

What is qualified privilege?

Use of the term 'privilege' reflects the legal principle that enables a person to resist disclosure of certain documents in a legal context.

Professor Guy Maddern,
Chair, ANZASM Steering Committee

This article uses the Australian and New Zealand Audit of Surgical Mortality (ANZASM) of the Royal Australasian College of Surgeons as its practical example; however, the same principles apply to any audit or activity (such as the morbidity audits), which is a declared quality assurance activity under the Commonwealth Health Insurance Act 1973.

PLEASE NOTE that this article is general in nature. Anyone requiring particular advice or seeking a considered opinion on the rights or obligations under qualified privilege should seek independent legal advice.

Qualified privilege is a generalised description given to the protection of information and documents within a quality assurance activity. ANZASM operates as a quality assurance activity and is used as an example for the purposes of this article.

What are Quality Assurance Activities (QAA)?
A QAA is an activity designed to monitor and evaluate health services, with the goal of improving the quality of health services delivered to the Australian public. ANZASM is most notable because it includes the peer review component, in which nominated reviewers give feedback on clinical practices and performance. The peer review process enables clinical events (albeit with the benefit of hindsight) to be analysed and reviewed for ongoing improvement of clinical services.

In order to attract the qualified privilege protection, ANZASM is declared under the Health Insurance Act 1973. There are similar provisions in the various state and territory health legislation schemes; however, the Commonwealth scheme has proved to be relatively static in its terms over time and has the benefit of being available for application in all states and territories. Hence, the Commonwealth scheme provides consistency for activities such as the College's audits which operate in many (and in some cases, across) state or territory boundaries.

What is the purpose of qualified privilege?
Qualified privilege exists to encourage full and frank disclosure and involvement in the QAA. The use of the term 'privilege' reflects the legal principle that enables a person to resist the disclosure of certain documents in a legal context.

What is protected within the QAA?
There are three categories of information (and/or documents) which are protected:

- information which came to be known solely as a result of the QAA
- documents brought into existence solely as a result of the QAA
- the participants in the QAA as long as they are acting in good faith (examples include the peer reviewers, surgeon participants and patients).

What are the consequences of disclosure?
The unauthorised disclosure of any information held within a QAA is an offence under the Act and carries a penalty of up to two years imprisonment. However, under the Commonwealth scheme (as in many others), there are prescribed circumstances in which information can be disclosed. Unless the proposed disclosure meets the prescribed test, the information (or document) cannot be disclosed.

The test for permitting disclosure?
There are three circumstances in which information held in a QAA can be disclosed:

- Information (or a document) can be disclosed, as long as the disclosure does not identify, either expressly or by implication, a particular individual or individuals.
- A person who would be identified by a disclosure (either expressly or by implication) has consented to the disclosure.
- Information or a document can be disclosed to the federal minister if it is necessary for the disclosure to occur, for the minister to determine whether certain conduct (detailed in the disclosure) constitutes a serious offence against a law in any state or territory

A person may be liable to a penalty of up to two years imprisonment if they disclose information outside of these prescribed circumstances.

The general exception to disclosure – non-identifying information

This exception enables the audit to publish aggregated data which discloses trends in the course of clinical practice, on a state- or territory-wide scale, on a de-identified basis.

The nature of the protection
The protection effectively extends to everything recorded in the course of the QAA activity. Therefore, everything from the information created in the surgical case form submitted to the audit to a first- or second-line assessment report is protected.

It should be noted that it is only the information held within the QAA which is protected. Much of the information submitted to a QAA is accessible in other areas and in other forms, such as hospital records. This information (in its original or alternative location) does not attract protection through the QAA activity, though it may of itself be protected by other means, such as through privacy legislation.

Some issues to keep in mind
The privilege is absolute in its nature. However, it is also possible to waive the privilege, either by intention or by implication. If, for example, a person consents to identifying information being disclosed, then the privilege is waived and cannot be regained.

I am a surgeon submitting to ANZASM and receiving peer-reviewed reports. What can I do with this information?
The fact that you are participating in the audit means that you are protected. The peer-reviewed reports are also protected. It is possible for you to consent to the disclosure of information, to the extent that it may identify you. Of course, once information is disclosed, the privilege of the protection of that information is lost.

It is also important to remember that you cannot disclose information which either expressly or implicitly identifies another person in the absence of their consent – this would include a patient or peer. Obviously in the case of ANZASM, there is no opportunity to obtain this consent.

In the face of an allegation or suggestion that there was a failure in clinical practices, it may at first seem useful to refer to and rely upon the peer review assessment as an exoneration of conduct. However, it must be borne in mind that the disclosure for these purposes could be in breach of the legislation, especially if the information from within the audit activity relates to a specific patient or incident, because it could be taken to identify an individual.

Furthermore, the feedback received by a surgeon through the audit process is not obtained in the medico-legal context, nor is it available for analysis in the same way as 'normal' medico-legal opinion. As a matter of practice the College would recommend against disclosure for this purpose, as it arguably offends the intended purpose of the legislation and the prerogative of the quality assurance function.

How will my privacy be protected now that participation in ANZASM is a requirement of the College Continuing Professional Development (CPD) Program?
Participation in ANZASM is now a requirement for Fellows in operative-based practice when a patient dies who has been admitted under the surgeon's care to a hospital participating in the audit.

Each year 3.5 per cent of Fellows are randomly selected to verify their CPD return. These Fellows are required to submit documentation showing that their CPD obligations have been met in that particular year.

The procedure for confirming whether or not a Fellow has participated in ANZASM is currently being finalised. It is anticipated that upon selection for verification, Fellows will be required to contact the project office of their state audit and request a letter confirming their participation in the audit. If a Fellow has had a reportable death and has participated in the audit, they will receive a letter confirming their participation. If a Fellow has not had a reportable death, they will receive a letter confirming that they have met their obligations for the purposes of the audit. The Fellow will then be required to submit this letter to the Department of Professional Standards for verification purposes. In this way Fellows selected to verify their CPD activities will consent to the disclosure of the fact of their participation. The details of the cases they have submitted to the mortality audits will not be disclosed to the Department of Professional Standards.

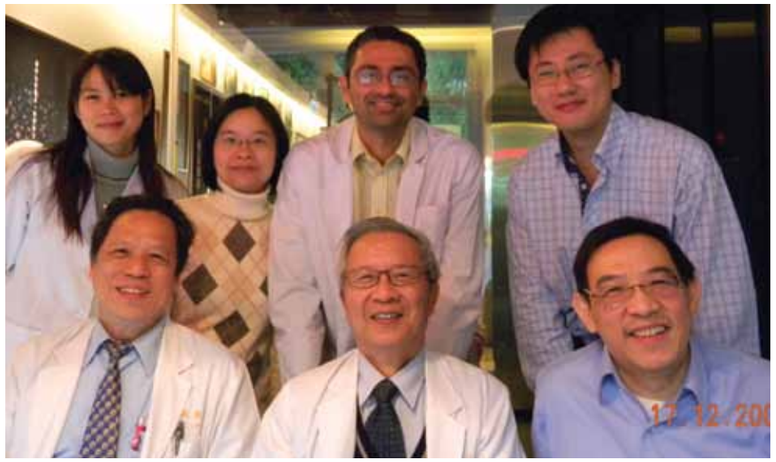
It is important to remember that a QAA has as its core focus the identification of trends in clinical practice and the continued development and improvement in clinical outcomes. It is a forward looking process, designed to highlight areas for improvement in clinical practice.

If you would like further information on ANZASM or on qualified privilege in general terms, please contact either Felicity England, Project Contracts Manager (felicity.england@surgeons.org) or Mr Gordon Guy, ANZASM Manager (gordon.guy@surgeons.

