Surgical news

Vol: 12
No:9
October
2011

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

College firms up support for Federal plain packaging campaign. PAGE 16

The College of Surgeons of
Australia and New Zealand

ON THE COVER:
College strengthens support for Plain Packaging

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Value for Money

Important changes over recent years

Ian Civil
President

It is a fascinating concept and one that I have pursued in numerous discussions as I have met with Fellows across both Australia and New Zealand. The College subscriptions are an event that we all share on an annual basis. The amount is significant enough to make one pause and question the return. Do we get value for money is the question Fellows not unreasonably ask.

As with your income tax payments, there is much that is done with your fees that does not seem to benefit you directly. Advocacy, compliance and appeals are all areas where the College responds on your behalf, but you will not necessarily see or appreciate the output unless the matter is very specific to you personally. On the other hand there are some areas where I hope Fellows will see and appreciate value. While I have been President there are three issues that I have pushed very hard to try and improve the visibility of the "value for money" proposition.

Many Fellows have commented on the new FRACS corporate brand. Inspired by a colleague in New Zealand, I encouraged the College Council and Executive to explore new branding that could be used by College Fellows on their own stationery and now this has also been expanded to include decals that can be used on glass surfaces. In a health care environment where the importance of our qualifications and standards are becoming more significant it is vital that we can differentiate ourselves and confirm that being a Fellow of the College is the standard. This will be the first of a number of initiatives to ensure "Surgeon of excellence" and FRACS are synonymous.

The second initiative has been the presence of the College at the Specialty Society meetings. This has dramatically increased over the past 12 months. It is important that the interface between the College and all the Specialty Societies is actively nurtured. ▶

FRACS Fellow of the Royal Australasian College of Surgeons

"On the other hand there are some areas where I hope Fellows will see and appreciate value"

Both the Vice President and I have been honoured by being asked to address the meetings with key presentations and also have the chance to catch up with many colleagues and inform them about the issues of the day. We live in contested days where external review and regulation are increasing.

The College strongly believes in the unity of surgery and presenting a coherent front in the health sector debates. Significant effort "behind the scenes" continues and may not be evident on a daily basis. It is a poignant moment when you understand that even when we are acting collectively, surgery is still a small percentage of the overall health budget and political focus. Splintered we will be ineffective.

The presence of a College stand at these meetings with the ability to network, gather feedback as well as distribute information about our activities is adding much value. Purchasing exhibition floor space and having a profile does not come without expense, but of course that directly benefits the Society in question and is very worthwhile.

The third component I am now impatient to see is the Information Technology transformation within the College. We live within a world that is "mobile" connected and IT facilitated. The College must have a meaningful and streamlined presence that adds significant value in this world.

I have undertaken my CPD documentation on line for some years, but am looking forward to the new web presence with significantly increased capacity for CPD, professional development e-learning and better access to our library and other educational resources.

Having worked in hospitals where IT 'roll-outs' have not been smooth, I appreciate that attention to detail, adherence to time lines and detailed project management are all required to ensure that IT projects happen. However, I am optimistic that this, the third key development over the past 18 months will hopefully deliver benefit to us all.

Council does spend significant time and effort identifying areas where value can be delivered for the benefit of all Fellows. These are some examples of how we are attempting to make your subscriptions deliver value to you in your practice on a day by day basis.

Training our surgeons

The College faces important challenges for training

Keith Mutimer
Vice President

As part of the Australian government's health reform process, Health Workforce Australia (HWA) is developing a National Training Plan (NTP) aimed at achieving self-sufficiency in the supply of medical personnel by 2025 within a global labour market.

As part of this process the College's Workforce Assessment department has developed surgical workforce models based on the NTP's assumptions and available data.

The key finding of this modelling is that unless there is a substantial increase in the number of graduating surgeons, Australia faces a surgical workforce crisis within the next 15 years.

To avoid this crisis, and assuming that the current surgeon per population ratio is adequately and safely servicing the Australian population, it is conservatively estimated that in addition to the 184 new surgeons currently graduating each year, a further 80 will have to graduate alongside them – a total of 264 new surgeons per annum.

This is to compensate for the increasing number of surgeons who will retire over the next 15 years, any small decrease in average working hours, and to allow for HWA's stated objective of reducing Australia's reliance on IMGs by as much as 95 per cent.

The average cost of training one surgical trainee, if he or she is expected to do 200 operative cases per year, is $903,000. Further expenditure is required for educational infrastructure and costs incurred by the supervisor. It follows therefore that if Australians are to continue to receive the standard of surgical care they currently receive, additional expenditure of at least $72 million per annum is needed on surgical training alone.

Given the logistics and expense of such an increase in training, this represents an unprecedented challenge to Australian governments, hospitals and Fellows of the Royal Australasian College of Surgeons.

New Vision for the Skills & Education Centre

Since the establishment of the Victorian Skills and Education Centre in 2004, thousands of Trainees, Fellows, other medical practitioners and medical students have benefited from world-class teaching across a wide array of skills. During that time, workshops have ranged from fundamental surgical skills courses to cadaveric workshops attracting participants from all around Australia and many from overseas. The ongoing educational activities on the Melbourne site continue a tradition dating back to 1851, when the future state education system was founded with the Model School.

With the establishment phase of the Skills and Education Centre well-consolidated and a strong customer base in place, the time is right to build on that success, ensuring the facility remains relevant and provides the best possible service to Fellows, Trainees and other stakeholders in line with the College's values and vision.

A significant issue is that while use of the skills laboratory by external organisations continues to increase annually, use by the surgical specialties has plateaued. Some specialties do not use the skills laboratory for training at all. While external customers provide a source of ongoing revenue which can then be invested in improving the facilities for Trainees and Fellows, the centre is keen to explore how it can be of more service to the College and its surgical specialties, especially those not currently utilising the facilities at all.

With that goal in mind, the Skills and Education Centre's oversight committee has ▶

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ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd.
ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

> *A significant issue is that while use of the skills laboratory by external organisations continues to increase annually, use by the surgical specialties has plateaued*

been re-established after an interval of several years. Chaired by College Councillor Associate Professor Helen O'Connell, this passionate and committed group comprises the Dean of Education, the Medical Director of the centre and representatives from several specialties. The committee has a role in providing guidance and assistance in the development of courses and workshops for the nine specialties, in alignment with their curricula.

A strategic planning workshop was recently instigated by the committee to explore options to maximise use of the centre's skills laboratory. Eighteen participants representing many of the specialties along with some external stakeholders brainstormed ideas aimed at a refreshed vision for the skills laboratory, and considered strategies for re-energising skills training programs in a sustainable way.

Strategies discussed included: focusing activity around a balanced portfolio of training programs with an appropriate mix of master classes, basic skills, and non-procedural training; identifying individual surgeons to act as champions of skills training; re-engaging the surgical specialties; exploring the case for employed part-time surgical trainers; capitalising on partnerships with trade; and scaling up the use of the centre's multimedia capabilities.

With the time demands experienced by surgeons, availability of faculty was identified as an important issue for surgical training. This suggests the need for renewed effort to nurture pro bono surgeons for highly specialised training, while also raising the question of the use of non-surgeons as instructors for selected basic skills training.

The main message to come out of the evening was the importance of partnerships to realise the strategies discussed.

Simply put, if the skills laboratory is to be used more for surgical training then demand for training courses across the specialties needs to increase. It is therefore essential that the training board of each specialty is engaged by the oversight committee to work together to design training programs. This shared task will ensure the centre's equipment is appropriate, guide the centre's engagement with the trade and provide advice to the specialties on managing the portfolio of training.

Your feedback would be welcome and if you would like to discuss how you think the centre could benefit your specialty or just have a tour, please contact Skills and Education Centre Medical Director, Donald Murphy or Manager, David Lawrence.

Professor U. R. Kidding

I tossed and turned, sleep eluded me – or maybe it hadn't and I was merely dreaming. My mind drifted ... Awake or dreaming, I jolted, my heart racing and the words of the Bard were in my mind ... "Of all base passions, fear is the most accursed" (King Henry VI, Part 1. Act V). I seemed to be awake, but asleep and the scenes were in front of me ...

On face value, the morbidity and mortality meeting was going to be mundane. The death of an 85-year-old male on the table during an elective abdominal aneurysm repair needed to be discussed, but would not be contentious. Although not perhaps expected, it did not seem unreasonable.

A meeting this young (in reality ageing at ever increasing rate), enthusiastic Clinical Director could chair with aplomb. I do pride myself on my anticipation, my control of events, but even I did not see this one coming. I always follow the dictum – "never ask a question unless you already know the answer". In fact I have used that dictum in reverse – not my nicest hour – when an exploitable advantage could appear.

The patient had bled to death – the surgeon blamed himself, took full responsibility. The details don't matter or perhaps they do. The surgeon, an experienced colleague, who I had in fact ear-marked to repair my own aneurysm should I develop one, explained that they had lost proximal control – catastrophic haemorrhage, cardiac arrest, death.

And then I stumbled, much to my future regret, I probed further – "why had they lost proximal control?"

I lapsed back into a deeper sleep. Was I the enthusiastic Clinical Director? Was I the "battle hardened" surgeon that had now paused and looked at me? The look that still haunted me of "what are you really asking?"

It turned out that my surgical colleague was overseeing the registrar – a good registrar nearing the end of his training. He entrusted a vital step in the procedure to the registrar. Alas he hadn't got it quite right. Try as he might, my surgical colleague was unable to remedy the situation in time – the patient died.

The question remained almost unanswered of would the patient had died if my surgical colleague and not the trainee had done the proximal end. He felt responsible. If he had performed the vital step in question, the patient would have most likely survived.

I tossed and turned again. I semi woke feeling sweaty and almost claustrophobic. Mumbling I went to sleep again, was I the Clinical Director, was I the trainee, or was I the battle hardened surgeon?

I had not planned for this to happen. I hate it when things happen that I hadn't planned for – whether it be during an operation or during a meeting that I was supposed to be controlling.

Suddenly the room became animated and questions began flooding the auditorium, a storm was approaching and I wish I had the opportunity to call a 'rain delay'! Perhaps I could wake up and my dreams and nightmare would just pass.

But with each question or comment, the issue grew. Is the primary role of surgeons in our institution patient care or training? If it is the former, why isn't the most qualified person doing the procedure? Why should a trainee be allowed to undertake a dangerous procedure, even if closely supervised? What happens in the private sector? Views polarised. I was not quick enough off the mark.

Had I been out of my depth as the trainee, slow off the mark as the surgeon-supervisor or just losing control of the meeting? Which one was I? Or was I all three? The debate raged in my mind.

I woke with a start. The meeting had ended. I had trudged back to my office uneasy in mind – just how do we train the surgeons of tomorrow?

My esteemed colleague and I had spent so much of our training observing and then went to UK to 'practice on the Poms'. However, that capacity to flex our developing surgical muscles was now closed with a unified Europe. So how will training change, how will we get those skills; will simulation or some other approach ensure that there are no 'sacrifices' to training? Something that we all do fear.

Weary Dunlop Boonpong Exchange Fellowship

A scholarship funded by the College that commemorates the bond forged between Australia and Thailand in the horrendous construction of the Thai-Burma railway during World War Two has now sponsored the visits of more than 70 Thai surgeons to Australia to advance their training.

Known as the Weary Dunlop Boonpong Exchange Fellowship, the program brings young Fellows of the Royal College of Surgeons in Thailand (RCST) to Australia to assist and observe under the supervision of a local mentor.

While the recipients are not registered for the provision of primary care mainly because of language requirements, they observe and assist elective operations during the day and emergency procedures at night and weekends. All have access to hospital libraries and participate in surgical meetings and audits and are encouraged to attend appropriate lectures relevant to their interests.

The exchange Fellowship is named after Sir Edward "Weary" Dunlop, one of Australia's greatest wartime heroes and life-long humanitarian and Mr Boonpong Sirivejbhan, a local man who helped the prisoners of war forced to build the railway by the Japanese.

Designed to not only boost the skills of the surgeons chosen, but to help them drive improvements in the Thai health system upon their return, the Scholarship consists of a $10,000 stipend with travel costs usually provided by the RCST.

Two recent recipients talk to *Surgical News* of the value of the Exchange program.

Dr Sitichok Wachirasrisirikul: Cardiothoracic Surgeon

Why did you wish to come to Australia to work and study? I wanted the opportunity for training in adult cardiac surgery outside my country in new knowledge, new and different techniques and to understand how Australian surgeons work.

When did you arrive and where have you been working? I am training at the Royal Prince Alfred Hospital in Sydney for six months.

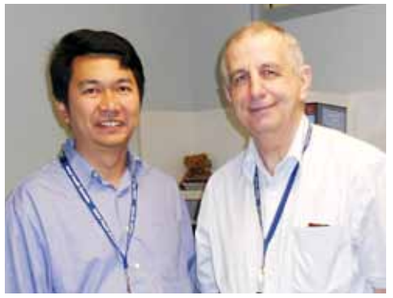
What new skills or knowledge have you gained? I have learnt a lot of techniques in CABG (conventional and off pump), aortic root surgery, thoracic surgery and some parts of TAVI. I also appreciate the chance to observe surgeons and to ask and discuss matters with Professors and Fellows.

How will this impact upon your work at home and the care of your patients? It will absolutely impact on my ideas and techniques when I go back to my workplace.

Have particular surgeons in Australia acted as mentors or provided support? Yes, I wish to thank Professor Paul G. Bannon who has been very helpful. There are many others, but I also think it is up to the scholar to take responsibility for what they wish to learn.

What has been the highlight of your stay so far? I could not understand very much in the first couple of weeks with the English language when I started to train, but it has improved by working with nurses, residents and Fellows.

How important do you think the Weary Dunlop Boonbong Scholarships are for the advancement of surgery in Thailand and the development of strong bonds between Australia and Thailand? I think it is very, very important for young Thai Surgeons to have such experiences and to come to Australia for further training and this programme is important because it is very difficult to find a scholarship like this because of the English language proficiency tests imposed on surgeons working outside medical universities.



Far left: Dr Sitichok Wachirasrisirikul with colleagues at the Royal Prince Alfred Hospital. **Left:** Dr Jarun Sayasathid out the front of Westmead hospital; **above,** with Dr Sylvio Provenzano and Dr Graham Nunn.

Dr Jarun Sayasathid: Cardiothoracic Surgeon.

Why did you wish to come to Australia to work and study? I wished to come to Australia because it has many famous cardiac surgeons and advanced technology and medical care. I hope to learn and obtain good experiences to improve my knowledge and skills when I return to the hospital in my home country. Thailand does not have many cardiac surgeons, especially paediatric cardiac surgeons. I finished my cardiothoracic training in 2004 and after that I worked as a Cardiothoracic Surgeon at Naresuan University Hospital in Phitsanulok province. The hospital, located in the North of Thailand, served a population of around seven million people. Nevertheless, there is no one who can do paediatric cardiac surgery, but me. I have many children with heart disease and many of them must be referred for surgery to a hospital in Bangkok. I can do adult cardiac operations and only simple congenital cardiac operations for children. Hence, I wished to come to Australia to work and improve my skills in paediatric cardiac surgery.

