Surgical news

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THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The vineyard has given Robert Lusby more enthusiasm for surgical work. PAGE 46

The College of Surgeons of Australia and New Zealand

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Times are changing

Political imperatives are one of the drivers

Ian Civil
President

As this President's Perspective is being written, there is uncertainty about the outcome of the Australian election. It should prompt us to reflect that the world of surgery does change and political imperatives are one of the drivers. Across Australia and also New Zealand, disillusionment with a sitting government regularly produces change and with it different approaches to health, health service delivery and regulation of surgical practice. All of these are relevant to the purpose and the structure of the College of Surgeons.

Over the last series of elections in Australia, the office of the College Vice President has been very active in seeking the opinion of the various political parties on the key issues identified by our Governance and Advocacy Committee in consultation with Regional Chairs and Councillors. The College has then informed its Fellows on the political responses and how those stack up against our areas of concern. The College has actively increased its profile as the body to consult on surgical issues in areas of workforce, service delivery and standards.

Strength in a unity of purpose

I am often asked about the purpose of the College in being the unifying force for surgery. Some specialty groups feel that a more subspecialty focus would "win the day" for their initiatives. While this is understandable there are strengths and weaknesses in this approach and from an overarching surgical perspective the latter feature dominates. There is much reason why an industrial mantra of "united we stand, divided we fall" is based on fact. All political parties and government bodies look at the size of the group and the impact that it can bring. While focused advocacy on a specialty-related issue will always be important, the ability to present a critical mass and the capacity to create ongoing relationships with the many government bodies that have a role in the health sector is vital. Governments delight in a fragmented and distracted series of small issue groups. They can be ignored more readily.

"There is much reason why an industrial mantra of 'united we stand, divided we fall' is based on fact"

What binds us together is stronger than the differences perceived

Although surgery is now practised in many different environments from the consulting room to day surgery facility to public and private hospitals, the commonality of purpose, the fundamental similarities in our approach to training, standards and ongoing professional development speak to the benefit of a common voice. However, this certainly does not stop individual issues being addressed and the combined approach by both the College and individual specialty society can prove particularly effective.

Ongoing regulation requirements

Although times are changing, there is no doubt about the constancy of direction in the change of our regulatory bodies. As most practising surgeons are aware, this trend is world wide. High profiled medical cases have given cause for regulatory bodies to be more emphatic around standards and the way they are demonstrated throughout a professional career. The Medical Board of Australia has now mandated the compulsory undertaking of continuing professional development and the successful certification of that to maintain registration. This has been in place in New Zealand for some time as has the requirement for mandatory reporting. As Australia catches up with New Zealand on both ▶

of these issues, it is important that the proposed changes are carefully monitored to see they are both reasonable and effective. The College continues to play a key role in interacting with the Medical Board of Australia and the Medical Council of New Zealand to ensure the systems work effectively at both an organisational and individual level.

So what is the value of the FRACS?

The College is moving strongly into re-branding the FRACS. This is the accepted standard of surgery in Australia and New Zealand. The College and the specialty societies still deliver an educational program that culminates in the FRACS as the measure of high surgical expertise. We have been substantially successful in ensuring that multiple standards for surgery with their associated problems have not been established.

Over the next few months our FRACS trademark will have a new profile and we will move to ensure that Fellows wanting to use our Coat of Arms on their own letterhead have an effective method of achieving this. Our recent interactions around cosmetic surgery and podiatric surgery as well as Bundaberg Hospital have demonstrated again the importance of clearly stating to the public that the FRACS is the standard. It is the capacity to have this recognition both nationally and internationally that is the most valuable intellectual property that is with the College.

As some things change other issues continue to be the same?

Despite the ongoing changes in our professional lives, there is always a small number of constants. One of them is that as organisations become larger, more sophisticated and with better infrastructure, the internal desire to separate and become totally autonomous grows. Most of the Fellows of the College would recognise this happened a number of times in the College's history and as an example the orthopaedic surgeons in Australia have reviewed their relationship with the College on a number of occasions.