Covidien Travelling Fellowship Grant

An invaluable three weeks at the Chang Gung Memorial Hospital in Linkou, Taiwan

Frank Wang



Frank Wang (back right) with (front row) Professor Yi Yin Jan (Director of Department of Surgery), Professor Miin Fu Chen (Emeritus President of Chang Gung Memorial Hospital) and Professor Ta Sen Yeh (Director of Division of General Surgery) and other members of the department.

This was not the first time I had been to Chang Gung Memorial Hospital in Linkou, Taiwan. I can still remember the fascinating three weeks I spent there as part of my sixth year elective term under the supervision of the then Director of General Surgery, Professor M. F. Chen.

Returning to the hospital some 11 years later to undertake one year of hepatopancreatobiliary (HPB) and liver transplantation fellowship, I am still amazed at the sheer size of the hospital campus and the available medical technologies and infrastructures.

Chang Gung Memorial Hospital is a privately owned, universityaffiliated, tertiary referral medical centre offering level 1 trauma service. The main campus in Linkou has 3,715 beds across the adults' hospital, the children's hospital and the women's hospital – 150 of which are allocated to general surgery. It also possesses 90 operating theatres, with six dedicated general surgical theatre rooms. In addition, there are four general surgical intensive care units, including one ICU for liver transplantation and the other for trauma patients. As one could imagine, getting lost in the tangled maze of hospital corridors is not an infrequent event.

The Department of General Surgery has a particularly strong focus on HPB surgery and liver transplantation, performing more than 75 major liver resections and up to 75 pancreatic resections annually. In addition, there are two liver transplantation lists per week, operating up to 70 liver transplants per year; the majority of which would be living related adult liver transplantation.

Enormous caseloads

A typical surgical outpatient clinic would see 60-80 patients in half the day between the consultant surgeon and the senior registrar (fifth year surgical resident). In order to cope with the enormous caseloads, surgical patient journey from outpatient clinics to surgical wards and operating theatres has been carefully streamlined to improve overall efficiency.

Nursing specialists such as cancer care/transplant co-coordinators and operating assistants have been heavily relied upon to overcome the relative shortage of medical staff.

One thing that has been echoed by all travelling Fellows is the fantastic opportunity to experience a different culture in surgical training. In contrast to the nation-wide SET selection, the surgical training in Taiwan is entirely hospital-based. Advanced surgical training occurs in the last three years of the five year surgical residency program and each trainee is assigned a mentor for the duration of the training to ensure high standards of clinical and technical skills.

The trainees work six days a week and the concept of safe working hours is virtually non-existent. There is a significant emphasis on academia within the hospital and the department, as attainment of higher degree and research publication has a direct impact on the progression along the surgical hierarchy and financial remuneration. I have been very fortunate to be involved with several clinical research projects[1] last year, among which one original article has been published in the *British Journal of Surgery*[2] as co-first author.

The other personal achievement has been the completion of my Master of Clinical Epidemiology (Biostatistics specialisation) with guidance from the academic professors in Chang Gung University.

What cannot be over-emphasised is the invaluable support I have received from the Younger Fellows Committee and the generous sponsorship from the Covidien Travelling Fellowship Grant. The financial contribution from the travel grant has assisted me in paying for the accommodation and supported the cost of living in Taiwan and enabled me to broaden my experience in HPB surgery and liver transplantation.

References

1. Kuo IM, Wang F, Liu KH, Jan YY. Post-gastrectomy acute pancreatitis in a patient with gastric carcinoma and pancreas divisum. *World J Gastroenterol* 2009;15(36): 4596-4600.

2. Wu TJ, Wang F, Lin YS, Chan KM, Yu MC, Lee WC. Right hepatectomy by the anterior method with liver hanging versus conventional approach for large hepatocellular carcinomas. *Br J Surg* 2010;97(7): 1070-1078.

2011 Younger Fellows Forum, Barossa Valley South Australia 29 April - 1 May 2011 Younger.Fellows@surgeons.org

Occupational Medicine (Bridging) Course

November workshops will engender better understanding of work practices

Edward Schutz, FRACS
Course Convenor and member of Medico Legal Committee

Surgeons have an important role to play in assisting patients to successfully return to work. An understanding of a patient's working environment is vital in order for surgeons to advise on restrictions and alternatives to their work practices. Knowing more about workplaces can also help to improve communication between all stakeholders involved in the return to work process.

The Occupational Medicine (Bridging) Course incorporates whole day factory visits. Previous courses have proved to be a very efficient way for Fellows to see many commonly performed jobs, which are of significant benefit in case assessment and in providing return to work advice. Fellows who participated in visits in early 2010 to the Ford Assembly Plant, Melbourne, and to the Coal Mine Training Facility, Woonona, found the experience very rewarding and were amazed at what they saw and learnt.

Two more workshops are planned for 2010. Each workshop will have:

- an introduction to the industry,
- case presentations of successful return to work events by recovering workers and treating doctors,
- a tour of the operations,
- information about each site's Return to Work program, and
- a question-and-answer session.

Future workshops

In2Store and Sutton Tools
Friday 12 November, Melbourne

MORNING: In2Store in Somerton, a northern suburb of Melbourne. This is the largest undercover distribution centre in Australia. It handles the Coles distribution centre and also several other major logistics operations. The operations we will see include transport, storage, forklifts, conveyors and assembling of orders using both mechanised and manual handling processes. Part of the visit will include interactive case presentations.

AFTERNOON: Sutton Tools in Thomastown, close to In2Store. This is a large precision engineering company which has been manufacturing cutting tools over four generations, including medical drills. The company is actively training apprentices and engaging with the community. You will see workers operating a wide range of machinery and packaging and distribution aspects. Part of the visit will include interactive case presentations with the expectation of seeing workers in their return to work jobs. Programmed maintenance activity is also planned to coincide with the visit so you will see the replacement of grinding wheels, which is a more complex operation.

BlueScope Steel
Friday, 19 November, Wollongong

This site produces steel from the blast furnace through to milled product and many distinct processes. It is a huge site and we will be transported by bus to several sections of the plant and 'kitted up'. It is a noisy site and we will have speaker headphones. Participants must be fit enough to climb stairs in order to see workers operating all the processes and machinery.

This is a opportunity to see the equivalent of four factories in one:

- Blast furnace,
- Basic oxygen steelmaking,
- Continuous slab casting, and
- Hot strip mill.

These activities have activity has been approved in the College's CPD Program. Fellows who participate can claim 5 points per hour in Category 7: Other Professional Development /Category 8: Medico Legal.

For more information visit www.surgeons.org and click on Fellows or contact the Professional Development Dept on +61 3 9249 1106 or email pdactivities@surgeons.org

Findings could revolutionise tumour treatment

Scholarship aided investigation that could drive cancer research for the next 100 years

Dr Tinte Itinteang

A 15-year-long investigation into the causes, behaviour and treatment of strawberry birthmarks (haemangioma) has culminated in findings that could revolutionise the treatment of certain tumours.

The research, headed by internationally-renowned New Zealand Plastic and Reconstructive Surgeon Professor Swee Tan, discovered not only the genes that controlled both the growth and remission of the tumours, but also isolated the stem cells involved.

That discovery in turn led to the eureka moment when the team, working out of the Gillies McIndoe Research Institute based at Hutt Hospital in collaboration with scientists at the School of Biological Sciences at Victoria University of Wellington, uncovered the system controlling the behaviours of the stem cells.

Part of that research was undertaken by Plastic and Reconstructive surgical trainee Dr Tinte Itinteang (pictured above with colleagues), the 2009 recipient of the Foundation for Surgery Scholarship.