When did you arrive and where have you been working? I had been an observer at Mater Children's Hospital in Brisbane for two months in October and November last year then I have been a Cardiothoracic Fellow at the Children's Hospital at Westmead since April.

What new skills or knowledge have you gained? I have gained a lot of knowledge and skills including operative techniques, how to approach and treat many complex congenital heart diseases, what it is like to work in such a health care system and also improving my English language.

How will this impact upon your work at home and the care of your patients? When I go back to my country later this year I will use this learning experience to improve myself, my team and the health care system. I hope I can better assist many children with congenital heart diseases in my country.

Have particular surgeons in Australia acted as mentors or provided support? Yes, I am greatly appreciative of Dr Graham Nunn at Mater Children's Hospital and Dr David Winlaw at Westmead Children's Hospital. Also I wish to thank everyone at both hospitals for their warm welcome, advice and the good care taken of me throughout the time I have been working here.

What has been the highlight of your stay so far? They would be the very nice experiences I have had with both the people and the complete facilities in the excellent hospitals I've worked at and the health system. I also have enjoyed the experience of living in this modern and beautiful country.

How important do you think the Weary Dunlop Boonbong Scholarships are for the advancement of surgery in Thailand and the development of strong bonds between Australia and Thailand? It's very difficult for many young surgeons in Thailand to apply to be a Fellow and get good experiences in a developed country like Australia. One of the major problems for us is the language, because we cannot pass the examination. Hence, the Weary Dunlop Boonpong Exchange Scholarships are very important to us as you give Thai surgeons the opportunity to live and be Fellows in Australia. We will take these wonderful experiences and knowledge to develop our careers and health care systems in Thailand. I think the programme definitely helps develop a strong bond between our countries.

With Karen Murphy

Improving patient care with audits

Now operating nationally, the audits are producing important information for improving practise

Professor Guy Maddern
Chair, ANZASM

Since the inception of the Audit of Surgical Mortality in Western Australia more than 10 years ago, there has been interest to develop this program nationally. The audit is now underway in every state and territory in Australia, and we hope that New Zealand will follow in the near future.

Each region continues to have its own autonomy and is led by a clinical director who works with a project manager and staff. They interact with surgeons, hospitals and their department of health so that regional reports produced are relevant to the needs and requirements of all stakeholders.

The primary objective of the mortality audit is peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors and trends associated with surgical mortality in an educative manner. Over time, the audit has been able to maintain a constant dataset across Australia. Each of the audits of surgical mortality has produced a range of reports (annual, progress, surgeon and hospital reports) plus case note review booklets and newsletters. These can be accessed on the College website at *www.surgeons.org/racs/research-and-audit/audits-of-surgical-mortality*. Due to the substantial dataset now available, trends can be identified.

Each audit either has started, or will soon be conducting, seminars and workshops highlighting important learnings from their respective audits. The Western Australia Audit of Surgical Mortality (WAASM) has conducted a series of workshops and has led the way in raising awareness across a range of important subjects such as:

DVT prophylaxis (2002)

This workshop was based on the clinical trends discovered early in the WAASM dataset in relation to DVT prophylaxis. Data collected since then has demonstrated measurable improvements (an increase of about 15 per cent) in the number of patients receiving DVT prophylaxis).

“The audit process is designed to highlight system and process errors and trends associated with surgical mortality in an educative manner

Anticoagulation in the perioperative patient (2005)

In 2005, WAASM held a conference for surgeons to discuss two main issues: the patient’s risk of thromboembolic events when anticoagulation therapy is interrupted; the risk of bleeding that is associated with the surgical procedure.

Fluid balance management in the surgical patient (2008)

In-depth investigations identified a subset of cases in which surgeons had reported problems with fluid balance management. While the analysis of this information is ongoing, the dissemination of information to surgeons on fluid management via reports and the symposium has raised awareness across the Western Australian surgical community.

The deteriorating patient (2011)

A common issue highlighted in the audit data across many regions has been the detrimental impact of delay. The critical importance of early recognition and immediate intervention is well recognised internationally.

For more information on the above, please visit the WAASM website at <http://www.surgeons.org/racs/research-and-audit/audits-of-surgical-mortality/western-australian-audit-of-surgical-mortality>

Queensland surgical dilemmas – distance, delays, deteriorating patient (November 2011)

The main aim of this workshop will be to raise awareness on how to identify and manage the signs of systemic sepsis in Queensland and the difficulties the state faces due to its geographic size in transferring patients from rural, outlying areas to a major metropolitan hospital.

For more information, please visit the QASM website at <http://www.surgeons.org/racs/research-and-audit/audits-of-surgical-mortality/queensland-audit-of-surgical-mortality>

The audits of surgical mortality can use the extensive information learned from audit activities to promote safer health care practices. The seminars have been set up based on topics highlighted in audit reports, plus more in-depth investigations of the issues. These workshops have increased the quantity and quality of information disseminated on issues that have greatly affected clinical governance and patient care across the country. Further workshops are planned for Tasmania, Victoria and South Australia in early 2012.

The College and the state departments of health can be proud of these important initiatives to promote best practice across the nation.

Thank you for your ongoing support.

Translating Australian research

Fellow Damien Bates moved to the US to pursue his research goals, but believes more can be done here

> *"I think Australia does awesome research and clinical work which has the potential to benefit … but there still seems to be an attitude which sees great research laid aside when the thesis is written"*

While Australia is at the forefront of global scientific and medical research, we still lag in translating that knowledge into practical and marketable products and technologies, according to surgeon-turned-industry-leader Mr Damien Bates.

Mr Bates, a Fellow of the RACS in Plastic and Reconstructive Surgery, left a full-time career in surgery six years ago to concentrate on translational medicine and for the past three years has worked as the Chief Medical Officer for research group Organogenesis.

The biotech company, based just south of Boston, US, is growing rapidly and now employs more than 500 staff and has successfully developed an FDA-approved bio-engineered tissue called Apligraf® which speeds the healing of diabetic foot and venous leg ulcers.

Damien Bates at the College in August.

During a visit to Melbourne in August to meet with representatives of research and venture capital companies, Mr Bates was invited to the College to give a presentation on translational medicine and his experience working in industry to develop products and technologies to improve patient care.

"I think Australia does awesome research and clinical work which has the potential to benefit both Australia and the world, but there still seems to be an attitude in Australia which sees great research laid aside when the thesis is written," he said.

"That means Australia does great proof-of-concept work, but that's where it stops whereas in the US it is more commonly seen as just the beginning and I believe that if we can get our great researchers and scholars and surgeons closer to industry it would benefit patients, the innovators and the Australian economy.

"I think most researchers who undertake a PhD would keenly love to see their work have practical application, but they don't know how to progress it, a problem that could be solved by holding forums on translational medicine at conferences, having industry representatives address trainees and surgeons and establishing a network of mentors and advisers."

In his presentation to the RACS meeting, Mr Bates said he first became interested in a career pursuing translational medicine after doing a PhD in developmental biology at the University of Melbourne and the Murdoch Institute which was part-funded through three RACS Scholarships.

In 2006 he continued his post-doctoral research at the University of Colorado working with a world leading scientist in limb development before leaving for industry and working with Baxter Health Care in Bio-Surgery first as a Medical Science Liaison and later as a Global Medical Director.

"While I greatly enjoyed the work I was doing at the University of Colorado, it was extremely esoteric research and I felt that I would never see translation of any of the science in my lifetime and that's when lightning struck," he said.

"Research is my passion, but then it occurred that it didn't just have to be conducted in the halls of academia and what I really enjoy about industry is that it forces you to be focused.

"You can't just go down any path of interest because you have to constantly think whether this will help generate a product. It is the ability to produce a product that generates value – both for our patients and for the shareholders of the company.

"This focus forces you to be productive and practical in everything you do and I like that."

Mr Bates said surgeons and scholars wishing to commercialise their research needed to understand both the pathways of getting a product to market and the market forces which would determine the likelihood of commercial success.

He said in the US, getting a new medical product or technology onto the market can take up to 12 years of research, studies and clinical trials to receive regulatory approval, a process which can cost up to $US1 billion.

Surgeons and scientists interested in translation medicine would benefit from knowing about the market potential of their idea, whether it addresses an unmet medical need, whether it could be cost-effectively scaled-up in production, how consistently they can produce their product, knowing if the clinical outcome was replicable upon a variety of patients in a variety of settings, how to navigate the intellectual property landscape and whether to out-license the idea or work within industry and at what point to do this during product development.

"These are the issues that I believe could be addressed and answered by bringing surgeons and scientists together with industry representatives, with people who work with the Therapeutic Goods Administration and with people in venture capital companies explaining how they value an idea," Mr Bates said.

"This could be done through forums at conferences, through webinars, through specific lectures offered to trainees or interested surgeons or by forming networks linking people with specific knowledge to those seeking it."

Mr Bates also told those attending the presentation that another approach could also be to present trainees with information on the broad spectrum of employment options offered by industry, in the belief that having more surgeons with clinical, research and commercial experience could shrink the gap between scholarship and industry.

"Surgeons have a skill-set that is very useful to industry and there are a variety of career paths within the commercial sector that do not necessarily involve leaving surgery full-time," he said.

"Within the pharmaceutical, biotech and device industry, relevant full-time career options for surgeons can be found in research and development, clinical operations, medical affairs, pharmacovigilance and marketing.

"Other industry options include consultancy work, employment within regulatory bodies such as the TGA in Australia, FDA in the US or the EMA in the EU while insurance companies and venture capital firms also have great need for clinical expertise."

Mr Bates said that in an era of globalisation, great ideas and research generated in Australia which had broad practical applications and which could be cost-effectively produced no longer needed to be sold to off-shore companies.

"We can do it here," he said.

"I think in the past that there hasn't been that culture of commercialisation in Australia as there has always been in the US. Indeed I think it was at times frowned upon, perhaps as part of a tall poppy syndrome or through the belief that only academic science was pure.

"But given the quality of clinical and research work now being conducted in Australia, it is clear that thinking has passed its used-by date and we should now be putting in great effort to turn that great work into marketable products for the good of patients everywhere."

Mr Bates said he would be happy to participate in web-based seminars or lectures if the RACS chose to hold a forum, saying that despite his life in America, he remained keenly interested in the Australian surgical profession particularly given the training, academic and financial support given him throughout his early career.

Top: Working in Northern Uganda with MSF in 1995 after completing the Part 1 Surgical Exam; Working in Haiti after the earthquake in early 2010 (on the left).

Change is inevitable, change is constant

Is it time for a name change to prevent confusion?

The recent New Zealand ASM was held in Queenstown.

Scott Stevenson
Chair, New Zealand National Board

As the seasons come and go, we are reminded our world is constantly changing. In New Zealand, early winter brings celebrations of Matariki – the Maori New Year. In late May, a small group of stars becomes visible in the north-eastern pre-dawn sky. Matariki is celebrated at the first new moon after the appearance of the Pleiades (The Seven Sisters). Like all New Year celebrations, it is a time to reflect on the past and prepare for the future. This mid-year celebration is one of the many ways New Zealand differs from Australia and as we move into spring, I suggest we should revisit changing our College's name to more accurately describe its bi-national character.

In June 2005, Murray Pfeifer, then Chair of the NZ National Board, wrote an article in *Surgical News*, presenting the case for replacing the term "Australasian" with "Australia and New Zealand". After Fellowship surveys and a Council vote in support of a name change, a postal ballot took place in 2007. While more than two thirds of Fellows supported a change, this majority did not reach the 75 per cent support required under the constitution in place at that time. The new constitution requires a two thirds majority for votes on changes in the Articles of Association.

Like all organisations, the body that represents surgeons in Australia and New Zealand has undergone many changes. Until the 1920s, surgeons were comfortable gathering in the Surgical Section of the Australasian Medical Congress of the British Medical Association. I don't think this body had an acronym.

As support grew for an independent body to represent surgeons, a series of meetings in 1926-1928 debated the issues, including an appropriate title. It seems opinion alternated between "Australasian College of Surgeons" and "College of Surgeons of Australasia". "CSA" was settled on initially, perhaps because the alternative would have led to Fellowship being abbreviated to FACS (which was already used by the American College, since its inception in 1913). Even at that time, it seems the College founders recognised the name may cause confusion, as the journal first published in 1928 had the title "*Journal of the College of Surgeons of Australasia which includes New Zealand*".

Adding Royal to the title in the 1930s required another name change and allowed Fellowship to become FRACS (avoiding conflict with the American award). However, continuing to use Australasian in our name has created confusion for many years. The mis-spelling and mis-understanding of our name is widespread both inside and outside the College. Fellows and government organisations (and even, occasionally, the College itself) write and speak of our organisation as the Royal Australian College.

As the unifying professional body for surgeons in Australia and New Zealand, I believe our title should list our two nations explicitly, rather than using a collective noun that has a variety of definitions, most extending well beyond our collective borders and into large areas of the Pacific.

A name change would align the College with the majority of the bi-national bodies, including many of our specialist surgical societies. When our anaesthetic colleagues (supported as a faculty of the RACS from 1952) became a separate bi-national college in 1992, they settled on Australia and New Zealand in their title.

Benjamin Disraeli was correct when he stated "change is inevitable, change is constant". I suggest is it time to initiate another vote on this matter, I believe it will be a step forward for the College. We can manage the issues around a name change, just as the College has coped with many changes during its 84-year history of unifying and representing the surgeons of our two nations.

THE SURGICAL RESEARCH SOCIETY 48TH ANNUAL MEETING

will be held in Adelaide
on Friday 11th November 2011
at the Basil Hetzel Institute,
Woodville

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

JEPSON LECTURER:
Professor Wayne Morrison
Director of the Bernard O'Brien Institute of Microsurgery and Professor of Surgery and Head of Department of Plastic and Reconstructive Surgery, St Vincent's Hospital, Melbourne.
"Tissue engineering – Regenerative surgery"

ASSOCIATION FOR ACADEMIC SURGERY GUEST SPEAKER:
Dr Justin Dimick
Director of Policy Research at the Center for Healthcare Outcomes & Policy and Assistant Professor of Surgery, University of Michigan
"Measuring surgical outcomes: Rethinking the calculus of quality"

CALL FOR ABSTRACTS:
We are now calling for abstracts; these must be submitted no later than Friday 30th September 2011. Abstract forms will be available from the email address below. Several awards are on offer for outstanding presentations.