The Australian Orthopaedic Association (AOA) is again undertaking a "due diligence" on formally removing its training program from under the College regulatory framework and to be directly responsible themselves to the Australian Medical Council, the Australian Competition and Consumer Commission and other bodies. Obviously any specialty society has the right to review the way it undertakes its activities. The College interfaces with all these external bodies as effectively as it can and interprets their regulations carefully. However, that does not mean this is the only way. Currently the specialty societies manage a largely autonomous training program where their standards are highlighted and maintained, but the strengths of all the nine specialties can provide advantage. However, this obviously requires the specialty society to see both the advantage and strengths of the FRACS and a College approach. Like in so many collective activities there are enormous strengths, but some constraints. Being seen as an "agent" can be viewed negatively whereas on the other hand the "protection" of the College in relation to the constraints of regulatory bodies and the legal framework of appeals is a significant advantage. The College is in regular dialogue with the Board of the AOA to ensure each body is aware of the issues under discussion and provide accurate information when that is required.

The most substantial constant

As I interact with many Fellows of the College I continue to be impressed by the most substantial constant in that despite all the ongoing change, Fellows continue to strive to provide surgical care of very high standard in an incredibly complex array of challenging environments. There is no doubt about the commitment of our colleagues to their patients, the community and our profession. It is indeed an honour to be the President of this College

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2011 YOUNGER FELLOWS FORUM
Barossa Valley SA, 29 April – 1 May 2011

2020 AND BEYOND:
Future Challenges for Surgical Practice

The 2011 Younger Fellows Forum (the Forum) is to be held in South Australia. The Forum offers a unique opportunity for a diverse and representative group of Younger Fellows to share ideas and experiences and debate issues that they believe affect their professional and/or personal lives.

During the Forum you can explore future challenges for surgical practice including medico-legal implications, the business of surgery and healthcare delivery in the 21st century. You will have the chance to socialise with your peers and engage in robust discussion with College councillors and international guests. The Younger Fellows Committee invites you to have your say, relax and be involved in your College!

Applications close Friday 29 October 2010.
For further information visit the College website www.surgeons.org
or call +61 3 9249 1122.

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

How? *Please complete a nomination form and return by fax, email or mail to the College Younger Fellows Secretariat Younger.Fellows@surgeons.org*

Cost? *This is a College sponsored event; delegates are required only to cover their travel expenses.*

Planning the 2011 census

Need for training across Australasia is paramount

Keith Mutimer
Vice President

With findings of the 2009 Surgical Workforce census recently featuring in the New Zealand and Tasmanian press, it is timely to look ahead to the next census – scheduled for 2011. While the 2009 census was notable for its excellent response rate, legitimate concerns were raised by New Zealand Fellows who felt they were completing an "Australian" census. Accordingly, the workforce office is endeavouring to prepare a New Zealand specific component of the 2011 census beyond the core questions.

Fellows should not hesitate to contact the College if they have other concerns or ideas that might improve the census. The best point of contact is the Workforce Planning and Research Officer, Ms Kellie Hardy, at kellie.hardy@surgeons.org

New Zealand's Workforce Needs

Rural hospitals provide the bulk of acute medical care for their communities in New Zealand. Yet relatively little research has been conducted into the working conditions in New Zealand's 44 rural hospitals.

This is in part attributable to the fact that New Zealand lacks an official definition of a "rural hospital" – despite rural hospitals servicing approximately 10 per cent of the population. The Ministry of Health's hospital services plans refer to "health centres", which may be beds, "sub acute units" or "secondary hospitals" .

Matters are further complicated by the fact that the Ministry of Health categorises some rural hospitals as "non-public" and therefore deems them to be private. These hospitals, however, are run by community organisations and funded by public money provided via contracts with their respective District Health Boards .

In July 2005, a working party was formed to examine the vocational issues faced by doctors working in New Zealand's small rural hospitals . The working party gathered only limited data on rural hospital medical workforces, restricting its inquiry to specialist General Practitioners and excluding from its terms of reference surgeons, physicians and emergency medicine physicians.

Of the New Zealand based respondents to the 2009 census, 77 per cent stated that there were sufficient surgical services within 30 minutes of practice, while 66 per cent stated there were sufficient surgical services within two hours of practice. Australian Fellows answered 80 per cent and 64 per cent respectively.