"Haemangiomas develop shortly after birth and affect up to one in 10 children, growing rapidly in the first year of life and then diminishing over the next decade," he said.

"However, for 10 per cent of these children, the tumours can grow so aggressively they can compromise the child's airway, eyesight and hearing and can ulcerate causing intense pain and bleeding for the infant.

"Until recently there was no satisfactory treatment for these children, and doctors resort to high dose steroids or even in severe cases chemotherapy.

Tumour 'suicide'

"Yet while such problematic haemangiomas affect only a small proportion of children, what made them a fascinating subject for research is that they obviously had internal systems that caused the tumour to grow and then spontaneously regress and if we could understand that system we could perhaps find a way to make the tumour cells die faster or, as we say, commit suicide."

According to Dr Itinteang that great leap forward came with a surprise discovery that beta blockers could cause the tumour to regress, yet even then the mechanisms were unknown.

Looking into that part of the puzzle became the basis of his PhD.

"We discovered that it was the Renin-Angiotensin system that was governing the behaviour of the stem cells, which was a considerable surprise given that it was thought only to regulate blood pressure," he said.

"Now we have found that using the beta-blocker Propranalol to block renin, stops stem cell multiplication which causes these cells to die, meaning that we can shrink the tumour within days and have it disappear within months."

The findings of the research have met with such admiration the team has already been awarded the prestigious John Mulliken Prize for the best basic science paper presented in Brussels at a conference of the International Society for the Study of Vascular Anomalies in April of this year.

In June, Dr Day and Dr Itinteang gave three presentations on their work at the annual meeting of the International Society for Stem Cell Research in San Francisco while Professor Tan has been invited to address the American Society of Plastic Surgeons' Meeting in Toronto in October.

Professor Tan has been quoted in New Zealand publications as saying the research into the haemangioma has the potential to drive cancer research for the next 100 years through the search to find methods to force tumour stem cells to die themselves rather than finding ways to kill them.

Intellectual rights

So significant are the implications of the research for cancer treatment and regenerative medicine, the news of the award presented in Belgium was kept quiet for some months as intellectual property rights were registered.

Dr Itinteang, originally from Kiribati, conducted his research through Victoria University's School of Biological Sciences under the supervision of Dr Darren Day and Professor Tan at the Gillies McIndoe Research Institute, and in collaboration with pathologist Dr Helen Brasch from the Hutt Hospital.

He said the team had recently received ethical approval to begin a clinical trial using ACE inhibitors for the treatment of haemangioma, which they believe could result in even lower doses, less side effects and faster regression.

He wished to thank not only the College for its support through the scholarship, but also the financial assistance provided by the Surgical Research Trust, the Wellington Regional Plastic Surgery Unit Research & Education Trust, the Reconstructive Plastic Surgery Research Foundation and Victoria University of Wellington's Internal Fund.

"The nature of such research into cell and molecular biology is very expensive with the cost of consumables quite high and these organisations funded most of it for which I am greatly appreciative," he said.

Dr Itinteang is now in the process of writing up his PhD Thesis and will return to the Plastic and Reconstructive surgery training program in December.

"I have always wanted to be a surgeon scientist and was greatly honoured to receive the Scholarship from the College, but still when I began this research I didn't expect to be involved in such exciting discoveries," he said.

"Yet the enigma and mystery presented by the behaviour of the haemangioma presented a great challenge that was hard to resist.

"Like all PhD students there were moments I felt a lot of doubt about my work, wondering if I had gone down the right path of investigation, but then we picked up this clue about the beta-blockers and then it just steamrolled, making this research a hugely satisfying experience."

With Karen Murphy

Congratulations on your achievements

We salute two worthy recipients of College Awards

Matthew Peters
The John Corboy Medal 2010

Matthew Peters is a fitting inaugural recipient of the first John Corboy Medal, given that he succeeded John Corboy as the Chair of the Royal Australasian College of Surgeons Trainees' Association (RACSTA) upon John's tragic passing in late 2007.

Matthew Peters is a leader among Trainees and is highly respected by his peers. He has served the college for five years in several roles and capacities with intelligence and dedication.

Matthew was first elected to the RACSTA committee in 2005. He served as Chair of the Queensland committee for two years and as Chair of the RACSTA Board for two years. During his tenure, he has represented Trainees at the Board of Surgical Education and Training, Education Board, the Surgical Leaders Forum, and as a Council Observer for two years.

He continues to serve the College as a member of the RACSTA Executive. He is an active participant of the Academy of Surgical Educators Advisory Committee, and is a co-opted member of the Younger Fellows Committee.

In all of these representative roles, Matthew has been a consistent and forthright advocate of Trainees. His views are widely respected, and as a result he has increased the profile of RACSTA and afforded it significant credibility.

Matthew has made major contributions to the establishment, growth and success of the Trainees' Association. Thanks to his effective leadership, RACSTA has evolved into a mature and well organised body that contributes strongly to surgical training. He has played an integral role in improving the relationship between surgical Trainees and the College. During his tenure, RACSTA initiated several significant projects including a survey of trainee working hours, and a training term feedback form. Matthew's service in these initiatives will help to ensure that the quality and safety of surgical training posts in Australasia is maintained.

Matthew's astuteness and diplomacy skills have been great assets in helping the College to negotiate several challenges. Matthew had significant representation in the transition to the SET scheme, and his input and insights helped to ensure that this was a smooth transition for most Trainees.

Trainees have appreciated Matthew's consistent focus on transparency and fairness, in such areas as Trainee interviews and selection criteria. He has been proactive in the College's response to bullying and harassment.

Matthew has fostered good relations between the College and several external parties. On Matthew's initiative, an international collaboration of Trainees' Associations was established, with Trainee representative groups from the US and the UK. He was awarded the Hugh Johnson Travel Grant for 2010, which he used to foster this collaboration. He initiated and presented a joint international trainees' perspective paper on working hours in surgical training at the last American College of Surgeons' Clinical Congress.

Matthew is regarded as an excellent and compassionate doctor. He has selflessly devoted his time to the College while maintaining his family commitments as a husband and devoted father of two, and continuing his training in plastic surgery.

The four criteria for the John Corboy medal are outstanding leadership, selfless service, tenacity, and service to the Trainees of the College. Matthew Peters has fulfilled all of these criteria with excellence, and he fully deserves the Award of the inaugural John Corboy Medal.

With Gregory O'Grady

Christine Allsop
Gordon Trinca Medal 2010

This award is presented to an individual who has excelled in any of the following criterion

1. An outstanding contribution to the Early Management of Severe Trauma (EMST) program.
2. A major contribution to trauma education or research
3. Demonstrated leadership in the management of the injured patient. Christine has contributed in all these areas of trauma care.

The EMST program celebrated its 20th year in Australia and New Zealand in 2008. Christine was a pivotal member of the team that nurtured its beginning. In September 1986, she accompanied Gordon Trinca, Stephen Deane, John Graham and Peter Danne to San Francisco to a special Advanced Trauma Life Support (ATLS) training course for overseas participants. Their task was to adapt and introduce the course to Australia and New Zealand. The American College insisted that the course be rebadged as the legal aspects of copyright had not been secured. EMST was born.

Christine's role was to recruit, develop and train the course co-ordinators in order for the program to begin. Course co-ordinators are the backbone of the program. They have to structure the course, manage the logistics, run all aspects of the course and keep everyone on side and liaise with directors, instructors and participants. She took on the task with great enthusiasm and dedication with an attitude that nothing was unachievable or impossible. She led by example. It was essential for courses to be run in regional and remote areas. Christine had an ability to set up a course in any environment, no matter how under-resourced or difficult. Soon she had a willing group of committed co-ordinators who followed her example. She set the standard and the attitudinal personality of our course co-ordinator group.