CONVENOR: Professor Guy Maddern

PRESIDENT: Professor John McCall

FOR FURTHER INFORMATION
CONTACT: Mrs Sue Pleass
T: +61 8 219 0900
E: academic.surgery@surgeons.org

College supports moves for plain packaging

The College continues its long tradition of health and safety advocacy

In line with its long and successful history as an advocate for public health reform, the College has strongly endorsed the Federal Government's plans to introduce plain packaging of tobacco products.

In its submission to the public consultation process earlier this year, the RACS urged the Federal Government to proceed with its legislative plans to enforce plain packaging and also called for a review of the Tobacco Advertising Prohibition Act to take place every three years.

It also rejected the self-interested and often self-contradictory arguments advanced against plain packaging by the tobacco lobby stating that the tone of the arguments clearly suggested industry fears that such measures may significantly reduce the uptake of smoking by young people.

If the legislation is passed, Australia will be the first country in the world to implement such measures to reduce brand recognition and point-of-sales presence on all tobacco products.

Smoking kills more than 15,000 Australians each year and is the known or probable cause of more than 25 diseases including coronary heart disease, stroke and a range of cancers. Smoking kills half its long-term users, reducing life expectancy by an average of 10 years.

At the start of the College's public campaign in support of the legislation, the President of the RACS, Mr Ian Civil, along with the President of the Royal Australasian College of Physicians, Professor John Kolbe, wrote to the Federal Health Minister late last year to applaud the Government on its plain packaging proposals.

In the letter to the Honourable Nicola Roxon, Mr Civil and Professor Kolbe wrote: "By removing the marketing tools that can be used on cigarette and other tobacco product packaging and reinforcing the idea that tobacco is not an ordinary consumer item, the lure of tobacco to new users will be reduced, helping to discourage a new generation from taking up this deadly habit.

"In light of the now-widespread restrictions on advertising in the mass media and outdoors, packaging has become the key promotional vehicle for the tobacco industry to encourage smokers and potential smokers in purchasing tobacco products.

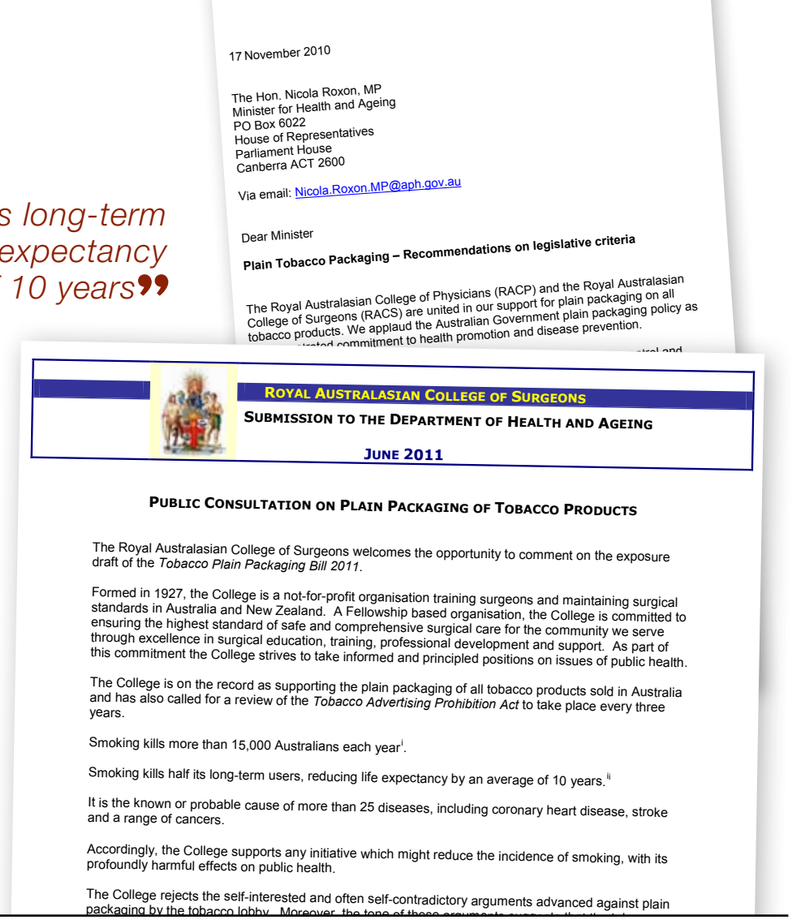
"(As such) we note estimates from Professor Rob Moodie of the National Preventative Health Taskforce that plain packaging might result in 100,000 fewer adults smoking and 25,000 fewer children taking up this appallingly harmful habit.

"The Australian Government would become a world leader in tobacco control and cancer prevention by mandating plain packaging of tobacco products and we applaud ... the policy as a demonstrated commitment to health promotion and disease prevention."

Specifically, the College called on the Government to remove all colours, brand imagery, corporate logos and trademarks, permitting manufacturers to only print the brand name in a mandated size, font and place in addition to required health warnings and other legally mandated product information.

It believes that the standardised appearance of all tobacco products would greatly reduce the status and appeal of tobacco and said that forcing all tobacco products to be sold in one colour would remove the chance for the tobacco industry to suggest some tobacco was "light" which created a false sense of reduced risk.

"Smoking kills half its long-term users, reducing life expectancy by an average of 10 years"


17 November 2010

The Hon. Nicola Roxon, MP
Minister for Health and Ageing
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Via email: Nicola.Roxon.MP@aph.gov.au

Dear Minister

Plain Tobacco Packaging – Recommendations on legislative criteria

The Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS) are united in our support for plain packaging on all tobacco products. We applaud the Australian Government plain packaging policy as

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUBMISSION TO THE DEPARTMENT OF HEALTH AND AGEING

JUNE 2011

PUBLIC CONSULTATION ON PLAIN PACKAGING OF TOBACCO PRODUCTS

The Royal Australasian College of Surgeons welcomes the opportunity to comment on the exposure draft of the *Tobacco Plain Packaging Bill 2011*.

Formed in 1927, the College is a not-for-profit organisation training surgeons and maintaining surgical standards in Australia and New Zealand. A Fellowship based organisation, the College is committed to ensuring the highest standard of safe and comprehensive surgical care for the community we serve through excellence in surgical education, training, professional development and support. As part of this commitment the College strives to take informed and principled positions on issues of public health.

The College is on the record as supporting the plain packaging of all tobacco products sold in Australia and has also called for a review of the *Tobacco Advertising Prohibition Act* to take place every three years.

Smoking kills more than 15,000 Australians each year[i].

Smoking kills half its long-term users, reducing life expectancy by an average of 10 years.[ii]

It is the known or probable cause of more than 25 diseases, including coronary heart disease, stroke and a range of cancers.

Accordingly, the College supports any initiative which might reduce the incidence of smoking, with its profoundly harmful effects on public health.

The College rejects the self-interested and often self-contradictory arguments advanced against plain packaging by the tobacco lobby. Moreover, the tone of these arguments

In its submission to the consultation process, the College rejected the argument advanced by the tobacco industry that there was no evidence plain packaging would reduce the incidence of smoking as an absurdity.

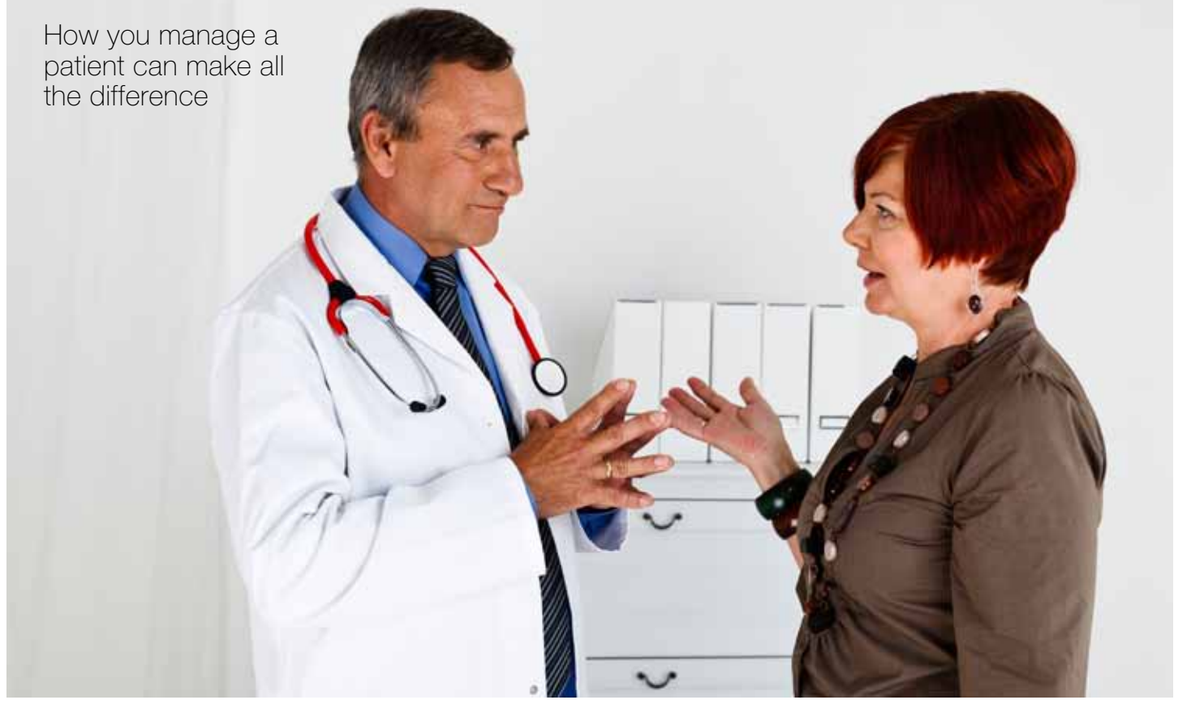
It said no evidence existed because such an initiative had never been tried before.

The RACS lobbied for road safety measures that are now commonplace around the world and has urged the Federal Government, the Opposition, Greens and Independents to support the legislation and allow Australia to lead the world on this issue, one of the most important public health challenges of the age.

With Karen Murphy

Complaints – and how to avoid them

How you manage a patient can make all the difference



Michael Gorton
College Solicitor

A recent study in the *Medical Journal of Australia* (MJA, Bismark et al, July 2011) identified that in the decade to 2010, complaints occurred at the rate of one in five doctors in Victoria in private practice, for complaints made by a patient to the Health Services Commissioner in Victoria.

More reassuringly, the study also identified that there was a significant concentration of complaints to a small group of doctors, who obviously had a significant number of multiple complaints. The study identified that surgery and psychiatry were significantly over-represented in the 'frequent flyer' group and, overseas trained doctors were significantly under-represented in that group.

The concentration of complaints to particular doctors mirrored the finding that 1 per cent of the medical workforce in private practice against whom complaints were made accounted for nearly 20 per cent of the complaints.

To some extent these conclusions will reassure doctors that sound practice should ensure that complaints against them will be avoided. There is no suggestion of any high levels of frivolous complaints and that, to some extent, patients do not complain lightly.

Nonetheless, other studies have confirmed that complaints can be avoided if doctors adopt an appropriate strategy to complaints when they are made, or potential claims when they arise.

Studies, both in Australia and overseas, have confirmed that one of the prime reasons for patients seeking to make claims against their doctor after an adverse outcome is the manner in which the doctor dealt with them and communicated with them.

In other words, the way doctors communicate with their patients after an adverse event will substantially influence whether the patient considers making a formal claim or even suing their doctor for negligence.

The doctor who is attentive, responsive and sympathetic after an adverse outcome (whether or not negligent) is less likely to be sued than the doctor who is dismissive, distant or less empathetic.

It is common knowledge that there are doctors who achieve less than optimal outcomes, but whose patients would never think of taking action against them. That is because their patients "love them" as a result of the attention, empathy and friendly treatment they receive.

There are certainly occasions when doctors, despite their best efforts, and with no suggestion of legal negligence, nonetheless face claims from patients because of the perception of less than optimal outcomes or the perception of poor care.

Open Disclosure

As part of the response by governments, both Federal and State, to the medical indemnity crises, legislation has been introduced into most states to permit "Open Disclosure". That is, the legislation now permits doctors to have a frank discussion with their patients, without there being adverse legal implications.

The legislation fosters the concept of openness and a frank discussion with patients after an adverse outcome (whether or not there has been negligence). There can be an open acknowledgment of an adverse outcome, and even an apology (to express regret for the fact that the patient has not had an optimal outcome).

It may not be 'trendy' in Australia to give an apology. However, in the case of adverse events, an apology may well be a critical factor as to whether a patient sues a doctor or not.

Legislation in most states now allows doctors to deal with adverse outcomes, without there being any admission of liability, by:

- expressing regret or apologising for an adverse outcome;
- expressing sorrow or sympathy;
- reducing fees; or waiving fees entirely.

Such events will also not constitute an admission of professional misconduct, or otherwise expose the doctors to civil liability for carelessness, incompetence, or unsatisfactory performance.

It's important to be aware of the following issues:

- It is critical to ensure that appropriate staff are involved in communication with the patient.
- Those involved in providing information to patients should have adequate training and be fully informed about the issues involved in open disclosure.
- Open disclosure, of necessity, involves medico-legal issues. It is about providing appropriate information to consumers, without necessarily an admission of liability.

This approach should give confidence to doctors and medical administrators to deal with adverse outcomes (whether negligence or not) in a caring and humane way. It is, after all, human nature to be able to express regret and sympathy where a patient has had an adverse outcome to treatment or procedure, without such concern being considered an admission of legal liability.

To do so may also reduce the risk of complaints, claims and litigation.

ANNUAL SCIENTIFIC CONGRESS Coordinator

The current Annual Scientific Congress Coordinator will retire from the position following the 2012 ASC in Kuala Lumpur (May 2012).

The College wishes to appoint a Fellow to the role before the current Coordinator retires to ensure an adequate hand-over period.

The Coordinator is based in the Conferences and Events department at the College in Melbourne. The role is remunerated at three sessions per week (plus superannuation) and is supported by a full time member of staff. The Coordinator works closely with the members of the Conferences and Events department, the Executive and Scientific committees convening each Annual Scientific Congress and the Chair of the ASC Planning and Review committee; the Coordinator is an ex officio member of each of these bodies.

The Position Description and Person Specification are available on the College website, under College Resources, Positions Vacant/College Positions. Alternatively, an email may be sent to careers@surgeons.org. Potential applicants may contact the current Coordinator (campbell.miles@surgeons.org) or the Director of External Affairs, Daliah Moss (daliah.moss@surgeons.org) for information regarding the role.

The closing date for applications (reference 372) is 28 October 2011. The start date is negotiable but it is envisaged that the new Coordinator would begin the role two months before the 2012 Annual Scientific Congress.

Younger Fellows Forum – Kuala Lumpur 2012

You can only expect the best from the Younger Fellows Forum in 2012

Seema Bagia
Younger Fellows Forum Convenor 2012

I'd like to take this opportunity to invite all Younger Fellows to submit an application to attend the Younger Fellows Forum for 2012. We are still exploring venues, but are currently looking at a lovely waterside location, about an hour outside of Kuala Lumpur.