The smaller the structure of a rural hospital, the more multi-skilled its workforce needs to be.

It is also apparent that the presence of adequate support services in rural hospitals is an important issue. For example, the laboratory is now such an integral part of the modern hospital that it would be hard for clinicians working in urban hospitals to imagine providing acute medical care without access to immediate blood test results. Yet this is the reality in many hospitals servicing rural and remote communities, even in a developed country such as New Zealand .

In some places the transient nature of the medical workforce can result in varying skill levels which, of course, affects the level and predictability of service provision. Responses ▶

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> *"It is crucial to the provision of safe and equitable surgical services in New Zealand's rural communities that we learn more"*

to the census question regarding the adequacy of infrastructure and surgical services – including ward care, pathology, radiology, anaesthetics, physicians, junior medical staff and allied health cover – were particularly interesting. The level of ward-based staff was identified by 30 per cent of New Zealand Fellows as barely adequate to dangerously inadequate (in Australia 29 per cent). Of the respondents 57 per cent considered the level to be adequate (in Australia 59%). The level of junior medical staff cover was considered by 33 per cent of respondents to be barely adequate to dangerously inadequate (in Australia 29 per cent), with 50 per cent of Fellows considering the cover adequate (in Australia 55 per cent).

With regard to pathology services, 77 per cent of New Zealand Fellows considered the cover adequate (in Australia 78 per cent), while 12 per cent found it barely adequate to dangerously inadequate (in Australia 11 per cent).

It is crucial to the provision of safe and equitable surgical services in New Zealand's rural communities that we learn more. And, of course, it is crucial that government responds to identified needs.

A renewed commitment to training

A long term commitment to growth in surgical supply is fundamental to meeting the future needs of New Zealand and Australian communities – in our cities and our country towns. While genuine commitment needs to be demonstrated by governments, and reflected in their budgets, we too must demonstrate commitment.

The need for training is paramount. In the New Zealand public sector, 55 per cent of respondents to the 2009 census identified a need for further colleagues in either half or full time capacity. In Australia, the figure was 50 per cent. This is probably a reflection of decisions taken by governments in both countries to reduce medical training places in the 1980s and 90s .

Interestingly, however, Fellows in both countries feel that the number of Trainees is about right. Fifty-seven per cent of New Zealand Fellows stated that the number of Trainees currently being trained is just right, with a further 19 per cent stating there are too many. Of Australian Fellows, 56 per cent stated that Trainee numbers were just right and a further 23 per cent stated there are too many.

This may not be the case for long, however. Currently, 34 per cent of active New Zealand Fellows are over the age of 55, 37 per cent plan to retire from public practice in the next 10 years (20 per cent in less than five), and 33 per cent plan to retire from private practice in the next 10 years (16 per cent in less than five). In Australia, 35 per cent of active Fellows are over the age of 52. Of these, 41 per cent intend to retire from public practice over the next 10 years (22 per cent in less than five years) and 36 per cent plan to retire from private practice in the next 10 years (17 per cent in less than five). These are clearly matters than warrant ongoing consideration and discussion.

I very much enjoyed the opportunity to talk with New Zealand based Fellows at your Annual Scientific Meeting in Queenstown in late August. The Deputy Chair, Relationships, Vince Cousins, also appreciated the chance to canvass some of the issues discussed above.

Rural surgery

I can't quite see your average Collins Street general surgeon doing the operations that the NT surgeons do with such aplomb

I.M.A Newfellow

Darwin is a great place to visit when the Southern capitals are foggy and wet. I am not sure if it is such a great place when Darwin is hot and wet. The Southern, Western Australian and Northern Territory (NT) regions held a combined meeting in Darwin in late August, which I attended. Rural surgery has never really been my thing, but after this inspiring meeting I wished that I was 30 years younger and just starting out in surgery (well maybe that would have to be 45 years younger when one looks at my age). If that was the case I would have loved to be working in the frontier of medicine – by this I do not mean in a southern based research Chair, but in the exciting frontier of rural surgery.