Christine has made many other contributions to trauma education and research. An intensive care trained nurse; she is currently the Trauma Review Project Manager for the New South Wales Institute of Trauma and Injury Management. She has been a committee member of the NSW Death Review Committee, the Trauma Services Committee and the Trauma Network Committee.

Christine has published and presented nationally and internationally on trauma care. Her contribution has been recognised by this College by the awarding of the Merit award in 1991. She is the first woman and the first nurse co-ordinator to receive this award.

With Phil Truskett

Short-term specified training

An IMG can now be assessed by the College in three different ways

Simon Williams
Chair, Board of Surgical Education and Training

In 2008, a uniform process for assessing International Medical Graduates (IMG) was developed as a Council of Australian Governments (COAG) initiative and implemented to provide nationally consistent alternative pathways to conditional registration. These were the Competent Authority pathway, the Standard pathway and a revised Specialist pathway.

The College has a role in the Specialist pathway. There are three different ways an IMG can now be assessed by the College of Surgeons.

- Advanced standing towards comparability (substantially or partially comparable to an Australian trained specialist – the specialist assessment pathway);
- Area of Need (AoN) assessment (based on an assessment of qualifications and experience against an AoN position description); and
- Specialists in Training (for overseas trained Specialists or Specialists in Training who wish to undertake specified training in Australia).

The Specialist Assessment pathway for registration is the only one that also provides IMGs with a pathway to Fellowship of the College. While IMGs applying for an AoN assessment are generally also assessed for comparability, an AoN assessment on its own does not lead to Fellowship.

The Specialist or Specialist in Training IMG undertaking a short-term specified training position assessment is not as well known as the other assessments performed by the College. This assessment is available to IMGs who may not have a specialist qualification, but wish to undertake a period of practice to Australia to acquire specific skills and knowledge. IMGs are required to apply directly to the Medical Board of Australia for conditional registration, with support from the relevant College.

Prior to submitting an application for assessment, it is essential that the employer/sponsor and/or institution has assessed and verified that the applicant:

- is an overseas-trained specialist or is an overseas specialist-in-training, having either passed the relevant specialist examinations or is no more than two years from completing specialist training in their country of training;
- will be undertaking this position (which may include such opportunities as exchange fellowships) for the purpose of specific training or upskilling in their specialty or obtaining experience in their specialty not available in their country of training;
- has the stated intention of returning to their country of training at the end of the short-term program, which shall not be for a period of longer than two years.

Based on a position description and details of the training program, the College's role in this assessment is to determine if a) the position offers valid educational experience and b) if the IMG nominated for the position has the appropriate skills and experience to undertake the educational program. At a minimum the position must provide:

- an appropriate scope of work
- adequate clinical and academic supervision and
- a designated supervisor

With the implementation of the Medical Board of Australia (MBA) there is an expectation that the IMG or their agent will provide information to the MBA to satisfy the requirements for limited registration for post-graduate training or supervised practice as a medical practitioner. The College assessment will form part of the application to the MBA.

Further information, including the Endorsement of Short-Term Training Positions in Australia Policy, is available on the College's website www.surgeons.org.

Are you a flying surgeon?

Have you ever thought of combining your surgical career with your love of flying?
Do you already provide a flying outreach service?

› I am trying to identify surgeons who have, or are interested in obtaining, a pilot's licence.
› The aim will be improving outreach services in Australia and education of remote practitioners through information sharing and collaboration.
› The initial proposal is to establish an on line chat group and organise an annual conference.

If you are interested in pursuing this concept then please contact Neil Meulman FRACS PPL. neilme@vic.chariot.net.au

For more than 20 years, the College has welcomed a Fellow of the American College of Surgeons (ACS), to participate in the Annual Scientific Congress (ASC). As well as participation in the ASC the Travelling Fellow visits hospitals and research institutions for further professional exchange. The College has recently established the Hugh Johnston ANZ Chapter of the ACS Travelling Fellowship, which provides support for an annual visit by an Australian or New Zealand surgeon to the ACS Congress. The first RACS Fellow is expected to travel to the ACS Congress in 2011.

Forming ties with USA

Dr Nipun Merchant,
MD, FACS, the ANZ Chapter Travelling Fellow for 2010 writes of his experience.

It was indeed an honour to serve as the 2010 American College of Surgeons Australia and New Zealand (ANZ) Travelling Fellow. This was truly a memorable experience. Travelling to the 'Land Down Under', meeting colleagues, Trainees and surgical leaders from Australia and New Zealand and exchanging ideas in scientific and social settings was unparalleled. Perhaps as important, I had the opportunity to develop what will hopefully become lasting friendships and collaborations for future interactions.

Perth

My journey began as my wife and I travelled to Perth where the 2010 Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS) was held. Perth is a beautiful city along the Indian Ocean and I was fascinated to learn that it is perhaps the most remote metropolitan area in the world.

One day prior to the commencement of the Congress, the 2nd Annual "Developing a Career in Academic Surgery" course, run jointly between the Association of Academic Surgery (AAS) and the Academic Section of the RACS, was held. Spearheaded by Fellow Richard Hanney in collaboration with members of the AAS, this course has been a tremendous success.

It provided an ideal forum for interaction and motivation for young, aspiring academic surgeons particularly as there is no pure model for academic training or promotion in the Australian health care system. The course focuses on providing young surgeons', trainees' and students' insights into careers in academic surgery and provides them with an opportunity to directly interact with more established surgeons in an effort to help inspire and recruit potential academic surgeons. During the course, I gave a talk entitled, "Building an Academic Career Pathway: Opportunities, Obstacles and Getting Past Them."

The ASC began the following day. Prior to my arrival, Dr John Buckingham, President of the ANZ Chapter of the ACS, had helped facilitate my trip by putting me in touch with several of the convenors responsible for organising the various scientific programs of the meeting. They, in turn, arranged for my participation in their respective sessions. I was involved in several aspects of the program including the Breast Cancer session of the Surgical Oncology program, the Colorectal Session, the Hepatopancreaticobiliary (HPB) session and of course had the privilege of delivering the ACS Keynote lecture.

Following the lecture, Professor John Buckingham hosted the luncheon of the ANZ Chapter members. The year 2010 marked the 25th anniversary of the ANZ Chapter. I had the opportunity to address the Chapter members, Professor Ian Gough, RACS, President of the Royal Australasian College of Surgeons and Dr Lamar McGinnis, President of the American College of Surgeons during this session, express my gratitude for their support of this fellowship and highlight the importance of this wonderful professional interchange. Dr Buckingham then made an exciting announcement. Starting next year, in addition to an ACS member travelling to the RACS meeting, an Australian Fellow will also be selected as a travelling fellow to the US and the ACS meeting, further enhancing the vibrant association between the ANZ Chapter with the ACS.

Sydney

After the RACS meeting, my wife and I travelled to Sydney, where our children joined us. We had the opportunity to see many of the sights. We were hosted there by several friends including Dr Richard Hanney and Dr Stan Sidhu. Dr Hanney took us to Cottage Point which, while within the Sydney city limits, feels like an oasis that would be found miles away from a major urban city.

While in Sydney I spent time with Dr Sidhu, Professor Ross Smith and Doctors Jaswinder Samra and Tom Hugh at the Royal North Shore Hospital. While there, I attended their HPB Tumour Board and Multi-disciplinary GI conference, spoke at their Surgical Grand Rounds and spent time with them in the operating room, discussing our research and exchanging ideas. My time at Royal North Shore Hospital highlighted the quality, depth and breadth of the clinical work being done there.

I then spent time at Bankstown Hospital with Dr Andrew Biankin. I participated in and spoke at their GI Tumor Board and participated in their ward rounds. It was interesting to note that early discharge management is more difficult there as they do not have a formal system for skilled home nursing care. Therefore, patients tend to stay in the hospital until they are more fully recovered.