We hope to explore a number of themes at this forum. The first is "Professionalism: What this means for a surgeon". The health service environment is changing from single practitioner practices to a more corporate environment so it is timely to explore the external and internal challenges to professionalism from commercialism, consumerism and the increasing involvement of technology industrialisation. John Quinn, the College's External Director Surgical Affairs (Aust) will offer an interactive session so that we can explore issues around professionalism and younger surgeons.

Sam Prince, a doctor who has completed some interesting work in aid projects, will discuss the second theme: 'Young Leadership and Challenges'. Sam is not your typical doctor or businessman. His Zambrero Mexican food chain helps to fund a "plate for plate" project and he has entrepreneurial mining interests. He uses business ventures to fund projects through the E-magine Foundation, his not-for-profit group that delivers health and education resources to indigenous Australians and developing countries. I am sure we will learn a lot from Sam's experiences.

The other area we hope to explore is the balance between private and public practice. Many surgeons enter the workforce with an aim to have a practice which straddles the public and private sectors. Often this practice becomes polarised over time, due to the difficulties in maintaining commitments in both sectors. This is partly a function of increasing work load, but is also the result of organisational difficulties which could perhaps be improved within the public and private sector.

We know that the UK has a predominantly public-based system and the US a more privatised system. The Australian system has in some ways been a balance between these two systems. Having worked in both health systems, I have come to appreciate our system and hope that we can preserve, and perhaps improve, it. We ideally want a public system that also allows and supports surgeons working in the private sector as it is important to keep talented and experienced surgeons contributing to the public sector. There are some health systems in which young surgeons start in the public system and, by their early forties, 'graduate' to the private sector, never to look back at the public sector. This is a loss of experience and talent for the public sector and leads to a two-tiered system of healthcare, which is not what I would hope for in Australia.

Over the two and a half days, I hope Forum delegates can explore the issues that relate to keeping a surgeon interested and engaged in the public sector. There will also be a lively debate about what should be done to facilitate the public/private balance by administration in both the public and private systems as well as the training issues within the public and private sector. Furthermore, we will explore whether or not this is in fact an effective model, i.e. to have surgeons who work in both the public and private system.

The Forum is a unique opportunity to provide recommendations to RACS Council about strategic issues and challenges faced by both private and public hospital systems in the next 10 years. The meeting is really what you, the Fellows, bring to it. I hope that these topics catch your interest and can't wait to see you all in Malaysia in 2012.

Applications are open from 1 September to 1 December 2011. For more information and a Forum registration form please email younger.fellows@surgeons.org or call +61 3 9249 1122.

Professional Development WORKSHOPS

Professional development is important as it supports your life-long learning. The activities offered by the College are tailored to the needs of surgeons. They enable you to acquire new skills and knowledge while providing an opportunity for reflection about how you can apply them in today's dynamic world.

>Writing Medico Legal Reports *NEW-redesigned evening program**

19 October, Brisbane

This workshop can help improve skills in preparing medico legal reports that comply with court rules. It is an opportunity to gain an understanding of the legalities of expert reports and the lawyer/expert relationship. Learn about report writing from the advocate and surgical perspectives.

>Polishing Presentation Skills

November date to be confirmed, Melbourne

This whole day workshop helps to advance your presentation skills and provide you with 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.

>Sustaining Your Business

18-20 November, Brisbane

This two-and-a-half day workshop provides the foundation for developing business plans and explores the various approaches to sustaining business growth and performance. Participants can learn the principles of sound financial management in order to understand effective budgetary management and be able to produce a budgetary plan. It addresses both perspectives of health practice management and the broader health service delivery environment.

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

11 November, Perth; 18 November, Melbourne

This new workshop focuses on the non- technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve your performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into elements or behavioural markers that can be used to identify a superior or substandard performance. Through a series of interactive exercises you will better understand how these markers can be used to reflect on your own performance and that of the surgeons you work with. **Target group** - Fellows, International Medical Graduates and senior SET trainees.

>Acute Neurotrauma Management (Rural)

17 November, Melbourne

This new workshop focuses on gaining the skills to deal with cases of neurotrauma in the rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Participants will develop a capacity to accurately evaluate whether on-the-spot treatment is required. The workshop teaches procedures (craniectomy, craniotomy, tap-shunt and a burr-hole procedure with Hudson Brace) through demonstration and practice on human cadaveric material. **Target group** – Surgeons as well as advanced Trainees and International Medical Graduates (IMG) working in rural hospitals.

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.

2011 DATES:
OCT - NOV 2011

NSW

20-22 October
Surgical Teachers Course, Sydney

25-27 November
AOA/RACS combined Medico Legal Section meeting

QLD

19 October
Writing Medico Legal Reports ***NEW** – redesigned evening program*

18-20 November
Sustaining Your Business

VIC

21 October
SAT SET, Wangaratta (Victorian AGS Meeting)

21 October
Keeping Trainees on Track (KToT), Wangaratta (Vic AGS Meeting) ***NEW***

17 November
Acute Neurotrauma Management (Rural), Melbourne

18 November
Non-Technical Skills for Surgeons (NOTSS), Melbourne ***NEW***

Tbc, November
Polishing Presentation Skills, Melbourne

WA

11 November
Non-Technical Skills for Surgeons (NOTSS), Perth ***NEW***

AUSTRALIAN AND NEW ZEALAND

Gastric and Oesophageal Surgical Association Audit

A tool for members of the ANZGOSA

Associate Professor Mark Smithers,
President of ANZGOSA and Interim Chair of the Audit Committee

The Australian and New Zealand Gastric and Oesophageal Surgical Association (ANZGOSA) Audit was officially launched in August 2010. The audit is a self-assessment tool for ANZGOSA members, collecting data on patients with oesophago-gastric cancer or gastrointestinal stromal tumour (GIST). Collated bi-national data will also form an accurate picture of upper gastrointestinal cancer treatment in Australia and New Zealand for research and assessment purposes. The precise details of any research are yet to be determined, but will concentrate on the surgical treatment of patients in this area.

The ANZGOSA Audit is managed by the Morbidity Audits department of the College and is open to all members of the ANZGOSA.

In 2011, the ANZGOSA Audit was declared a Quality Assurance Activity under the Commonwealth Health Insurance (Quality Assurance Confidentiality) Amendment Act (1992) in Australia and a protected quality assurance activity under the Health Practitioners Competence Assurance Act 2003 in New Zealand. The purpose of this legislation is to ensure that information that becomes available as a result of the activity can not be disclosed, other than for general reporting purposes (i.e. aggregated results in annual reports or research papers).

ANZGOSA surgeons submit data to the audit through an online portal via secure log-in. Surgeons can request that a separate data manager account be linked to theirs so that their data can be entered by a third party (e.g. hospital data manager, receptionist, registrar). Data manager access allows data managers to log-in and enter data for multiple surgeons while restricting access to only those hospitals where they have permission (e.g. a public hospital data manager will only see patients from that hospital). Data managers are issued with their own username and account which can be disabled if an employee leaves an organisation. This prevents the need for password sharing and the inherent security risk this involves.

Data collected includes patient demographics, pre-treatment diagnosis and staging, surgical details, complications (intra-operative and post-operative) and histopathology.

The latest feature being developed for the audit is an institutional upload program. An upload program allows institutions with a large case volume and sufficient commonality of fields to have their data directly uploaded into the system each year, rather than having to re-enter data manually. This program is still under development and will be available to users once a technology solution has been fully developed and tested.

Further plans for the audit include the ability to export personal data to analyse in external software such as Microsoft Excel, as well as the addition of a reporting suite to the online portal. The reporting suite will allow for comparison of individual surgical performance against the bi-national aggregate according to pre-determined areas of interest for ANZGOSA.

Active participation in the audit demonstrates both an appreciation of the importance of quality surgical care in this area and a commitment to achieving such quality.

>For further information on the data collected or on how to become part of this initiative, see the ANZGOSA Audit webpage: www.surgeons.org/anzgosa; or contact the audit helpdesk at anzgosa.audit@surgeons.org or +61 8 8219 0918.

>For further information on the ANZGOSA generally, see the ANZGOSA website: www.anzgosa.org

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 ' asc.surgeons.org ' and 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, Medicolegal, 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 'Review' 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 for 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 except cross-discipline.
9. A 50 word CV is required from each presenter to facilitate their introduction by the Chair.
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
Bariatric Surgery *(Trainee)*	$500
Breast Surgery *(Trainee)*	$500
Burns Surgery *(Trainee)*	$500
Cardiothoracic Surgery *(Trainee)*	$500
Craniomaxillofacial Surgery *(Trainee)*	$500
Colorectal Surgery *(Mark Killingback Prize for Young Fellows & Trainees)*	$500
Endocrine Surgery *(Tom Reeve Prize - Trainee)*	$500
General Surgery *(Trainee)*	$500
Head & Neck Surgery *(Trainee)*	$500
Hepatobiliary Surgery *(Trainee)*	$500
Neurosurgery *(Trainee)*	$500
Paediatric Surgery *(Trainee)*	$500
Plastic & Reconstructive Surgery *(Trainee)*	$500
Surgical Education *(Not exclusively for Trainees)*	$500
Surgical History *(Trainee)*	$500
Surgical Oncology *(Trainee)*	$500
Trauma Surgery *(Trainee)*	$500
Upper GI Surgery *(Trainee)*	$500
Vascular Surgery *(Trainee)*	$500

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 ' asc.surgeons.org ' AND CLICK ON 'ABSTRACT SUBMISSION'.

THE CLOSING DATE FOR ALL SCIENTIFIC PAPER ABSTRACT SUBMISSION IS 23 JANUARY 2012.

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	October 2011
Closure of Abstracts	23 January 2012
Closure of Early Registration	13 March 2012

Kuala Lumpur ASC 2012 Program Overview (indicative only)

	Sunday 6 May	Monday 7 May	Tuesday 8 May	Wednesday 9 May	Thursday 10 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	Keynote Lectures	President's Lecture	Keynote Lectures
12.30pm – 1.30pm		Lunch	Lunch	Lunch	Lunch
1.30pm – 2.00pm		Keynote Lectures	Named Lectures and Keynote Lectures	Named Lectures and Keynote Lectures	Named Lectures and Keynote Lectures
Session 3 2.00pm – 3.30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
3.30pm – 4.00pm		Afternoon Tea	Afternoon Tea	Afternoon Tea	Afternoon Tea
Session 4 4.00pm – 5.30pm	4.30pm Convocation Ceremony	Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
7.00pm – 11.00pm	6.00pm Welcome Cocktail Reception	Sectional Dinners and Younger Fellows & Trainees Dinner	Sectional Dinners	Congress Dinner	

Research Paper Specialties

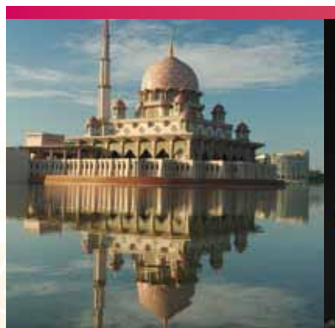
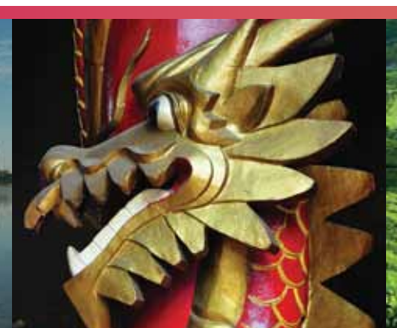
Authors of research papers and posters are invited to submit abstracts for consideration and inclusion in the Scientific Program in the following areas:

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

ASC Executive

Convener	Mr Philip Truskett
Scientific Convener	Mr Raffi Qasabian
Member of Executive	Mr David Storey
Member of Executive	Mr John Cartmill
Member of Executive	Mr Joseph Lizzio
ASC Scientific Coordinator	Mr Campbell Miles
ASC Manager	Ms Lindy Moffat
ASC Executive Officer	Ms Katie Fagan
NSW Regional Manager	Ms Beverley Lindley

For further information contact:
asc.registration@surgeons.org

Scientific Conveners

		College & Industry Sponsored Visitors	
Bariatric Surgery	Dr John Jorgensen Mr Ken Loi	Dr Raul J Rosenthal Dr Randy Seeley Professor Wei-Jei Lee	USA USA Taiwan
Breast Surgery	Dr Kylie Snook Dr Patsy Soon	Dr Eisuke Fukuma Dr Armando Giuliano Mr Douglas Macmillan	Japan USA UK
Burn Surgery	Professor Peter Maitz	Professor Paul van Zuijlen	Netherlands
Cardiothoracic Surgery	Mr Paul Bannon Associate Professor Brian McCaughan Dr Tristan Yan	Professor Scott LeMaire Professor Alec Patterson Dr Valerie Rusch	USA USA USA
Colorectal Surgery	Mr Chris Byrne	Professor Anders Mellgren Mr Ian Lindsey Professor Arun Rojanasakul Dr Parvez Sheik Professor Samuel Tay	USA UK Thailand India India
Craniomaxillofacial Surgery	Mr Mark Moore	Associate Professor Oleh Antonyshyn Dr Eduardo Rodriguez	USA USA
Endocrine Surgery	Dr Mark Sywak	Professor Jonathan Serpell Professor Gerard Doherty	Australia USA
General Surgery	Professor Michael Cox	Mr Simon Paterson-Brown Dr Ernest (Gene) Moore Associate Professor Phillip Carson	UK USA Australia
Head & Neck Surgery	Mr Jonathan Clark	Dr Douglas Chepeha Professor Jeffrey Myers Dr Kee Chee Soo Professor Dr Abdullah Sani Dr N G Iyer	USA USA Singapore Singapore Singapore
HPB & Upper GI Surgery	Mr Arthur Richardson	Professor Diane Simeone	USA
International Forum	Dr Michael Hollands	Dr Charles Mock	USA
Medicolegal	Dr Neil Berry	Dr Mark Sidhom Mr Peter Semmler	Australia Australia
Military Surgery	Mr Brett Courtenay Mr Anthony Chambers	Associate Professor Philip Iau	Singapore
Neurosurgery	Mr Andrew Chin Kam	Professor Katsumo Tomita Dr Larry Khoo Dr Kornelis Poelstra	Japan USA USA
Paediatric Surgery	Dr Wee Chia	Dr Anne John Dato' Dr Zakaria Zahari	Malaysia Malaysia
Pain Medicine	Mr Mark Dexter	Associate Professor Raj Sundaraj Professor Christopher Winfree	Australia USA
Plastic & Reconstructive Surgery	Dr Anand Ramakrishnan	Mr David Elliot Professor Susan Mackinnon Dr Maria Siemionow	UK USA USA
Rural Surgery	Mr Graham Stewart		
Senior Surgeons	Mr Robert Rae	Mr Anthony Jackson	Australia
Surgical Education	Dr Mary Langcake	Professor Rhona Flin	UK
Surgical History	Mr Philip Sharp	Professor Irvin Modlin	USA
Surgical Oncology	Mr Warren Hargreaves	Mr Andrew Hayes Professor Khee Che Soo	UK Singapore
Trainees Association	Dr Sally Ng		
Transplantation Surgery	Mr David Joseph	Dr Kim Olthoff	USA
Trauma Surgery	Professor Zsolt Balogh	Professor Hans-Christoph Pape	Germany
Vascular Surgery	Mr Ravi Huilgol	Dr Jon Matsumura Professor Nicholas Cheshire	USA UK
Women in Surgery	Dr Cindy Mak		

Visitor list correct as at August 2011

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Accessing a growing Library

New products make the online library easier to use

Cathy Ferguson
Chair, Fellowship Services

In the past few years, the College Online Library has grown exponentially in both subscription packages and usage. Like other similar large scale libraries, the challenge for the College continues to be to provide a user friendly interface along with the opportunity to discover everything the Library holds that is relevant to the individual user. The following paragraphs explain some of the recent changes and improvements.