They deal with everything

The papers that were presented included papers from Darwin surgeons that indicated that they were not just general surgeons, but generalist general surgeons. They could open a head for trauma, a chest for almost anything and an abdomen for urology, vascular, upper and lower gastrointestinal and also deal with paediatric problems. As well as the technical aspects of surgery they had to deal with the difficult area of indigenous health. I can't quite see your average Collins Street general surgeon doing the operations that the NT surgeons do with such aplomb. As for my super sub-specialty of left big toe surgery, I would be of no use in the NT or indeed in any rural area.

There were of course the usual odd injuries. The NT people seem to have a fixation with the wild creatures of the Top End. One presenter could not help slipping in a chest x-ray of a crocodile crush injury (a chest crushing injury caused by a croc bite – not a crushed croc). I recall one presentation in Darwin some years ago of a case of a man who had a crocodile injury to the arm; when his case notes were retrieved his past history included another crocodile injury. One would think that he would have heard of the maxim, "Once bitten, twice shy". But then he was a professional crocodile egg collector. It seems that the NT Times (not a paper read by many southerners and if you can believe what they say not read by any Darwinians at all) has a regular diet of crocs, scantily clad young women, tragedies, scandals of all sorts and more crocs. They do have an excellent cryptic crossword, however – not that I would ever read the paper of course.

The difficulties faced by rural surgeons include having to have a very wide range of skills, living in areas that may be difficult for spouses to follow their careers, a narrower range of educational possibilities for children, under-funding of medical services, lack of specialist support services and difficult clinical problems. After seeing the range of conditions treated in Darwin and the special health problems they treat, I am amazed that any surgeon is willing to work there – but they do and do a remarkable job.

It was ironic that the last day of the meeting in crocodile territory coincided with the other big crocodile event, namely the Federal Election when we all vote for the bunch of crocodiles in Canberra. Of the two lots of crocodiles I think that I prefer the ones in the NT, as they are at least in a warm climate and not as cold-blooded as the Canberra crocs.

Fellowship examination workshop

The Court of Examiners is keen to strengthen the Fellowship Examination

Spencer Beasley
Chair, Court of Examiners

A major review of the Fellowship Examination is underway. As part of that process, a Fellowship Examination workshop was held immediately prior to the May examination in Sydney. This was attended by the senior examiner of each specialty and a number of other Fellows and staff with ongoing responsibilities for the examination. This is the first time the Fellowship Examination has come under such intense scrutiny for many decades.

The Court of Examiners is keen to strengthen the Fellowship Examination, and make it more effective as a true "exit" examination.

It has become evident already that several refinements to the examination are required urgently. There is a particular need to better integrate the Fellowship Examination with the other assessment processes of Surgical Education and Training (SET), and to better align each specialty's examination with the relevant specialty curriculum.

In general, the Fellowship Examination tests the clinical application of knowledge, and clinical and operative judgement. The assessment tools available to examiners now are more varied and sophisticated than before, but often require considerable Information Technology (IT) support: establishing this has been recognised as a priority area. Greater IT support is also required for analysis of the validity and reliability of each component of the examination, and for monitoring and providing feedback on examiner performance.

Candidates increasing

The examinations themselves are much more structured than they used to be and their conduct requires a high level of expertise by members of the Court of Examiners. This has obliged the Court to commence development of a program for training new examiners, and to monitor current examiner performance.

There has been a steady increase in the numbers of candidates presenting to each examination, a trend that is not only expected to continue, but is also likely to happen at an increased rate as Trainees of the expanded SET program come through the system. Even now, some of the examinations are massive logistical exercises: for example the last examination had 211 candidates, 116 examiners and 380 patients spread across 11 venues. There is a risk that the size of the examinations may become unmanageable, inefficient and unnecessarily expensive. Consequently, there is a working group reviewing the configuration, frequency and location options for future examinations.

Current policy requires the Deputy Chair of the Court to be of a different nationality to that of the Chair. The vagaries of Council elections for the Chair mean that sometimes the nationality of those holding both positions has to change simultaneously and frequently, with a certain loss of continuity. The executive of the Court has unanimously recommended that there be two deputy Chairs, one from each country, and their tenure would be unaffected by any change in Chair.