Dr Biankin also took me to the Garvan Institute, a free-standing facility of biomedical research, currently undergoing a multi-million dollar expansion, where he runs the Pancreas Cancer Genome Project. I spoke with several members of his laboratory and gave a talk based on my laboratory research in "Src Signaling in Pancreas". This was truly a premier group of researchers who stimulated inquisitive interaction.

Melbourne

From Sydney, my family and I travelled to Melbourne where we were hosted by my good friend, Fellow Dr Bruce Mann, of the Royal Women's Hospital. Dr Mann and I have known each other for more than 14 years since our time together as Surgical Oncology Fellows at Memorial Sloan-Kettering Cancer Center (MSKCC). He, his lovely wife, Fellow Dr Julie Miller, and their three children were most gracious and opened up their home to us during our stay in Melbourne.

Dr Mann had arranged for me to meet with several of the trainees and registrars who had prepared several short talks. I was joined there by Fellow Cuong Dong, an upper GI surgeon in Melbourne and also MSKCC alumni. It was a pleasure spending the afternoon with them and discussing their thoughts about their training as it compared to training in the US and also their aspirations of and concerns about pursuing an academic career.

In Melbourne, I also visited several other colleagues and medical centres. I met with Tony Burgess, PhD from the Ludwig Institute, with whom we have an ongoing collaboration of our colorectal cancer genetic profiling work.

I was hosted by Fellow Ben Thomson, HPB and upper GI surgeon at the Peter MacCallum Cancer Centre (the 'Peter Mac') where I attended the HPB Tumour Board and toured their facilities. I also spent time with Wayne Phillips, one of their leading scientists, discussing our respective research and understanding the differences in research funding between our two nations.

One of the most memorable meetings I had was with Professor Robert Thomas, previously the Chief of Surgical Oncology at Peter Mac and who now works for the Department of Health for the Victorian State Government. The state and federal government have committed almost $1 billion to create a comprehensive cancer centre in Melbourne, a combined effort between several institutions including Royal Melbourne, Royal Women's, Peter Mac and the Ludwig Institute, among others. A stimulating discussion following our meeting about the change that had to occur in the mindset and culture of some of these institutions to bring their important resources together for the benefit of a greater good.

After a whirlwind tour of Perth, Sydney and Melbourne, it became quite apparent that clinical care and research in Australia is second-to-none. Despite many similarities to the US, there are also dramatic differences in the way our Australian colleagues practice surgery – particularly the two-tier, 'public' and 'private' system.

The worldwide economic downturn has affected many public hospitals leading to significant cuts in resources. Therefore, most academic surgeons engage in a parallel private practice to supplement their income. As in the US, with these added clinical responsibilities, many academic surgeons continue to struggle with the time and financial constraints associated with their academic pursuits. However, while previously, most trainees in Australia had to go oversees to pursue additional research training, there has been tremendous growth in several centres of research excellence, providing high-quality training for young surgeons.

Another revelation I encountered visiting different parts of Australia was fierce regional pride and passionate people. Debates persist as to the best sport – Australian Rules Football versus Rugby League. Australians are also very passionate about their wines and I sampled some excellent vintages.

I would like to thank the American College of Surgeons and the Australian and New Zealand Chapter for providing this once-in-a-lifetime experience for my family and me. My trip to Australia was full of professional and personal development. It allowed me to establish important clinical and basic science collaborations, and promoted an intense exchange of ideas. I know many of the friends that I met during this trip will be lifelong colleagues. I am indeed indebted to the ACS for this generous opportunity.

Presentations by the ACS Travelling Fellow at the 2010 RACS ASC

"Molecular Imaging and Prediction of Tumour Response" – based on some of our research on in vivo imaging of cellular proliferation, apoptosis, and drug delivery to tumours.

"An Experimentally Derived Metastasis Gene Expression Profile Predicts Recurrence and Death In Colon Cancer Patients" – based on some of our recent work in which we identified a 34 gene profile derived from a liver metastasis mouse model and advance human colorectal cancers that is highly predictive of good or poor prognosis in Stage II and III colon cancer patients.

"Current Approaches to Management of Pancreatico-enteric Neuroendocrine Tumors." ACS Keynote lecture – "Progress in Pancreas Cancer Management: Not an Oxymoron" - described some of the significant advances made in the understanding of the molecular and genetic progression of pancreas cancer resulting in potential novel therapies.

Homestay Accommodation for Visiting Scholars

Through the RACS International Scholarships Program and Project China, 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 visiting 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, 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 reasonable rental and eternal appreciation.

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

Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring St, Melbourne Victoria 3000, Australia
T: + 61 3 9249 1211 F: + 61 3 9249 1236
E: international.scholarships@surgeons.org

Wine is poetry in a bottle - R.L. Stevenson

The techniques of wine production are basic, cut and dry like a surgical mind

OPXIV

Felix Behan
Victorian Fellow

I was pleasantly surprised recently when Val Usatoff, a wine connoisseur (with cellar), gave me a bottle of Lake's Folly wine from the Hunter Valley. It prompted me to explore the history on this prestigious boutique vineyard. I gleaned that the founder, Dr Max Lake (who passed away in 2009) established the vineyard in 1963. My late friend John Hueston, pre-eminent in the international field as a hand surgeon first acquainted me with this label in 1974. Max Lake and John had met through their mutual interest in hand surgery and subsequently with the establishment of the Australian Hand Surgical Society.

There is another interesting connection with the surgical fraternity. My former registrar, Ramin Shayanm, is the grandson of Leonard Atkins. Leonard was a close friend of Max Lake, both being on the staff at the Bankstown Hospital in the '60s. Ramin's grandfather, now 95 years of age, revealed the origin of the title for the vineyard. Max Lake was a bon vivant and epicurean with a perennial love of life. Leonard was the same, both enjoying a long life – be it genetics, wine or both?

When Max was about to establish the vineyard in 1963, the first planted in the Hunter Valley in the 20th century, Atkins was doing most of the on-call work for Bankstown at the time (when Max was not available). Leonard unhesitatingly suggested 'Lake's Folly' when asked by Max what to call the produce. Later on, when the winery was well-established, they entertained William Dobell, another Hunter Valley local whose studio was at Wangi. While enjoying the fruits of this boutique vineyard, it prompted Leonard to whisper in Max's ear sotto voce "looks like Lake's Folly was a success". This story reminds of the quote from the Queen Mother saying to her daughter one day over lunch "perhaps, darling, you shouldn't have that second glass of wine. You have to rule this afternoon." Wine quotes usually have an element of lubricated spontaneity.

Ownership of this boutique vineyard is now in the hands of Peter Fogarty (since 2000). It concentrates on two wine varieties – Cabernet and Chardonnay. The techniques of wine production are basic, cut and dry like a surgical mind, and the terroire is superb. I liked the simple summary of production – hand-picked, gentle crushing, open fermentation, extended yeast lees contact for the Chardonnay and discreet exposure to French oaks (Margaret, my assistant had to explain the meaning of lees to me – you can appreciate I'm a beer drinker). The vineyard epitomises the ingredients for its success, embracing the grape varieties chosen, vine location, pruning for low production with high quality and trellising for flavour concentration.

Enviable reputation

Various wine experts have praised the fruits of the vineyard over the years. In 1973 Len Evans says the quality of the wine is such that its importance greatly outweighs its size. Dan Murphy placed it in the "very great" category. Halliday in the Australian Wine Guide states this vineyard has the enviable reputation for quality and style. The 2000 vintage he rates "as close to perfection as the real world will allow". In his 2006 Wine Companion, he sees only four Hunter Valley wines making the best of the best three from Lake's Folly. What a rewarding thing to say about a vineyard started by a surgeon and I am sure his surgical ethos of simplicity and technical refinement would have contributed to its success.