A-Z listing of E-Journals and E-Books

The Library is using a new commercial product for the Journals A-Z listing. This replaces the manually maintained listing, which had become impractical because of the expansion in the Library's subscriptions. There are now thousands of journal titles available to library users. The new A-Z listing allows the publishers' packages to be added and displayed fully, without needing to identify and list all the titles within the package. It helps users to see the breadth of the collection.

There are hundreds more journal titles now displayed in the A-Z list; for example, there are now 291 titles beginning with the letter A. A comprehensive list means that more user clicks are now required to get through the title lists. The assumption is that the benefits to library users of a comprehensive listing outweigh the requirement for additional clicks. In this, the College is using the model of University and similar large scale libraries.

Specialty pages in the Online Library

As a counterpoint to the comprehensive A-Z listing on the main Online Library page, each of the specialty page listings is maintained manually. This provides a selective easy to use listing, limited to journals and e-books likely to be highly relevant to that specialty.

This approach provides both comprehensive and very specific access for Fellows and Trainees.

ANZ Journal of Surgery

The *ANZ Journal of Surgery* can be accessed from the Online Library main page via several pathways. There are two specific links, one at the top of the table of contents, at the top of the page, and a second in the area of the page called Online resources listed alphabetically. The journal is also in the comprehensive A-Z list.

Summon search facility

Summon is a powerful search tool that is linked to the A-Z product (i.e. it is a comprehensive database of this library's full text content). Summon is designed to retrieve the full text of all articles and/or book references relevant to the search keywords. In an optimal response the full text links will go directly to the full text article. That happens about one time in five, and there are two further steps for most searches. This is the result of the complexity of having numerous different publisher platforms.

Summon makes a complicated library accessible and remains a convenient alternative to Medline which links to the Library's full text about 10 per cent of the time, depending on the search.

It is possible to put a complete journal article title into Summon and have it reliably appear at the top of the list that is returned, making it quicker than finding a journal title and then the specific article.

Web site single log in and EZ Proxy

The Online Library, like many libraries, uses a product called EZ Proxy which makes it possible to overcome the requirement for numerous different user logins for different publishers.

> *"The challenge for the College continues to be to provide a user friendly interface along with the opportunity to discover everything the Library holds"*

Until recently, external users of the Library would sometimes come up against the requirement for an EZ Proxy password which was provided via two step message/action. The extra password was needed only once in each session, in the first full text access attempt, and not with any consequent clicks. In the past, most users who encountered this have not found it too difficult.

The request for extra login became much more common, for some users, with the introduction of the added layer of Summon, to the point where the user experience was overly complex and frustrating. Consideration of this problem has led to the recognition that additional security requirements for access to the Library resources are not warranted.

The EZ proxy password requirement has now been completely removed. This will certainly reduce the number of clicks for many Fellows and Trainees.

Future improvements to the Online Library

Over the past few years, the Online Library has grown considerably in complexity.

Expansion of the Library will continue in 2012. We hope that the new A-Z list and Summon search feature continue to help make a growing library accessible. Our goal is to make the Online Library as rewarding and useful as we can. If you would like to make any comments or suggestions about the Library service, please email library staff on college.library@surgeons.org

Learn how to knock out bullies at work

Bullying is an important issue to the College, and we continue to promote professionalism of Fellows through our Code of Conduct and our *Bullying and Harassment* booklet, both available from the College

Ruth Callaghan

There are laws and procedures to protect everyone from workplace harassment, finds Ruth Callaghan.

The young doctor looked after patients in his hospital unit on weekends and provided the details to a senior specialist each Monday – and that's where the trouble started.

In a complaint letter to his hospital director, the young doctor said he dreaded the handover meetings.

If he summarised the patients' situations, he was attacked for not providing enough detail, he said. If he provided detail, he would be told to be more succinct. Sometimes he would be ignored, then accused of not keeping his superior informed.

"Every day, I enter the hospital with apprehension and tension, fear of being trivialised and humiliated in front of my colleagues, other staff and my patients," he wrote.

As the Australian Industrial Relations Commission tried to untangle the conflict — one of several incidents that led to the senior specialist's dismissal — it wasn't clear if bullying was taking place. More experienced doctors saw the senior specialist as excellent, professional and able to make swift decisions.

Junior staff found the same behaviour rude and patronising. The commission eventually found the senior specialist had been unfairly dismissed and ordered his reinstatement.

The dispute is one of thousands heard every year in formal settings like the AIRC or informally in the staff canteen, showing the complexity of relationships formed at work.

Where previous generations might have clocked off and gone out for the evening with friends, it is increasingly common for our work to represent our most significant connections with other people.

So when those connections get crossed, things can get bad — fast.

Michael Sheehan, from Relationships Australia, says misunderstanding other people or believing they should be seeing things a particular way are common problems where even reasonable people can be misled by their own perceptions.

Mr Sheehan, who helps train organisations in the skills needed to deal with angry clients, says differences of opinion are normal and accepting this is a first step to finding some compromise.

"The whole aim of living with other people is to negotiate," he says. "People need to expect that no one will agree with us all the time and that people have different points of view and it is about coming to some sort of consensus."

When you mix those different opinions into a work situation, though, conflict can result, particularly when there is friction between layers in the office hierarchy.

"With a hierarchy, the person is in charge and they have the right to direct what you do," Mr Sheehan says. "You can still be assertive and say how you feel and offer your suggestions, while understanding it is their decision."

Relationships Australia encourages people to be assertive in their workplaces, but warns there is a difference between that and being aggressive.

"Someone might have an opinion or the boss might ask you to do something, or there might be an issue where you are asked to do something additional. Then you might need to clarify things or point out you have other work to do," Mr Sheehan says.

"You need to be assertive, but that means being able to tell someone how you feel about the situation, then listen to their response, then come up with a compromise."

If that fails, he recommends appealing to a higher authority.

"I always encourage everyone to know what the grievance procedure is and ask about it so you know what you can do if someone is bullying you or your immediate line manager is being difficult," he says.

Many organisations do work to reduce the chance of office relationships falling apart – for good economic reasons.

The number of complaints about bullying in the workplace in WA has risen to above 600 a year. Nationally, there are about 1,500 successful workplace claims each year for bullying and work-related harassment, each taking an average three months of lost work time to resolve.

A recent Productivity Commission report puts the number of Australian workers who are likely to be bullied or harassed in the workplace at 1.5 million, while the Beyond Bullying Association estimates up to 5 million Australians will experience bullying at some point in their working lives.

That makes it a threat to employers as well: the Productivity Commission estimates the annual cost of workplace bullying to employers and the economy in Australia can be up to $36 billion in lost productivity, stress leave, higher staff turnover and other costs.

And for every reported case, there are many more toxic office relationships in which a person might be aggressive, sarcastic, intimidating, rude or insensitive, yet not reach the threshold of "bully".

Graham Castledine is a solicitor and accredited mediator, as well as chairman of the WA chapter of LEADR, the Association of Dispute Resolvers.

The association trains mediators and can connect businesses or community groups – or even families – with a professional who can help resolve problems when they arise, before they get into more complicated legal waters.

He says mediation is not new in bigger workplaces, but more organisations are seeing the value in having a third party untangle damaging conflicts.

"More and more employers are understanding the benefits of mediation because it is an informal process that can enable people to discuss the issue in a confidential way," Mr Castledine says. "It can maybe help them resolve what is going on without needing more formal processes that can be costly and damaging to relationships."

The role of the mediator is to help all parties have a chance to discuss the issue in a controlled way – and even if one side is more articulate than the other, the mediator can help drill down to the core problems.

"I think when a working relationship has reached a point where it is becoming destructive to the people involved and their workmates, then that's the time for mediation to begin," Mr Castledine says. Obviously there is a certain amount managers can do and you would encourage them to get involved and see if it is just a matter of working through the issues.

"But when you have a problem that has gone from being a basic personality clash to something being very negative and destructive to the workplace then it is probably a good idea to get those people off site into a different location and try to get to the bottom of what is going on. Part of mediation is to work out where you do have common ground and building on that.

"Even the smallest consensus can lead towards resolution."

This article originally appeared in the West Australian *newspaper on 13 July, 2011.*

Are you at fault?

Dealing with other people's prickly or unpleasant habits is one thing – but what if you are the difficult person?

Author Gretchen Rubin, who wrote *The Happiness Project* and runs a blog of the same name, says there are signs to look for – including that other people might not appear to appreciate your willingness to help them out.

Maybe you offer to host Christmas lunch, for example, only to have people turn you down.

Or you might feel you are generous with your wisdom and insight, but find people are less than enthusiastic about taking your advice. Another sign might be that you are accused of being "over" truthful, or you find yourself often defending statements with: "It was just a joke."

Michael Sheehan, from Relationships Australia, says the best way to find out if you are the difficult person in a situation is to learn more about what is called "emotional intelligence", a way of measuring how well you assess and control your own emotions and how well you read the emotions of others.

The second step is to ask other people how they find you.

"You can seek feedback – if you are always asking 'How did I go, was I too hard on that person'; that is one way to know whether or not you are OK," Mr Sheehan says.

But he warns that the more difficult a person is, the less likely they are to believe what they are told.

"Difficult people don't have that sensitivity or don't think they are doing the wrong thing so they never ask those questions," he says.

"For some people it is difficult to get that insight, but for those who want to know if they are doing the right thing, it is helpful to get that feedback."

Covidien Travelling Fellows Grant

Ash Chehata recently visited various European countries as a Covidien Travelling Fellow

Ash Chehata
Covidien Travelling Fellow

My Upper Limb Fellowship was always planned as an overseas educational adventure not only for myself, but the entire family. With my newly pregnant wife and two children we bundled all 10 suitcases on board, destined for Europe. Half way through the flight I was sure I had made the biggest mistake of my life. My children had spilt everything possible on the surrounding passengers and the entire scene was beginning to exhaust both myself and my wife.

It was only once we landed and were met by the Professor in Milan that the tide suddenly turned. We were whisked away to a 'très chic' apartment in the city and within 24 hours of reaching the city I had consumed multiple espressos and was on the on-call roster in the Elbow and Shoulder Unit of Prof Alessandro Castagna. His unrelenting work ethic, professionalism and hospitality turned the entire journey into a pleasure with him becoming not only my mentor, but a close friend.

The days were exciting although exhausting with two theatres running simultaneously with six to seven cases in each. Many cases were tertiary referrals from around Europe and there was a steady stream of International Visitors. I was paired with a Russian Surgeon and then an American from Providence, which allowed for a truly varied exchange of ideas on the best course of management in a Northern Italian Hospital.

There was a busy schedule of courses and presentations along with peripheral hospital visits. The first weekend we travelled to Rome to perform an operating list and clinic at the International Villa Stuart Sports Institute. We then spent the next day touring the Italian Olympic Village and the new shoulder institute where we were involved in assessing athletes' techniques in various throwing sports. The next day was spent via an invitation by the Olympic Committee to review the Shoulder and Elbow protocols for the Italian National Ski Team and also to begin a rehabilitation protocol that was instigated by Prof Castagna and his Sports Physician, Marco Conti.

The clinic in Rome was a tertiary referral centre for young adults with osteoarthritis of the shoulder and various unique arthroplastys were being devised and trialled. Again the week of operating was extremely challenging with revision shoulder surgery for both rotator cuff and instability.

The following week was taken up preparing for the Italian National Shoulder and the Italian National Elbow Meeting in Brescia. The invited speakers were from the Mayo clinic and we were together on the podium with simultaneous translation for the entire congress. A week later we performed Live Arthroscopic Surgery using a synthetic ligament to bridge massive cuff tears in a Local Italian Meeting in Venice.

The travelling continued with a Cadaver course in Utrecht, The Netherlands, where we again performed live surgery alongside the current president of Shoulder Surgery in Europe. Norway was our next stop at the International Arthroscopy Meeting. Here we presented on instability of the shoulder and chaired the conference regarding synthetic ligaments in the shoulder and plasma rich platelets in Rotator Cuff Surgery.

> *"[My supervisor's] unrelenting work ethic, professionalism and hospitality turned the entire journey into a pleasure with him becoming not only my mentor, but a close friend"*

I was invited to test the new Arthroscopic LaserJet equipment in Arezzo, Tuscany which was a beautiful location and because of Prof Castagna we attended the Closed International Meeting of Acromioclavicular Joint in Copenhagen where I was able to question an International Faculty such as Mr Itio from Japan and Mr Mazzoca from the US, leaders in their field on AC joint pathology.

We shared a luxury liner from Copenhagen to Norway and had an interesting question and answer time with Brazilian and Columbian Arthroscopy enthusiasts. The Shoulder Unit was trialling the reverse shoulder replacements with various new bearing surfaces and performed more than 150 per year so the experience in joint replacement as well as the management of revision arthroplasty surgery was second to none.

It was a terribly sad day when leaving although the promise of returning with my own original research for the Milan Shoulder meeting in a few years softened the farewell. Even my kids were unhappy leaving their playgroups. Although, we thought we were prepared for a third child when my wife began having labour pains on the overnight train between Milan and Barcelona, a 16 hour ride. I was almost inconsolable. Thankfully it was a false alarm. She delivered three days later!

Barcelona was more child friendly than we could ever have imagined and this alone was so soothing, let alone the vibrancy of the city and cultural entertainment. My week was split up between operating and cadaveric wrist research in the Barcelona University and I was paired with an American fellow from New York. We worked together to investigate the effect of distal scaphoid resection and the effect on the dorsal ligaments of the wrist. The research paper has been accepted at this year's American Hand Society Meeting in Las Vegas.