The next few years should be exciting for the Court of Examiners as it implements those changes required to keep the Fellowship Examination relevant and of quality.

2010 Sydney Colorectal Surgical Meeting

13 November 2010

Sofitel Sydney Wentworth

Peter Loder Chair, Sydney Colorectal Surgical Meeting

Pierre Chapuis Chair, Scientific Program Committee

Further information and sponsorship opportunities contact: Royal Australasian College of Surgeons

E: 2010Colorectal.SM@surgeons.org T: +61 3 9249 1248 F: +61 3 9276 7431

College Conferences and Events Management

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

AUSTRAUMA - 11TH

Annual Trauma, Critical Care & Emergency Surgery Conference

Sydney Convention
& Exhibition Centre
Darling Harbour, Sydney

17 - 19 February 2011

Conference Convener: Dr Valerie Malka

Further info & sponsorship opportunities:
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T: +61 3 9249 1139 F: +61 3 9276 7431

Annual Scientific Congress

Adelaide Convention Centre, Adelaide, Australia

2 – 6 May 2011

Royal Australasian College of Surgeons

UNITY THROUGH DIVERSITY 80 years of the ASC

Assessment of International Medical Graduates

Trade practices and legal issues

Michael Gorton
College Solicitor

The assessment of International Medical Graduate (IMGs) doctors is a valuable and necessary part of our culture of safety and standards of performance for the medical profession. The "Patel Case" highlights the need to ensure that those who practise in Australia and New Zealand are appropriately trained, skilled and experienced.

Medical Colleges are best placed to assess the prior learning and experience of specialist medical practitioners.

However, such decisions are also affected by other legal requirements:

1> The need for fair and impartial assessment processes.

2> The application of consistent and objective assessment criteria.

3> The right of review/appeal.

The decisions also operate in the context of the Trade Practices Act – anti-competition law that seeks to ensure that barriers to IMGs into medicine are not artificial or designed to protect the "businesses" of existing doctors.

There has been a long history in the development of the College's processes and procedures for IMG assessments, and it is worth recalling some of that history.

1> Almost a decade ago the Australian Competition and Consumer Commission (ACCC) formally made allegations against the College and the Australian Orthopaedic Association (AOA) in relation to the conduct of the training program and assessment of overseas medical graduates. In essence, the ACCC alleged that the College and the AOA operated a "closed shop" conducting a program which had unnecessary and arbitrary restrictions on the entry of potential surgeons to Fellowship, and therefore to the surgical markets in Australia. The then rules of the College for its training program and assessment of overseas medical graduates was alleged as being unnecessarily restrictive, and in breach of various provisions of the Trade Practices Act, notably section 45 of the Trade Practices Act.

2> The ACCC issues arose at a time when the College was also dealing with the recommendations of the Brennan Report, which required medical colleges generally to have greater transparency and objectivity in the rules and regulations governing their training programs, and selection procedures. The Brennan Report also required that the medical colleges implement independent appeals mechanisms.

3> As a response to some of these issues, the College determined to make an application to the ACCC for "Authorisation", being a procedure by which the College could be "approved" to continue to carry out its programs, with immunity from trade practices allegations.

As a result of that process, the ACCC granted Authorisation, and determined a number of conditions applicable to the College's training program, selection processes and assessment processes.

Those conditions were detailed and included such measures as:

> The introduction of jurisdictional representatives to the various committees of the College, to act as full members of selection committees, advisory committees, etc.

> The requirement to ensure that the criteria for selection and assessment is objective, transparent and publicised.

> The need to ensure that review and appeal processes are fully transparent, and contain independent members who can provide assurances to the public that decisions are made on a transparent and objective basis.

> The removal of any arbitrary processes, such as a right of veto, or the introduction of non-objective criteria to the selection or assessment process.

These conditions became the pro-forma template for all medical colleges, not just the College, and in effect became the basis upon which the ACCC would allow medical colleges to continue to conduct independent training programs without interference, and without further allegations of anti-competitive conduct under the Trade Practices Act.