Wineries in Australia have a long association with the medical profession. It prompted me to phone my colleague Phil Slattery, another international hand surgeon of repute whose winery lies in the Yarra Valley in Victoria. I asked for a one-liner of his experiences and he said "never again!" He mentioned various surgeons around Australia who had explored this hobby not only to enjoy some profits, but also more importantly to have a tangible end-product to hold, to feel, to taste and to enjoy (of course, I'm talking about a glass of wine). He recalled an episode that occurred at the Australian Hand Surgery Society Meeting in the Clare Valley in South Australia in 1999. A show of hands indicated that almost 80 per cent in the group were associated with vineyards either commercially or recreationally.

When you see an outcome like the Max Lake story, we all yearn for the rewards at the end of the rainbow. While some are commercially successful ventures, others have a sad end (drought, overproduction, world glut and financial crisis).

Wayne Stott's prestigious and commercially successful winery Wild Wood has fallen victim to such an outcome. The Victorian Government will forcibly acquire this marvellous vineyard in 2020 for infrastructure development, as reported in The Age some months back (I hope the price reflects the value).

In South Australia, Richard Hamilton, from a family lineage of successful vintners, produces among others, Old Vine Shiraz, of a quality that ranks with the best in my experience. Another colleague Gwyn Morgan is yet another wine producer, whose Merlot was given to me one evening when I enjoyed his family's hospitality. It is an Australian wine with the Bordeaux characteristic (colour, texture and aroma). You appreciate I avoid descriptors of wine experts like blackcurrant, chocolate and cassis etc, which as we know often reflect the oak factor in the casks).

In a recent publication of Surgical Life, I came upon some more historical information. The first Australian wine doctor was Dr Penfold. Having trained at Bart's, he settled outside Adelaide in a place called Magill. His medical practice was conducted from his cottage called the Grange. His wife Diana used French cuttings to produce the Mary Penfold wine – an ideal treatment for anaemia at the time.

I visited the Lindemann's winery museum years ago. It was established by Dr Henry Lindemann, another Bart's graduate, producing table wines and fortified wines, the latter being the basis of the apothecary mixtures he formulated.

In Western Australia, at Margaret River, Dr Kevin Cullen, a paediatrician, planted his vineyards in 1966. At Vasse Felix the initial plantings by Dr Cullen were followed by the establishment of a vineyard by Dr Tom Cullity, a cardiologist.

Medicine and vines

Thus one can appreciate a long standing connection exists between the medical profession and the product of the vine. Is it the reversion to an open air environment with one's hands in the soil? Is it the complete separation of lifestyle from the commitments of the medical profession and the impositions of hospital politics which are left behind on Friday afternoon? Is it the element of a high disposable income (formerly) among the medical profession? But most importantly, every person loves a cellar where his wine is stored, selected on merit with the dust as a bonus and the cobwebs adding to the mystique.

If Grange is expensive, let me conclude with a brief story that appeared in the financial pages of *The Age* some months back. It was about a book called The Billionaire's Vinegar, documenting the litigation and possible fraud surrounding the most expensive bottle of wine ever sold at auction at Christie's in 1985. Michael Broadbent was the world renowned wine connoisseur, establishing Christie's wine department. The book was written by Benjamin Wallace and reached the top of the New York Times best-seller list.

Lot 337 was the first item on the program and Chateau Lafite from 1787 was the oldest authenticated vintage of red wine ever to come on the Christie's market. More importantly 1787 was etched onto the glass bottle with the initials Th. J, denoting Thomas Jefferson. A German wine collector Rodenstadt made the discovery fortuitously in a house in Paris, in the Marais district, where the bottles were cellared and hermetically sealed between 50-57°F since the time of the French Revolution.

He had the knack of making discoveries of rare wine which was the subject of wine tastings for the elite that he often conducted.

Was it a good year?

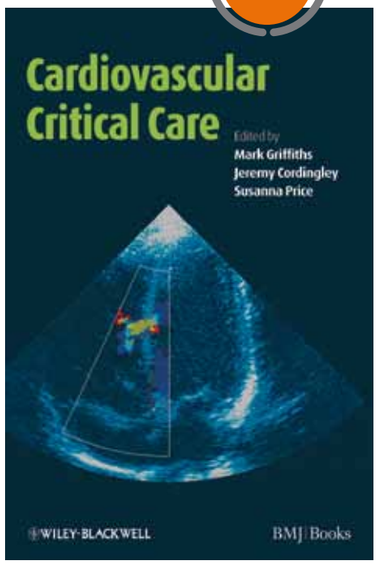
From the circumstantial evidence, Broadbent argued overwhelmingly for the wine's authenticity. I love the quote from the Christie's catalogue "Estimated value – inestimable". The auction attracted the attention of collectors from around the world, particularly American (before the 1987 crash). The price volleyed between £20,000 to £40,000 and when the bidding reached £75,000 a new record was set for a bottle of wine. It was bought by an American. The rest of the book I leave you to peruse and enjoy but when certain elements came to light such as modern printing of labels in the old style, but attached with modern glue, allegations of fraud surfaced. The American buyer thinks he has been short changed and the matter is now the subject of legal proceedings; but really it is as exciting as a Sherlock Holmes mystery.

In conclusion I must quote from another famous American also a consul in Paris in the late 18th century, Benjamin Franklin who once said "time is money" – which is really a synopsis of this liquid tale.

Welcome to the Surgeons' BOOKCLUB

Highlighted in this month's issue are recent and new titles from across the spectrum of books available from John Wiley & Sons.

BOOK OF THE MONTH 20% Discount



Cardiovascular Critical Care

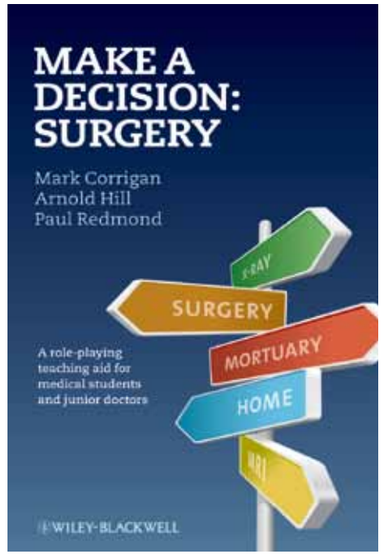
Mark Griffiths, Jeremy Cordingley and Susanna Price (Editors)
9781405148573 | Hbk | 496 pages | August 2010
~~AU$150.00~~ / AU$120.00

Remarkable improvements in cardiac survival rates have made cardiovascular critical care much more common, but no less challenging for the practitioner. This important volume draws on the skills of an expert team of editors and contributors to present a timely overview of clinical practice.
The book covers the full range of the field, from pre-operative assessment and the haematological complications of cardiovascular surgery and critical care to the care of patients with:

- Arrhythmias
- Heart Failure
- Adult Congenital Heart Disease
- Mitral Valve Disease
- Aortic Valve Disease
- Infective Endocarditis
- Vasculitis

The authors also address the special problems associated with the management of conditions consequent upon pregnancy, eclampsia, and the hypertensive crisis.