The time spent with Marc Garcia-Elias and Albert lluch was invaluable and fascinating with regular meetings and teaching sessions. Their philosophy and approach to hand and wrist pathology was not only ground breaking, but was the culmination of treating the entire spectrum of hand and wrist pathology from newborns to adults over a combined 75 year experience.

Even carpal tunnel release was different performing plastys and reconstruction of the ligament rather than just incision. We learnt new nerve sparing capsulotomies and the new ligament reconstruction for Scapho-lunate tears, capitate resurfacing and wrist arthroplasty using pyrocarbon inserts. In the end I was left with more questions than answers, but with a great vigour to delve more deeply in finding an answer to common problems.

My overseas experience has confirmed the diversity of surgical techniques and approaches for similar problems yet all share a common goal in trying to achieve the best possible outcomes for the patients. My whole family has returned brimming with unforgettable memories and with a huge number of new-found friends. Most importantly it was the inevitable cross-pollination of ideas for both research and management strategies that I hope will allow for better care for my patients.

The Younger Fellows Committee in partnership with Covidien offers two Travelling Scholarships annually which can help to offset the cost of studying overseas.

If you require more information please contact the Younger Fellows Secretariat at Younger.Fellows@surgeons.org or on +61 3 9249 1122.

Helping those who have little

The ups and downs of a career in hand surgery has led to some great achievements

Gerard Sormann at work; QHF fundraiser at Brighton Rotary with two tendon transfer patients and one bionic implant to restore hand function.
Right inset: Grip Aid, applied to fingertips improves friction resistance.

During the thirty-plus years of his career, now-retired Plastic and Reconstructive Surgeon, Mr Gerard Sormann has seen the best and the worst of times in the development of genetic and technological advances believed capable of returning movement to the paralysed.

As the head of restoration of hand function surgery for quadriplegic patients in the Austin Hospital's Spinal Unit, some such breakthroughs seemed to hold enormous promise only to turn to dust and ashes while more practical ideas resulted in actual improvements.

There was, of course, the time when stem cells seemed to be the holy grail of spinal cord regeneration, yet little advance has been made in this field of research in more than 15 years.

Then, in Mr Sormann's particular field of interest, there came bionics.

Developed in the US at the Case-Western University, the bionic device for restoration of upper limb movement, known as the "Freehand System", was introduced into Australia by Dr Sormann in the 1990s.

Believing the units to offer great potential, Mr Sormann lobbied for the funds to pay for the devices, known as functional nerve stimulation implants, and to participate in the US-based FDA trials, but with little success.

So frustrated was he by this, that in 1991 he established the Quadriplegic Hand Foundation (QHF) to help fund the purchase of the $50,000-units. The foundation received such strong support that it was also able to fund the building of a new ward at the Austin Hospital for spinal patients needing elective surgery.

Twelve patients had the bionic units successfully implanted in Australia. Then disaster struck in the US where "A trial to use the same device to restore lower-limb movement failed," Mr Sormann said.

"This was very disappointing, but I continued my interest in this field as Adjunct Professor in Bionic Engineering at the Royal Melbourne Institute of Technology. We patented a unique method of remotely-powering implanted bionic devices.

"This means that bionic implants would not need a battery nor wires and could be powered through irradiating the body at a very safe and specific frequency to stimulate nerves and muscles.

"This technology is still some years away from practical use, but with the rapid advances this does have potential for practical application and may be picked up again by scientists and engineers in the future."

Mr Sormann, who was born in Paris and came to Australia as a young boy, said he chose to become a surgeon and particularly a hand surgeon after having suffered a significant hand injury as a toddler.

> *"Quadriplegic patients suffer such great loss that I believed if I could at least restore some hand function and extend arm movement such patients could at least feed themselves and even paint …"*

"I crushed one of my fingers in a door and lost the tip of it, which was quite traumatic, but then the surgeon sewed it back on and I remember feeling absolutely thrilled that could be done," he said.

"Later during my general surgery training I assisted a plastic surgeon to rebuild a thumb and that impassioned me to such an extent that I realised hand surgery was my calling.

"Hands are an extension of the brain and are not only vital for basic survival, of course, but also as a means of expressing ourselves, of reaching out to touch others, to shake hands, to show love and affection.

"Quadriplegic patients suffer such great loss that I believed that if I could at least restore some hand function and extend arm movement such patients could at least feed themselves and even paint, write and possibly drive a car."

Dr Sormann became involved in the treatment of quadriplegic patients in his role as Head of the Unit of Plastic and Reconstructive Surgery at the Austin Hospital treating the problems of pressure sores in spinal patients.

Having trained at Columbia University Medical Centre in the US and at the renowned McIndoe Burns Unit in the UK, he not only introduced microsurgery and fascio-maxillary surgery to the services offered at the Austin Hospital, but designed a number of procedures that are now commonly undertaken around the world.

"Over the years I invented the use of a silicon device for stabilising the thumb instead of fusing the bones, as well as developing the Brachioradialis Flip operation in which a forearm muscle is used to extend the elbow which is very successfully used around the world," he said.

"After the bionic devices were taken off the market, we went back to tendon transfer surgery to restore elbow extension, wrist extension and finger and thumb flexion and grasp and very successfully treated hundreds of patients.

"We also invented "Grip Aid", a substance applied to the hands of patients with weak or absent grip, which facilitates a tenodesis grip using friction resistance principles such as that of tyre treads, which is now provided to patients at spinal rehabilitation units at no charge here and around the world.

"A young lad in Switzerland has used this to provide the grip to hold a pen and is now finishing a university degree, while a portrait painter has been able to continue working; so while it does not have the excitement of other advances, it is satisfying to have developed something of such practical use."

Throughout these years of thrilling advances and disappointing set-backs, Mr Sormann also became an active board member of the International Quadriplegic Hand Surgery Congress and hosted the congress in Melbourne in 1997.

He travelled the world training surgeons and setting up units first in the UK and then in Israel and in 2010 was invited to be keynote speaker at the South African Spinal Injury Congress during which he ran workshops.

A unit has since been established in Pretoria to conduct such surgery while Mr Sormann has also trained three surgeons at the Austin Hospital.

With an estimated 5-6000 people in Australia now quadriplegic, Mr Sormann also established an out-reach service based at the Austin Hospital to conduct hand function restoration surgery for patients in South Australia, Tasmania and the Northern Territory.

Now in semi-retirement, Mr Sormann is concentrating on teaching at various international centres, with offers of training positions coming in from the US and meanwhile indulging his passions for sailing and travel.

Looking back, Mr Sormann listed the highlights of his career as hosting the Congress in Melbourne, establishing hand function restoration units around the world and treating the backlog of patients in need of such surgery through the outreach service.

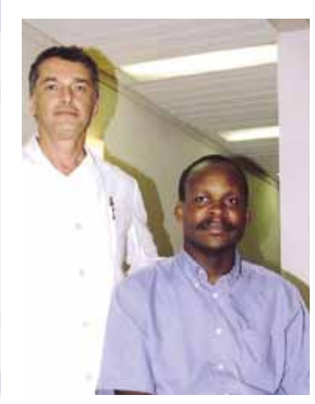
"Just recently I was informed of the first such surgeries in South Africa and that was a very rewarding moment," he said.

"It was Australia, and Melbourne in particular through the efforts of the RACS, where the push to enforce the use of seat belts, helmets and airbags originated, all of which have significantly reduced the number of people suffering complete quadriplegia and that has been enormously gratifying to witness.

"I have always thought quadriplegic people the most deprived of all patients and felt compelled to offer all the help I could.

"I spent my career hoping that if I could give them a little more upper-limb function, a little more movement, that would be a most rewarding endeavour."

With Karen Murphy



Teamwork behind the Fellowship Examination

A great deal of teamwork and organisation goes on behind the scenes of examinations

Spencer Beasley
Chair, Court of Examiners

Examinations don't just happen. They require the commitment, dedication and goodwill of Fellows, Examiners and patients with support from the College examinations department if they are to run smoothly. Our College is unique in that it conducts nine different exams concurrently – while maintaining the genuine sense of collegiality for which our Court of Examiners is renowned. Detailed planning for the examinations commences approximately 18 months beforehand.

The Executive of the Court consists of the Chair and two Deputy Chairs, and the Senior Examiners from each of the nine Specialty Courts. The Senior Examiners represent their specialty at the Executive meeting and share ideas and best practice regarding the conduct of the exam. They also lead their specialty in ensuring the Fellowship Examination remains at the high standard at which it has always been conducted, and that it is continuously reviewed and improved to ensure maximum reliability and validity, and to fit in with the requirements of each specialty's curriculum.

This development and review process is conducted annually at the Specialty Workshops held in February and March. The Senior Examiners are supported by the Deputy Senior Examiner in their specialty, a newly created role to help with the ever increasing responsibilities of the Senior Examiner. The Examiners are involved in the creation of questions, provision of images and, if the examination is being held in their home city, are often called upon to coordinate the sourcing of patients for the clinical component of the examination. Often they rely on colleagues to assist in finding suitable patients.

The Court Registrar is a Fellow nominated by the relevant College Regional Committee to undertake the supernumerary role for the exam. As a 'non-court' member, he or she is responsible for ensuring the vivas run without problems. The Court Registrar organises the Surgical Anatomy component of the examination and is a point of contact for the local coordinators in all nine specialties should any issues arise.

The Local Coordinators are the cogs who make the exam run. Without their assistance on the ground in securing venues, organising patients, collating histories, as well as arranging catering, parking, transportation, marshalls (and even hospital computer "log ins") the Fellowship Examination would not be successful. This role represents a significant and time-consuming commitment by our Fellows, especially in the week leading up to the examination.

The College Examinations Department with the assistance of the respective Regional Office team are integral in their support to all involved in the examinations. It is widely recognised that they go well beyond the call of duty as they ensure the candidates and Examiners have everything they need, and their help is valued and appreciated by the Court.

It would be fair to say that the success of the Fellowship examination is in large part attributable to the commitment and teamwork of the Fellows and staff involved behind the scenes.

The support team for the Otolaryngology Head and Neck Surgery Fellowship Examination led by Mr Sam Arena, FRACS (centre)

Court Registrar -	Mr Tim Bright, FRACS
Cardiothoracic Surgery –	Dr Michael Worthington
General Surgery -	Dr Cea-Cea Moller, FRACS (Royal Adelaide Hospital)
General Surgery -	Dr Sarah Thompson, FRACS (Royal Adelaide Hospital)
General Surgery –	Dr Marina Yeow, FRACS (Flinders Medical Centre)
General Surgery -	Dr Harsh Kanhere, FRACS (Queen Elizabeth Hospital)
Orthopaedic Surgery -	Dr Rob Wallace, FRACS
Plastic & Reconstructive Surgery -	Mr Anthony Porter, FRACS
Vascular Surgery -	Mr Mark Hamilton, FRACS

‘No Time to Stand and Stare’

Sir Alan Newton’s influence at the College ended too soon

Mike Hollands
Treasurer

A Foundation Fellow, but not a founder, Sir Alan Newton’s contribution to the College began with his appointment as Honorary Secretary/Treasurer in 1929 and only ended with his death in 1949.

Newton’s medical career began at the University of Melbourne (MBBS 1909, MS 1912) where he held the Beany surgical scholarship. He completed his training with Victor Hurley and William Upjohn and the trio then moved to the Melbourne (later the Royal Melbourne) Hospital where they obtained posts as Residents and as Honorary Surgeons. Newton described his mentor at the hospital, Frederick Bird as a ‘dextrous surgeon and a sound teacher’ – qualities that could describe Newton himself, for like Bird, he was to become ‘one of the great figures associated with the Melbourne Hospital’.

After service with the Royal Army Medical Corps during World War I – in 1917 he worked with the American surgeon, Harvey Cushing at Ypres – Newton returned to Australia and the Melbourne Hospital. During the 1920s he quickly acquired an extensive surgical practice and like his near contemporary Sir Thomas Dunhill, became a leading exponent of thyroid surgery, specialising in difficult goitre operations.

Surgical circles in Melbourne in the late 1920s were quite insular in both geographical and political terms. Therefore it is not surprising that Newton, who impressed Sir Henry Newland with his clear thinking and ability to grasp essential concepts, was involved with the fledgling College. When Newton joined the Council in 1929, his rooms at 85 Spring Street, which he shared with Sir Robert Hamilton Russell, were just around the corner from the College’s premises at 6 Collins Street. Hugh Devine and AL Kenny also had rooms in Collins Street and according to Newton’s secretary Marjorie Butler, Devine was a frequent caller at number 85. She recalls the following incident from the 1930s which she saw as ‘indicative of his [Devine’s] frequent, familiar and unexpected presence’.

“*It is not surprising that Newton, who impressed Sir Henry Newland with his clear thinking and ability to grasp essential concepts, was involved with the fledgling College*”

Late one morning when Sir Alan had been dealing with two difficult goitre operations, I received an urgent message from the hospital – ‘please tell Sir Alan that one patient is bleeding slightly’. I took up my stand near the front doorstep and on arrival of Sir Alan and his theatre sister, the Daimler headed them quickly back to the hospital. On his return Sir Alan queried anxiously ‘You wouldn’t have told Hugh about that would you?’ ‘Oh no’, I said, but I smiled, even the great are human. They were great friends and though, perhaps not always in complete agreement, this was of benefit to the College; for all matters were discussed fully between them.

Both knighted in 1936, each sharing an interest in thyroid surgery and serving a term as president of the College during World War II, Newton and Devine were complementary characters who meshed the various threads of the College into a cohesive body. One of Newton’s ‘threads’ especially after he became Censor-in-Chief in 1933, was his work on an examination system for admission to Fellowship. He also delineated the role of the College in post-graduate education. In an article published in the *Medical Journal of Australia* in1936 he says:

The College is not content to merely bestow a diploma on those deemed worthy of its Fellowship. The education of a surgeon must continue throughout his lifetime.

Marjorie Butler considered that apart from the College, Sir Alan Newton’s major achievements were his contribution to medical education and his work with the Medical Equipment Control Committee during World War II.

Although intimidating to some, Newton was an imposing and influential teacher. In the 1940s, he became the George Steward Lecturer in Surgery at the University of Melbourne and in this role, initiated improvements to the curriculum and promoted the idea of Chairs of Medicine and Surgery. In one of his last speeches (read by his brother Dr WS Newton), given at the Alfred Hospital in 1948 and entitled: ‘No Time to Stand and Stare’, he advocates the establishment ‘as soon as possible of Departments of Medicine and Surgery, with a unit at each Clinical School’.

Newton’s literary output was prolific – between 1927 and 1948 he produced 35 published and many unpublished, papers. His interests were broad, ranging from his ‘pet’ subject of goitre to medical education and other more obscure topics. In a letter of 1939 to the Secretary of the British Medical Association, he refutes AJ Trinca’s ‘official’ stance regarding congenital hernia and worker’s compensation.