4> Ultimately, after three years, the College determined not to renew Authorisation, on the basis, particularly, that the College's processes had been greatly reformed whilst holding Authorisation. The College took the position that it had substantially reviewed and improved its processes in relation to transparency and objectivity, to a point where it no longer needed the immunity afforded the College by Authorisation. This leaves the College currently without immunity from allegations of breach of the Trade Practices Act; although so long as the College maintains the agreed conditions that arose from Authorisation, it is unlikely that the ACCC would make any significant move against the College. To date, although a number of third parties have made these allegations to the ACCC, the College has been able to satisfy the ACCC that it continues to follow the former conditions of Authorisation, and that it maintains objective and transparent processes as originally envisaged.

5> One of the conditions of both the ACCC Authorisation, and adopted by the Australian Medical Council (AMC) for accreditation processes, was the requirement that the College have formal and transparent processes between the College and the specialist surgical societies for the implementation of all requirements of the Training Program and IMG Assessment. Following full consultation, the College entered into a memorandum of understanding (MOU) with each of the specialist surgical societies to address these matters. In particular, both the College and the Societies committed to conducting the Training Program under the processes accredited with the AMC.

6> Further review of processes has occurred in collaboration with other medical colleges, and with JSCOTS and the AMC. The emphasis by these external bodies is to maintain the objectivity and transparency of the processes, as well as to move to nationally consistent processes and policies. Obviously, if the College participates in nationally consistent processes, which have been endorsed by external bodies such as the AMC, Joint Standing Committee on Overseas Trained Specialist (JSCOTS) and others, it is less open to the criticism that it is engaging in anti-competitive conduct and can more easily maintain the argument that it is simply applying appropriate standards of assessment.

7> In this context, any suggestions for change need to consider:

7.1> the advantages of maintaining nationally consistent processes and procedures with other medical colleges, as endorsed by external regulatory bodies;

7.2> maintaining the processes and procedures within the confines of the conditions originally imposed by the ACCC, as necessary to protect the College from allegations that it was engaging in anti-competitive conduct;

7.3> the need to ensure that the College is not exposed to potential claims by third parties (trainees, applicants for assessment etc.) who could make individual allegations that the College was in breach of the Trade Practices Act;

7.4> the College's general reputation, with government and others, to maintain the College's claim that its processes are entirely objective and transparent.

Some of the suggestions for change, such as:

- a right of veto, presumably on an arbitrary basis;
- the removal or limitation of involvement of jurisdictional representatives;
- the limitation of the independent right of review and appeal;

would substantially reverse some of the areas required previously by the ACCC, and which now form a significant and important part of the objectivity and transparency of College processes.

> *"In particular, both the College and the Societies committed to conducting the Training Program under the processes accredited with the AMC."*

It is not the intention of this paper to assert that no changes can be made to College processes, or that improvements to its processes cannot be developed over a period of time. However, any reform must be considered within the parameters of the legal, policy and political framework in which the College must now operate.

Excessive Working Hours and Fatigue

We are getting fewer breaks and our pagers ring constantly

Dr Ina Training

At least once every day somebody asks me "Hi, how are you?" We usually all respond to this type of question with the obligatory, "Fine, how are you?" but lately the first thought that crosses my mind is, "tired".

Australians on average work 38.6 hours/week, and average weekly hours have been increasing. Most hospital based doctors work demanding hours including night shift, on-call, and overtime (whether rostered or not). Recent figures suggest that this has been reduced from 100 to 70 hours/week, which is still almost twice the national average. This would be consistent with the average 60-90 hours/week I have observed, and although this number appears to be decreasing, my impression is that the amount of what I call "Active Brain Time" is increasing. We are getting fewer breaks and our pagers ring constantly. Although hospitals have instituted "protected time" for interns, these are in the guise of tutorials. And who doesn't eat their lunch while looking up test results and generally catching up with paperwork? That is, if they get lunch. So our actual working hours have gone down, but our "Active Brain Time" has gone up.