15% Discount

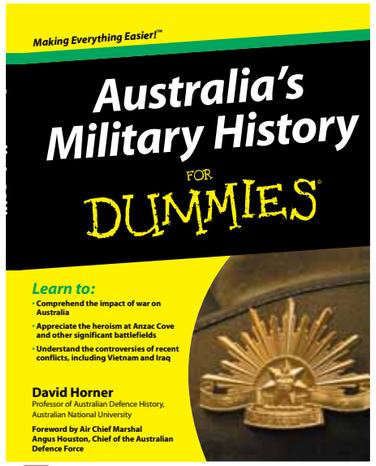


Make A Decision: Surgery

Mark Corrigan, Arnold Hill, Paul Redmond
9781405196840 | Pbk | 224 pages | August 2010
~~AU$29.95~~ / AU$25.46

Taking a role-playing approach, *Make A Decision:* Surgery allows you to be the book's main character – Dr A. Simpson – a junior general surgeon on call in a busy teaching hospital. Your decisions and actions determine the clinical outcomes of real patients within a number of scenarios. Every decision you make is scored and evidence-based feedback is presented at the end of each scenario together with the correct clinical response and an explanation of what actually happened to the patient.
Blood work and radiological investigations presented in typical clinical formats allow you to practise your data interpretation skills, while your skills in clinical communication are tested to the full as you interact with patients and their families as well as co-members of staff.
Perfect for medical students, junior doctors, and surgery trainees who are looking for a scenario-based, interactive way to learn.

15% Discount



Australia's Military History For Dummies

David Horner
9781742169835 | Pbk | 384 pages | August 2010
~~AU$45.00~~ / AU$38.25

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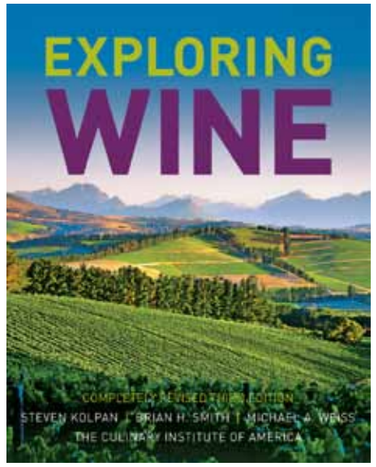

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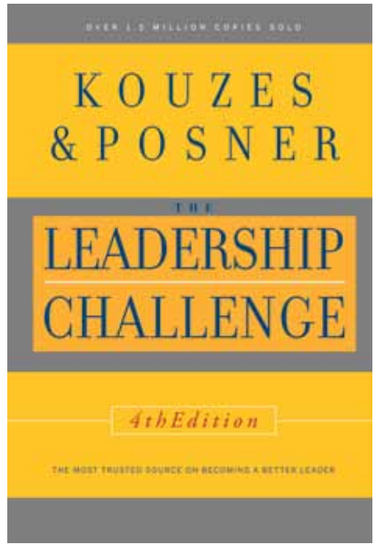

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Statutory Protection

Dear Editor,

I refer to the article on Mandatory Reporting (*Surgical News*, Vol 11, No 7, August 2010) by College Solicitor Michael Gorton with particular reference to the section headed "Protection". In that section, Mr Gorton indicates that Section 237 of the Health Practitioner Regulation National Law Act 2009 provides statutory protection for health professionals who report notifiable conduct provided that the report is made in "good faith". Section 237 applies not only to mandatory notification of conduct as defined in Section 140 of the Act but also to voluntary notifications made under Section 144. The grounds for voluntary notification are wider than those for mandatory notification, but the statutory protection remains the same.

Fellows of the College should be aware that this statutory protection does not prevent a professional about whom a complaint has been lodged from instituting proceedings in defamation. MIPS has had one recent case where this occurred when not only was the action brought in defamation but it was also brought for "injurious falsehood" and additionally for "misleading or deceptive conduct" under the NSW Fair Trading Act. After a number of days of legal argument the court struck out the action in defamation, the two other causes of action remain on foot. The plaintiff has lodged an Appeal with respect to the action in defamation. All this indicates that while there is some statutory protection for health professionals who report other practitioners, they are not necessarily protected from legal actions being brought even though some of those may well fail.

It is for the reporting practitioner to establish that the report was made in good faith and to do so may present a considerable challenge where the practitioners are from the same branch or specialty of their profession. It is MIPS' view that where the question of good faith in mandatory reporting is raised that that should be a matter treated as a disciplinary rather than a legal question.

Failure of a healthcare practitioner to report in accordance with the legislation does not constitute an offence but may result in a finding that they have engaged in professional misconduct by not doing so. It is important to ensure that any Fellow when making a notification, mandatory or voluntary, makes it in good faith, and ensures that they have formed a reasonable belief of the alleged misconduct when undertaking mandatory notification.

Yours faithfully,
RWL Turner LLB FRCS FAORthaS
Chairman

College response

Dear Editor,

I have reviewed the correspondence from Mr Turner.

I am aware of the case in New South Wales to which Mr Turner refers. That case is based on the NSW legislation, which does not offer as extensive protection as is afforded by Section 237 of the National Law, which now applies to mandatory reporting.

The particular case in NSW is based on a more limited protection to those who make a mandatory report in NSW under the former NSW legislation.

The protection afforded under the new National Law is broader and provides: "A person is not liable civilly, criminally or under an administrative process for giving the information."

The protection under section 237 for a mandatory report, or a voluntary report, is far more extensive than the protection given under NSW legislation.

There have been a number of reports in the general media about the case in NSW. It is important to note that it is a case only referrable to the previous NSW legislation, and not the new National Law.

Yours faithfully,
Michael Gorton
College Solicitor

In Memoriam

Information about deceased Fellows

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

Donald Wallace Fleming, WA General surgeon
Andrew Brian Fagan, SA Orthopaedic surgeon
Douglas Trevor Beetham, NZ General surgeon
Sir Randal Elliott KBE GCStJ, NZ Ophthalmologist
Gaston Napoleon Arthurs, NSW Neurosurgeon
Alan Geoffrey Watt, WA General surgeon
Ian Reid, NSW paediatric surgeon
Rowland Norman Gale, TAS vascular surgeon
Barrie Russell Jones, NZ ophthalmologist

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website www.surgeons.org go to the Fellows page and click on In Memoriam.

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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

The Royal Australasian College of Surgeons invites nominations of worthy individuals for a SURGEONS INTERNATIONAL AWARD

The Award provides for doctors, nurses or other health professionals from developing communities to undertake short term visits, usually of 4-6 weeks duration, to one or more Australian hospitals to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's country.

The Award may cover a return economy class airfare, necessary accommodation costs and living expenses for the recipient. The value of the award varies up to a total amount of AU $12,000, depending on the requirements of the candidate's programme.

More than one award can be made in any one year.

NOMINATION CRITERIA

> Surgeons participating in the RACS International Development Program are encouraged to nominate worthy individuals they have identified while undertaking international development activities.
> Surgeons who nominate worthy individuals with whom they have had contact must be willing to accept the responsibility for arranging a suitable program and acting as a personal host to the award recipient.

NOMINATIONS MUST INCLUDE

> Personal and professional information concerning the nominee;
> Objectives of the proposed visit;
> Anticipated benefits to the nominee and their home country;
> Names of the International Development Program team members responsible for organising the visit (including accommodation, training program and travel within Australia);
> An outline of the proposed training program and activities; and
> Letters of recommendation from the nominee's hospital and/or Health Department with an indication of the local importance of any upskilling resulting from the Award.

FORWARD NOMINATIONS TO:

International Scholarships Officer
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 – 290 Spring Street, East Melbourne VIC 3002
E: international.scholarships@surgeons.org
T: +61 3 9249 1211 F: +61 3 9276 7431

8th Cowlishaw Symposium

THE SPEAKERS ARE:
Mr Wyn Beasley,
Mr Felix Behan,
Mr Geoff Down,
Hon Prof Sam Mellick,
Ms Elizabeth Milford
Prof John Royle,
Mr Phillip Sharp,
Prof Donald Simpson
Prof Alan Thurston,

Mr Sharp has been invited to deliver the eponymous address (the Russell Memorial Lecture).