Acceptance of his [Mr Trinca’s] *views would be, in my opinion, unjust to the worker, who should receive compensation if he could prove that a hernia developed, directly or indirectly, after an excessive effort of strain sustained while at work, irrespective of marked immediate symptoms.*

In demand as an orator, Sir Alan Newton’s speeches from the 1940s in the College Archive include one given at a Royal Empire Society lunch for Sir Gordon Gordon-Taylor, at the conferral of Sir Howard Florey’s Honorary Fellowship at the College of Physicians, at the opening of the Rupert Bunny Exhibition at the National Gallery of Victoria and a speech to honour the return of Sir Robert Menzies to the office of Prime Minister. Newton’s speech at Scotch College’s prize giving in 1946 was so impressive that a master at the College was heard to say: ‘We had Menzies last year and he’s no fool, but this year’s effort knocked him cock-eyed’.

The Medical Equipment Control Committee was established at the beginning of World War II to supervise ‘the importing, manufacture and distribution of medical and veterinary equipment and drugs’. Chairman from 1940, Newton was reputedly ‘masterly at circumventing or cutting red tape’. In 1940, on the eve of Japanese occupation and without official sanction, he managed to purchase the Java quinine crop – an important coup in a time of material shortages. His philosophy outlined in the Syme Triennial Lecture of 1944, was simple:

Top: Examiners on the steps of the College, 1937 – Sir Alan Newton, Professor Frederic Wood Jones, Dr Charles Kellaway, Professor A Huggett, Mr Cecil Wakeley, Sir Hugh Devine and Mr HG Wheeler, Secretary of the RACS

Above: Sir Alan Newton, Sir John Ramsay and Sir Hugh Devine, 1939
Opposite page: Victor Hurley, Alan Newton, William Upjohn, 1912 Courtesy of the RMH Archive

The best way of exercising control of anything is to get so much of it that control is unnecessary. The best way to get medical equipment in a world at war is to make it. The fact that we have helped ourselves in this way has led the United Kingdom and the United States to give favourable consideration to our requests for those things we cannot make.

Newton’s work with the Medical Equipment Control Committee coincided with his Presidency of the College (1943-5) and this heavy workload may have contributed to his early death in 1949. Clarity of vision and foresight were his forte and his words in a speech to the Royal Asian College of Surgeons in 1944, still ring true today.

Science knows no national boundaries and scientific ability is not the prerequisite of any one race although any country can suppress it by abolishing independence of thought, regimenting its people and denying adequate facilities for research work.

Written by Elizabeth Milford, College Archivist

Hot Tubbing with the best!

Being a part of legal proceedings has its complexities

David Hardman
Medico Legal Executive

When your friendly lawyer invites you to come hot-tubbing, it may not be the experience you had in mind. The courts have developed a process, used in cases where the expert evidence is central to the issues in dispute, whereby experts from both sides of a dispute gather to discuss their expert evidence, in an attempt to develop a consensus view to help the courts.

A new experience for the medical expert involved in medico-legal proceedings is the invitation, or more accurately, the direction, to participate in a, lawyer free, joint conference with the other experts involved in the same matter.

Such a joint conference, otherwise termed concurrent evidence or expert conference is sometimes identified by the legal slang term 'hot tubbing'. The purpose of the hot tub is to resolve the issues in contention between the medical experts.

The actual 'hot tub' process is that the experts, that is, those medical experts who have submitted reports for the plaintiff and the defendant, are required to meet, as a sworn panel, without lawyers, and discuss the medical issues from their own viewpoint and form a consensus understanding of the issues in contention.

The experts, in good faith, should be willing to consider alternative factual premises and opinions. The joint conference can only work if the witnesses are genuinely prepared to shift their ground.

The hot tubbing experience gives back to the experts a proper role in the court room. It enables the experts to ask questions of each other, and to respond to those questions. The experts can ask, and answer, each other questions in the same way they would interact in their hospital environment, discussing any issue of clinical concern. The outcome of this meeting is a document that identifies the matters upon which they agree, and those matters upon which they disagree.

Any matters upon which they disagree then become the agenda for a discussion in the court room. The judge is responsible for chairing that courtroom discussion, and asking questions as the judge believes to be appropriate, in order to assist the judge to understand what the witnesses are saying.

The introduction of the joint conference has occurred in response to some concerns about the manner in which expert evidence is presented to the courts. There is a frequent perception of bias. Lord Woolf in the interim report, Access to Justice said:

"Expert witnesses used to be genuinely independent experts; men of outstanding eminence in their field. Today they are in practice hired guns. There is a new breed of litigation hangers-on, whose main expertise is to craft reports which will conceal anything that might be to the disadvantage of their clients."

In response to these types of concerns, the court rules changed. These rules evolve in an attempt to balance concepts of justice against the real constraints of administrative efficiency and fiscal accountability. In 1998, the Federal Court Rules were amended to facilitate the use of 'hot tubs'. About this time, similar guidelines were introduced in other jurisdictions.

The Federal Court issued guidelines for expert witnesses, essentially a code of conduct. The principal purpose of those guidelines was to outline the responsibilities of the expert witness to the Court:

(i) 'An expert witness has an overriding duty to assist the Court on matters relevant to the expert's area of expertise';
(ii) 'An expert witness is not an advocate for a party'; and
(iii) 'The expert witness' paramount duty is to the Court and not to the person retaining the expert'.

> *"The outcome of this meeting is a document that identifies the matters upon which (the experts) agree, and those matters upon which they disagree."*

With a decade of experience with the joint conference approach, the courts have reported on the effect of the changes. The Federal Court's experience is that the 'hot tub' narrows the issues in dispute; it is beneficial for all of the expert evidence to be presented while fresh in the mind of the decision maker (the judge); reduces the level of partisanship of experts; and results in a saving in hearing time.

Another concern about the legal process that fostered the development of the joint conference is the view that the adversarial trial may discourage the leading experts from advising the courts.

There is a view that the expert is often paid to promote a position that supports one side or the other. The experts did not see the process as fair; they didn't see it as aimed at identifying in any genuine way, what it was that the expert had to contribute to the case. Rather it was a contest with winners and losers.

Should you get involved?

Consequently, some experts are reluctant to get involved as court witnesses, but this view is to the detriment of the legal system. "The justice system must ensure that the leading experts on relevant issues accept a role in the dispute resolution process. Second rate experts will result in inferior justice and an erosion of confidence in the entire system."

Although the joint conference process has many supporters and judicial proponents, the support is not unanimous within the legal profession. Lawyers, especially plaintiff lawyers, have very real concerns about the gradual erosion of the traditional bulwarks that protect the interests and legal rights of the plaintiff.

There is some concern within legal circles that the use of joint conferences is part of the emerging role of the judicial activist. In some circumstances there is a concern that judicial decision making may be beyond the powers given by legislation or precedent. This concern was foreseen by H.V. Evatt, "The sooner we get back to the ideals that justice should be administrated according to the law and not according to claptrap the better it will be for all."

There are a variety of concerns about joint conference arrangements. These concerns include:

(i) [Hot tubbing] may change expert performances, but to the extent that experts conform to judicial expectations and engage in a more collegial discussion, this does not make the evidence or any consensus reliable or even more reliable.
(ii) The Joint conference or expert conference is part of the trial that is conducted away from the view of the plaintiff, defendant and their legal representatives. This denies the process of justice.
(iii) If there is a difference in the professional positions of the experts (e.g. young surgeon and the professor who taught him), the junior may be intimidated by the imbalance in position. The more articulate expert may have more influence than his professional opinion deserves. Experts may assume the role of advocate and influence the outcome.
(iv) A clinician with a particular atypical or bizarre theory can dominate the discussions and contribute little to the appropriate resolution of the issue in question.
(v) The lawyer spends a lot of money on the reports, and should have the right to present those reports, at a time and in a manner, to the court that allows the lawyers to best put their clients' case.

There is no doubt that the lawyers will continue to argue about the development of the trial process, but from the view point of the medico-legal expert the joint conference is likely to continue. So when you are asked to jump into the hot tub, remember you are there for the court, not the lawyer. Try not to muddy the water!

An extended version of this essay with references is available by contacting MedicoLegalSection@surgeons.org or calling +61 3 9276 7433

This article originally ran in the March 2011 issue of Surgical News, however was incorrectly attributed to the wrong author.

In Memoriam

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

>Duncan Simon, NZ Plastic & Reconstructive surgeon
>Neil Miles, NSW General surgeon
>Douglas Cohen, NSW General surgeon
>Aird Hill Eti Enosa, Samoan General surgeon

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.

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 Angela.D'Castro@surgeons.org
NT college.nt@surgeons.org

Has surgical research lost its way?

My August reading of surgical journals included (1) "Dr Berci receives the College's Jacobson Innovation Award for 2011" in the August *Bulletin of the American College of Surgeons*. Melbourne surgeons will remember his start in endoscopic research in 1957 at the Alfred and Royal Melbourne Hospitals; and (2) "Shifting the curve promoting surgical research in training" by Professor John A Windsor in the August *Surgical News* (Page 24, Vol 12, No 7) of the Royal Australasian College of Surgeons.

My immediate thought was, has surgical research lost its way and thus lost its appeal to another generation of surgeons? In answer to Professor Windsor's remark that contributions would be welcome from Fellows, I would like to add some musings of a retired surgeon.

One of the reasons that I became a surgeon was that I had manual dexterity and enjoyed doing things for my fellow human beings. My experience as teacher of medical students and residents in Philadelphia confirms that the essentially practical aspect is still part of what makes students become surgeons. Surgeons who have clinical expertise and manual dexterity continue to inspire students and residents to emulate them in spite of less than ideal interpersonal skills.

Our College does sterling work and is a leader in surgical teaching and care in a number of third world countries where hundreds of thousands of people are without surgeons and where the practical wielding surgeon's skills will be needed for many years to come. Delivery of these surgical skills should be part of surgical research. Scientific literacy is an essential facility in the explosion of medical publications and Professor J.C. Hall's articles "How to dissect surgical journals" should be mandatory reading in Medical Schools and SET training and examinations. Basic surgical knowledge is necessary to the understanding of biological systems, but surgical research has I feel, lost its way in moving into molecularly orientated scientific research where basic scientists and physicians are more appropriately found.

There is a vast potential for surgical research in implantable devices. The present problems surrounding hip joint implantation suggest that basic surgical research tenets were violated or not used with respect to tissue response to materials and end points of physical usefulness of the implants over years, to name just a couple of essential details that should emerge from such research. Has surgical research been wrested from the academic community by the implant industry or has it lost its way?

Surgeons as hands on professionals are ideally placed to translate knowledge and technology into clinical practice and I see that there is an area of surgical research taking telemedicine, surgery and consultation to third world countries where the RACS has such an impressive history of involvement. Practical surgeons could survey specific areas of need for frequency of surgical pathology and population density and determine surgical instrument need, educational need and consultation services appropriate to the residents of the area. Parenthetically obstetric facility and expertise may loom large as a requirement in such research.

These are just two areas where I see the surgical student would find surgical research appropriate to their own surgical raison d'etre.

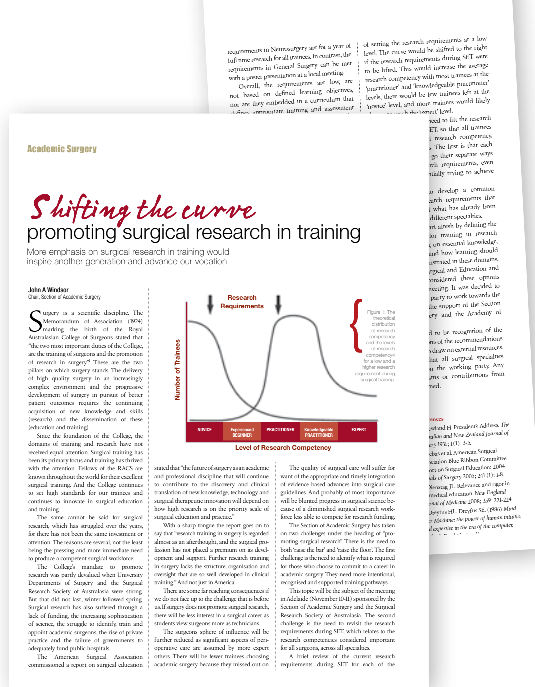
Regarding administrative aspects of surgical research: Should every University Department of Surgery have a Department of Research and what should be the compass of surgical research? The head of research should be involved with private industry and law makers if we are to prevent such events as the present orthopedic problems from lack of continuing surgical research involvement and longtime oversight.

ASERSNIP-S is an important and unique organisation that looks into global research and is particularly useful to practicing surgeons and their patients with respect to emerging technologies. Sadly a number of studies leave the reader with the comment that further studies will be needed before concrete useable (my remarks) statements can be made. This indicates a need for more well thought-out research with at least a reason and goal for the research and a useable end point. This can only come from seriously well trained researchers if we are to get beyond the anecdotal, personal series of case reports which have been the bedrock of surgical advance in the peer reviewed literature.

Training for research is as important as training in any subspecialty and I would urge that it should be post FRACS and as structured as any other specialty. Current surgical training is constrained enough with mandated work hours to say nothing about quality of life issues to add further mandated time in the run up to the big hurdle FRACS. The research Fellow should have grounding in diagnostic, technical and post op. management of surgical cases as a starting point for surgical research. He/she should know how to dissect surgical journals to understand what has gone before, regarding the project proposed. He/she should also be trained and aware of what policy, legal and private industry considerations could be related to their research project. This depth of study cannot be seriously accomplished in the run up to the FRACS.

Dr Berci was a practical surgeon who saw that emerging technologies in lenses and illumination had a place in surgery and thus in surgical research. He has continued to expand this essentially practical work of surgery and technology. We have developing technologies in visual communications, implantable devices and neuroelectronic prosthetic applications as well as the less glamorous, but equally important surgical research into what works and why, and what does not work and why not, to appeal to the next generation of aspiring surgeons. We should leave enzyme systems and molecular biology to professionals who know how to manipulate these systems. If we seriously wish to inspire young surgeons to consider surgical research as a career, we should stick with our strengths because that is where serious research is needed.

John R. Dalton MD, FRACS, FACS.
Wye Mills MD, USA.



Congratulations on your achievements

Brandon Adams
2011 John Corby Medal

The John Corboy Medal is the only College medal awarded to Trainees, and is a significant honour. The four criteria for the John Corboy Medal are outstanding leadership, selfless service, tenacity, and service to the Trainees of the College. The Awardee for 2011 has fulfilled all of these criteria with excellence, and is Dr Brandon Adams.

In addition to his workload as a plastics trainee, Brandon Adams has excelled in a busy portfolio of professional service activities over several years.