According to the Australian Medical Association (AMA) 2006 Safe Hours Audit, two thirds of hospital doctors are working hours that expose them to significant risks of fatigue. It has been well documented that there is increased risk of accidents in medical staff that are fatigued, such as needle stick injuries and motor vehicle accidents. The "meat" of the matter, though, is why these incidents actually occur. There is evidence from psychology studies that fatigue increases risk-taking behaviour and inhibits our abilities to make rational decisions. The increase in risk-taking appears to be linked to an inability to perceive the consequences or reward of our actions, and a reduced sense of reward for correct actions. This has exceedingly important ramifications for the safety of our patients and ourselves.

Fatigue risk

It is well recognised that being awake in excess of 17 hours straight is equivalent to a blood alcohol level reading of 0.05. Recently, many hospital administrations have taken the opinion that if you are paid to work then you should be working, i.e. "Active Brain Time" for the entire duration of your shift. Therefore, they have used this argument to reallocate beds or rooms supplied for night staff. Instead they expect you to drive home with fatigue equivalent to being drunk. If you are involved in a car accident on the way home and somebody dies, who is responsible? Who gets sued for wrongful loss of life? You? Or the hospital that has contracted you to work a cover shift/on-call and not provided a bed for you to rid the sleep debt before attempting the drive home? Is this the equivalent of getting you drunk and then giving you the keys?

There is always the argument that you can refuse to work the cover shift, refuse the overtime involved in sorting out your last patient and giving an adequate handover. Of course, the unsaid that goes along with this is you can kiss your training position goodbye too. And while I suspect that the hospital won't explode (contrary to popular belief) if everyone went home at the exact end of their "rostered shift", I'm sure that it is unfeasible to walk out in the middle of an operation or ward round, and all those beloved efficiency markers such as "Patient length of stay", "Complications" and "Patient Deaths" would blow out quite ridiculously.

The AMA has a Fatigue Risk Assessment tool for Junior Doctor rosters, which can be viewed on http://www.ama.com.au/node/3758 and allows you to audit and calculate your risk assessment for fatigue. Unfortunately, I haven't had time to sit down and complete it yet, but I can anticipate what it will say. I'm fatigued, how about you?

2010 professional development workshops

In 2010 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities can assist you to strengthen your communication, business, leadership and management abilities.

Practice Made Perfect
14 October 2010, Adelaide

This whole day workshop is a great opportunity to improve your business outcomes by developing your practice staff, giving them the tools for building strong practice processes. They will learn about the six P's of sound business and practice management; purpose, planning, promotion/marketing, people, performance and problem solving. Participants will take away a practical action plan to apply what they have learnt to their workplace. *Proudly supported by Health Communications Network*

Surgical Teachers Course
21-23 October 2010, Adelaide

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

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

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

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

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

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

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

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

professional development workshops

DATES: SEP – NOVEMBER 2010

NSW
3 September, Sydney
Supervisors and Trainers for SET (SAT SET)
29-31 October, Sydney
Process Communication Model
5 November, Sydney
Polishing Presentation Skills
19 November, Sydney
Occupational Medicine: Industry site visits
20 November, Sydney
Writing Reports for Court

QLD
17 September, Sanctuary Cove
Supervisors and Trainers for SET (SAT SET)
17-19 November, Brisbane
Process Communication Model

SA
14 October, Adelaide
Practice Made Perfect
21-23 October, Adelaide
Surgical Teachers Course

VIC
8 September, Melbourne
Practice Made Perfect
11 September, Melbourne
Supervisors and Trainers for SET (SAT SET)
25-26 September, Melbourne
Preparation for Practice
29-30 October, Melbourne
From the Flight Deck
11 November, Melbourne
Supervisors and Trainers for SET (SAT SET)
12 November, Melbourne
Occupational Medicine: Industry site visits
13 November, Melbourne
Communication Skills for Cancer Clinicians
19-21 November, Melbourne
Leadership in a Climate of Change

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

2010 ASC Evaluation

All 25 programs received a positive rating in regard to their educational value

Marianne Vonau
Chair, Professional Development

Campbell Miles
ASC Co-ordinator

Well done to everyone who helped make the Annual Scientific Congress (ASC) in Perth such a success. The first ASC was held in Canberra in 1928 and since then it has become a key educational activity and the biggest multi-disciplinary surgical meeting held in Australia and New Zealand. The June edition of Surgical News described the 2010 ASC highlights and this article responds to the feedback from some of the delegates.