Sat 6 November 9:30am

Royal Australasian College of Surgeons, 250-290 Spring St, East Melbourne **(Level 2Training Area)**

Fee: $120.00 inc.

GST per person covers morning tea, lunch, afternoon tea and cocktail reception

Contact geoff.down@surgeons.org +61 3 9276 7447

8TH COWLISHAW SYMPOSIUM

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Cancellations must be received in writing prior to Friday 15 October 2010 and will incur a 20% cancellation fee. Cancellations received after this date will not be refunded.

Grafting in the 1950s

Experimentation was the name of the game in the 1950s

Bernard Catchpole,
West Australian Fellow

It was about 1956 that an interest in making arteries was born, in the Department of Surgery, the University of Sheffield, England. Dick Jepson was Foundation Professor in charge, later to be also appointed Foundation Professor in Adelaide. Many new materials were becoming available and a liaison was established with Courtaulds, the fibre and fabric conglomerate and with a young man with interest and ingenuity in weaving tubes.

About that time, Charles Rob, Professor of Surgery of St Mary's Hospital in London, began to use polyvinyl alcohol (PVAl) sponge for aortic replacement. We followed suit. The hospital engineers made a set of formers in brass. Each was a solid rod to which was screwed at one end two smaller calibre rods to represent the aorta and the two common iliac arteries. Three sizes of these bifurcations were made. To make a PVAl aorta, numerous pieces of foam about six to eight millimetres thick were wrapped around the former. The strips of uniformly applied foam were then bound in place by cotton tape wrapping the entire bifurcation. When the time came to replace an aortic aneurysm, the appropriate sized preparation was autoclaved.

This heat treatment bonded the PVAl foam to produce a soft white smooth bifurcation which would hold sutures well and could be cut without any fraying of the cut edges. These grafts went in exceptionally well. Charles Rob made a film for BBC Television demonstrating an aortic replacement. However, shortly into the series of aneurysm replacement, the grafts began to rupture. The material was abandoned! We did not know that PVAl is slowly, but inexorably water soluble.

Nylon was being used and grafts became commercially available. The woven fabric tubes were crimped to make them flexible without kinking and 'calendered' or heat rolled to reduce bleeding through the fabric's interstices. The results were usable, but rather stiff and the cut ends tended to fray. Not ideal.

New type of tube

Meanwhile, our young weaver had got to work. He made a new type of tube from nylon. It consisted of a coiled monofilament covered by a fine braid of multifil, both of nylon. This gave strength to the tube by providing the weft as it ran around the tube, multifil nylon being used for the warp. This tube was flexible and was studied experimentally.[1]

Dacron (the polyester fibre brand of Dupont) or Terylene (the brand name of ICI's fibre) were available, and Courtaulds was producing Courlene, a polyethylene fibre which our weaver wove into tubes. We worked on these. A problem was how to make these tubes kink free and not too porous. Eventually we solved this by using a finely threaded brass rod, which fitted into the polyethylene tube. A length of thin wire was then wound round the graft (to be) driving it into the depths of the thread. It was then boiled for five minutes, cooled, and the brass rod removed. This left a crimped flexible tube. Its fibres had been compressed by the wire and heat, but was still too porous. A finer polyethylene fibre would have been better to reduce fabric interstices size. The material was inert in the tissues and looked promising.[2]

At about this time, we realised that how various fibres behaved in the tissues was not very clear. Did they lose strength in the tissues and did they stir up a reaction? So we measured the breaking strengths of a range of fibres of both natural and synthetic material, buried lengths of them in the Rectus abdominis sheath of animals for six months, and re-examined them. We found that silk, which contains a good deal of the protein keratin, lost all strength and fragmented. Linen thread being largely of cellulose lost almost all of its strength within the six months. Polyester, polytetrafluorethylene (PTFE) and polyethylene lost virtually none of their strength, but not so nylon. The fine fibrils of a multifil thread rapidly broke up in the tissues although the thicker monofil retained much of their strength. This proved to be due to a chemical change on the surface

> *"However, shortly into the series of aneurysm replacement, the grafts began to rupture. The material was abandoned! We did not know that PVAl is slowly, but inexorably water soluble."*

of the nylon which left a coating without strength, but which was waterproof. Thus the monofil was protected, but the process seeped right through the fine multifil fibre, causing their failure.[3]

Vascular valves

While experimenting with polyethylene tubes, we developed some valves. If the end of a fabric tube is inverted to form an intraluminal cuff, and is then stitched to the wall in the long axis in three places 120 degrees apart, a crude tricuspid valve is formed. A suitable former with three circumferential bulges could be used to develop a 'sinus' behind each cusp during the heat calendering process of the tube.

Our weaver made for us a woven tube with heavier monofilaments at three positions 120 degrees apart. By teasing these from the fabric which was then cut away, we could form chordae tendinae from the centre of each cusp, fusing their ends to their parent monofilament just proximal to the cusp margin.

Would these have worked? Experimentation was the name of the game in the 1950s.

References

1. A new type of arterial prosthesis. Catchpole, B.N. and Curran, R.C. *Surgery,* 44,1958, 994-1007.
2. Polythene fabric as an arterial prosthesis. Catchpole, B.N. and Curran R.C. *Angiology*, 10,1959, 99-108.
3. Durability of suture materials. Catchpole, B.N. and Winn S.A. *Lancet*, 2,1960, 236-240.

COVIDIEN TRAVELLING FELLOWSHIP GRANT

The Younger Fellows Committee in partnership with Covidien Healthcare, is pleased to offer two Travelling Scholarships (value $7,500 AUD each) to assist Younger Fellows who are travelling overseas in 2011 to further post Fellowship studies and diversify their surgical experiences.

The applicant must be a Younger Fellow of the College (within ten years of gaining Fellowship) at the time of submitting their application, who is planning to travel overseas within the next 12 months to further post Fellowship studies prior to returning to Australasia to practice.

Application requirements

Please attach a short CV in addition to the information below.

All applicants are required to provide details of planned visit (approximately 1 page) including proposed itinerary, details of work and/or study to be undertaken and envisaged benefits of this activity. Details of any financial support or funding already secured (e.g. personal funds, research grants, sponsorship and/or other grants) and the proposed use of the Grant funds should also be included. The Covidien Travelling Fellowship Grant is each valued at **AUD$7,500 each.**

For an application form and further information, please contact the Younger Fellows Secretariat on +61 3 9249 1122 or Younger.Fellows@surgeons.org

Applications close 5.00pm Friday 29 October 2010.

TRAUMA/RURAL SURGICAL FELLOWSHIP
ROYAL DARWIN HOSPITAL

A position exists for a suitably qualified candidate for 12 months in 2011 with a flexible commencement time.

The position is funded by the National Critical Care & Trauma Response Centre (NCCTRC) and there is opportunity for planning and participating in disaster response, and opportunities for trauma research.

The position is based at Royal Darwin Hospital in the Northern Territory, but involves outreach work to regional hospitals in Katherine and Gove, as well as visits to isolated Indigenous communities.

As a 'General Surgeon' you will have the opportunity to definitively manage subspecialty areas such as neurotrauma, burns, vascular, paediatrics, urology and thoracic surgery, both electively and in acute care /trauma.

This position would be of interest to those interested in rural surgery, or working as a surgeon in remote environments such as humanitarian or military situations. There is extensive exposure to Indigenous health issues.

This position is excellent preparation for anyone interested in a rural or regional surgical career.

Enquiries and further information can be obtained from:
DavidJ.Read@nt.gov.au *or*
Len.Notaras@nt.gov.au

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