Brandon is renowned for tenacious leadership. In 2003, as a student leader, Brandon was instrumental in devising the Advanced Choice of Employment Scheme and then lobbying for its introduction. This successful scheme has now efficiently matched over 2500 graduating doctors to employment in New Zealand over eight years.

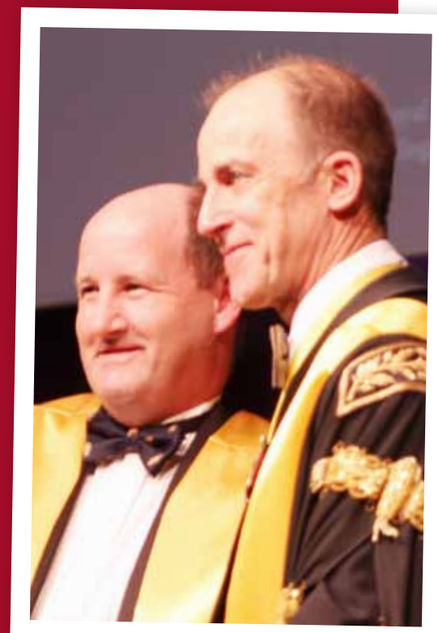
Brandon has served the New Zealand Medical Association for seven productive years, including as Chair of the Doctors in Training Council from 2008 to 2010. In this role, Brandon has been a passionate advocate of medical collegiality, and his exemplary service has improved junior doctor training and welfare. Brandon is recognised by RMOs, senior doctors, and administrators alike as a spokesman for New Zealand junior doctors.

Brandon has served as a committed representative on the RACS Trainees Association for four years and in several capacities. His leadership skills were formative in providing direction and momentum to the early committee, and he was a key voice during the transition to SET. Trainees have appreciated Brandon's intelligence, wisdom and diplomacy skills, and he has contributed to the College becoming more responsive to the needs of its trainee members.

Aside from these outstanding contributions to the medical community, Brandon has achieved academically, being regarded as an excellent trainee and having achieved 10 research publications in his early career.

Brandon is a selfless leader, an effector of positive change, and above all, a role model of trainee professionalism. He is the deserving awardee of the 2011 John Corboy Medal.

The John Mitchell Crouch Fellowship is the premier research award of the Royal Australasian College of Surgeons. It is separate from Foundation Grants and independently funded. The Fellowship commemorates an outstanding younger Fellow of the College who died in 1977 on the threshold of a highly promising career. John Mitchell Crouch was a young surgeon who showed astute clinical, organisational and research abilities and this award is made to an individual who, in the opinion of Council, is making an outstanding contribution to the advancement of surgery.



David Little
2011 John Mitchell Crouch Fellowship

Professor David Little graduated MBBS in 1986 from the University of Sydney. After completing his specialist training in the Australian Orthopaedic Association training scheme (in 1994), he became a Fellow of the College and went on to complete his PhD on bisphosphonates in distraction osteogenesis (in 2005). He undertook fellowships in Paediatric Orthopaedics in America at the Shriners Hospital for Children in Portland, Oregon, and Texas Scottish Rite Hospital for Children in Dallas.

In his career to date, he has received several prestigious awards, including the Basic Science Paper Award for the outstanding paper at the 2005 and the 2010 Paediatric Orthopaedic Society of North America meetings. He was an ABC Travelling Fellow in North America, and received the Australian Orthopaedic Associate's Award for Orthopaedic Research for his contribution to international orthopaedic research.

Professor Little has been invited to lecture at a number of national and international meetings in Australia, South Korea, USA and Spain, and has been published in several high impact publications, with 21 of his papers being cited at least 21 times. He has expanded his teaching role with research students in the last five years, being involved in the supervision of three students to completion of a PhD as well as five current PhD students.

Currently the Head of the Orthopaedic Research and Biotechnology Unit at the Children's Hospital at Westmead (CHW) NSW, and Senior Staff Specialist in Paediatric Orthopaedics, David is also a Conjoint Professor at the University of Sydney. In 2003, he published the first paper suggesting that bisphosphonates may be a useful therapy in osteonecrosis. Since then he has pioneered the investigation of bisphosphonates modulation of bone repair. The receipt of the John Mitchell Crouch Fellowship will assist Associate Professor Little in his current research into the cellular contribution to bone repair and bone tissue engineering, research which has high translational value to many areas of clinical need in orthopaedics. The current focus of his department's research includes improving bone healing outcomes in neurofibromatosis, and using muscle for in vivo bone tissue engineering.

Associate Professor David Little is a highly respected clinical leader with a busy clinical load, who has a highly productive research track record and whose laboratory has a considerable international reputation. He is a commendable recipient of the 2011 John Mitchell Crouch Fellowship.

Citation kindly provided by Julian Smith FRACS

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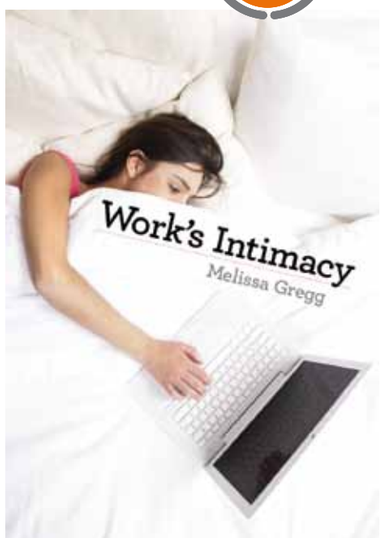

Work's Intimacy

Melissa Gregg

9780745650289 | Pbk | 200 pages | August 2011

~~AU$29.95~~ | **AU$22.46**
Member Price

This book provides a long-overdue account of online technology and its impact on the work and lifestyles of professional employees. It moves between the offices and homes of workers in the new 'knowledge' economy to provide intimate insight into the personal, family, and wider social tensions emerging in today's rapidly changing work environment.

This ground breaking book explores how aspiring and established professionals each try to cope with the unprecedented intimacy of technologically-mediated work, and how its seductions seem poised to triumph over the few remaining relationships that may stand in its way.

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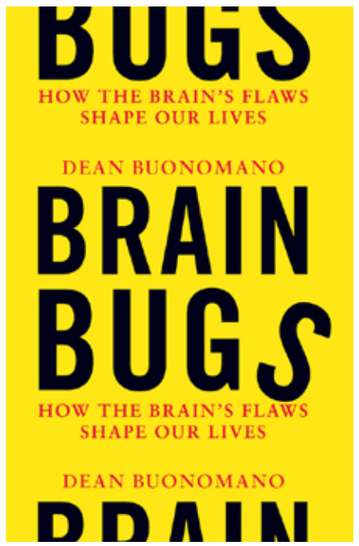

Brain Bugs: How the Brain's Flaws Shape Our Lives

Dean Buonomano

9780393076028 | Hbk | 336 pages | July 2011

~~AU$32.95~~ | **AU$28.00**
Member Price

With its trillions of connections, the human brain is more beautiful and complex than anything we could ever build, but it's far from perfect. Our memory is unreliable; we can't multiply large sums in our heads; advertising manipulates our judgement; we tend to distrust people who are different from us; supernatural beliefs and superstitions are hard to shake; we prefer instant gratification to long-term gain; and what we presume to be rational decisions are often anything but.

Drawing on striking examples and fascinating studies, neuroscientist Dean Buonomano illuminates the causes and consequences of these 'bugs' in terms of the brain's innermost workings and their evolutionary purposes. He then goes one step further, examining how our brains function – and malfunction – in the digital, predator-free, information-saturated, special effects-addled world that we have built for ourselves.

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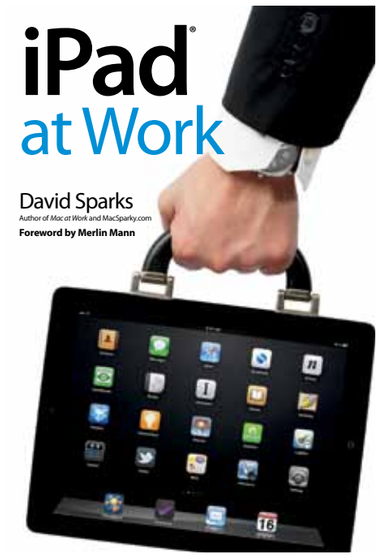

iPad at Work

David Sparks

9781118100561 | Pbk | 368 pages | October 2011

~~AU$37.95~~ | **AU$28.46**
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Great ideas and advice on using your iPad as a business tool. More and more iPad users are discovering that the versatile, portable iPad has countless business uses, and increasing numbers of high-profile companies are integrating iPads into the enterprise.

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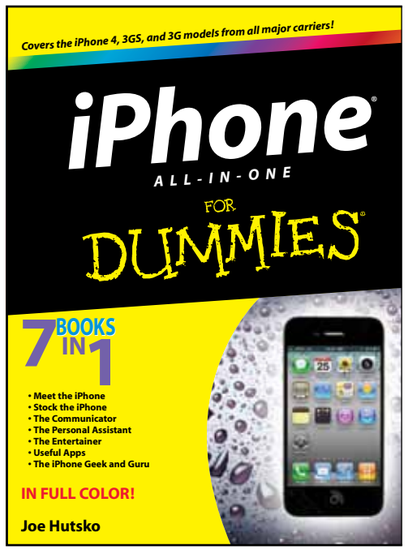

iPhone All-in-One For Dummies

Joe Hutsko, Barbara Boyd

9781118101193 | Pbk | 592 pages | October 2011

~~AU$42.95~~ | **AU$32.21**
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Go from smartphone newbie to iPhone expert with this amazing all-in-one guide! Here's the book for iPhone users who want it all--the basics to get started and the advanced info that puts all the iPhone s power at your fingertips. iPhone All-in-One For Dummies includes seven minibooks – nearly 600 pages in full color--packed with next-step information for iPhone power users at home, at work, or on the go.

Writing in the famous straightforward yet fun For Dummies style, tech experts John Hutsko and Barbara Boyd get you acquainted with your iPhone and take you step by step from simple to advanced: surfing the Web to taking photos and videos; staying in touch via e-mail, video calls, and social media to losing yourself in e-books and magazines to guru-level techniques anyone can learn.

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Super Freedom: Create a Worry-Free Financial Future in 6 Steps

Trish Power

9781742469713 | Pbk | 288 pages | September 2011

~~AU$32.95~~ | **AU$24.71**
Member Price

Super Freedom is just that a guide for women to super. This guide has a strong, aspirational focus on what superannuation can provide for women, regardless of their marital circumstances, age or even their current superannuation balances. For women it s not so much about the actual amount of super they have, but what they can do with it, eg travel, shop, live.

Throwing aside the shackles of jargon and terminology, Trish Power s guide to superannuation for women, provides with women with everything they need to know about how much super they need, getting their super set up, how to increase their super balance, how to move into retirement, insurance and estate planning.

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Research a passion of the heart

Dr Yi Chen looks forward to more collaborative research

Working in collaboration with scientists in Melbourne and Seattle, cardiothoracic trainee Dr Yi Chen has not only described the role played by the protein activin A in myocardial ischaemia reperfusion injury (IRI), but has also shown that the naturally-occurring compound follistatin can reduce IRI by neutralising the effect of activin A.

As part of his PhD thesis, which he is now in the process of finalising, Dr Chen used mouse models to investigate the effects of using follistatin, an anti-fibrotic agent, as a way to reduce the inflammatory response caused by the effects of activin A during myocardial reperfusion.

Having proved the hypothesis in animal models, Dr Chen said that in the future, if follistatin could be commercially produced, it could be used either before or during heart surgery to reduce IRI.

"Every time the heart stops and then blood is restored, the patient suffers some degree of ischaemic reperfusion injury, which means that even patients who have had successful heart surgery often do not get the full benefits of it," Dr Chen said.

"Having looked at the role of activin A in cardiopulmonary bypass at the start of my research, I then wanted to see if it plays any role in myocardial IRI because the problem of IRI is so common and in severe cases can lead to a significantly prolonged stay in intensive care.

"It was most rewarding to investigate follistatin and to see how it binds with activin A to neutralise its action in setting off IRI and in future, after a great many other questions have been answered, it may be possible to put it into the cardioplegia solution as a part of a myocardial protection strategy."

Dr Chen said, however, that the science was still in a very preliminary stage now with much still to be understood both about activin A and follistatin. He said activin A had only been isolated within the past 20 years and that while it was originally understood to be primarily a reproductive hormone, subsequent research pointed to a larger role as part of the body's defence mechanism.

He said work was now underway to determine exactly how and when activin A was released as well as the mechanisms controlling the production of follistatin.

Dr Chen has received three RACS scholarship to support his research, the latest being the Surgeon Scientist Scholarship for 2010.

He has undertaken his PhD under the supervision of Professor Julian Smith from the Department of Surgery at Monash University and Associate Professor Mark Hedger and Dr David Phillips at the Monash Institute of Medical Research.

His work has also been undertaken as a collaborative project with scientists at the Baker Institute in Melbourne and the Department of Surgery, University of Washington, Seattle, which Dr Chen visited to undertake the in vivo mouse studies.

"The people I worked with in Seattle have great expertise in animal models of myocardial ischaemia reperfusion and it was a wonderful experience to work alongside them and learn from them," he said.

Dr Chen presented his early findings at the Annual Scientific Meeting of the Australasian Society of Cardiothoracic Surgeons in 2009 and now has a number of articles awaiting publication.

He said he was honoured to have received such strong support from the College and said that even though he is now back in full-time training at the Monash Medical Centre he hoped to continue his research in the field.

"This is an interesting area of cardiac research because IRI can have potentially devastating effects on patients even when cardiac surgeons are doing everything they can to treat it," he said.

"It happens to every patient who has a heart attack and even if the original problem can be remedied through surgery, IRI can still weaken the heart and increase morbidity and mortality.

"While I am now concentrating on finishing my cardiothoracic training, I hope to still find the time to work alongside other researchers in our attempt to answer the questions still remaining relating to both activin A and follistatin because if the science could be translated into a product, the benefits to patients could be enormous."

With Karen Murphy

NOT ONLY DOES IT FEEL LIKE A SECOND SKIN

IT HAS ITS OWN IMMUNE SYSTEM

Kills >99% of a hepatitis C virus surrogate

Kills 99% of HIV-1 strain Mn*

Kills >99.7% of 8 common infectious bacteria

Only GAMMEX® Powder-Free Glove with AMT Antimicrobial Technology combines the added protection of a unique antimicrobial inner coating with unsurpassed fit and comfort.

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* HIV-1 strain Mn is a well-studied, virulent strain of HIV-1.
GAMMEX Powder-Free with AMT contains natural rubber latex, which may cause allergic reactions.
GAMMEX Powder-Free with AMT is not proven to protect against blood-borne infections where the skin is broken, cut, or punctured.
Australia Patent No. 703926 and New Zealand Patent No. 556353. AU and worldwide patents pending.