Evaluation is an integral component of the planning and delivery of educational activities so a special thank you to everyone who took the time to provide feedback about the ASC. Your suggestions help the College ensure that future meetings represent a high quality educational experience that meets the Fellowship's needs. Congratulations to Navin Rudolph, a Surgical Trainee, for winning the iPOD Touch evaluation survey prize.

All 1493 ASC delegates were provided with an evaluation questionnaire in their ASC satchels. The 2010 evaluation return rate was 27 per cent which compares very favourably to 16 per cent in 2009. Our thanks go to Michael Levitt (ASC Convenor), David Oliver (ASC Scientific Convenor), Michael Hollands (Chair, ASC Planning and Review Committee) and the Chairs of the scientific programs for their efforts to promote the evaluation.

Completing an evaluation can help people to reflect on their learning so that personal and professional growth can take place. Ideas that result from participation in learning which do not lead to action have little chance of enhancing our competence and performance. As part of the evaluation task, respondents reflected on areas of their practice that would benefit from review and/or refinement.

Respondents indicated that overall they were satisfied with the ASC scientific program. All 25 programs received a positive rating in regard to their educational value with an average rating above 3.5 out of five (one being least satisfied, five being most satisfied); 16 programs had an average rating above of four out of five. The combined General, Rural, Trauma and Hepatopancreaticobiliary session 'Problems with Bleeding – What Must the Surgeon Know?' and the Plastic & Reconstructive Surgery session 'Cleft Lip and Palate' received particular praise. The combined General, Hepatopancreaticobiliary, Rural, Upper GI and Paedi-

atric session 'Difficult Gall Bladder' as well as the Breast Surgery and Colorectal Surgery program also received positive comments.

The ASC is a large and complex event that is held each year in a different city. In general, the meeting returns to a major Australian or New Zealand centre every six years. The meeting is convened by local surgeons who comprise an executive committee and a scientific committee; all together up to 30 surgeons work amicably to mount the meeting. It is usual that the members of the two committees have not previously been involved in convening an ASC or a meeting of this complexity. All are volunteers who work pro bono over the two years of planning.

Program advice and budgetary control reside with the ASC co-ordinator and the College's Conferences and Events Management, respectively. Whilst the ASC Planning and Review committee is responsible for policy, it is the co-ordinator who is responsible for instituting change at the executive and scientific committee levels. Change, and we hope improvement, arises from several sources; from the evaluation forms, from discussion with individual delegates and from the review of best practice. Some of the best recommendations have come from program conveners who have worked on the ASC over two years and have gained an excellent insight into the program. However, there are valid reasons why others cannot be implemented.

'Maintain a balanced program that allows a choice of programs with minimum 'clashes'

On occasions an individual suggestion for improvement is so obvious one wishes that one had had the epiphany oneself and it is instituted as soon as possible. Recommendations from the evaluation forms sometimes constitute such a resoundingly obvious improvement, but others require a 'weight of numbers' over several years to ensure the recommendation has significant support. This is difficult to gauge if a very small percentage of delegates complete the forms. An example is the change from a five-day format to a four-day format. This very significant change was only instituted after several years of feedback from significant numbers of delegates. The perfectly predicable result of this 20 per cent reduction in program time is the recommendation above, namely 'Maintain a balanced program that allows a choice of programs with minimum 'clashes'. In a four-day program covering 25 sections, minimising clashes will never translate into 'no clashes'. Of course, the College's Virtual Congress (VC) is in place for just this reason, enabling surgeons to view what they could not due to a program clash. With new technology it has been possible on the VC to view all the invited presentations with both PowerPoint and audio.

Continue to offer Master sessions and other practical sessions

The Masterclass program is one of the successes of the Congress. It has grown from a single Masterclass in 2005 to 17 Masterclasses in 2010. The average attendance per Masterclass this year was 130 delegates. The feedback regarding practical sessions within the scientific program is a continuing one. The co-ordinator expounds on this element in the program to each new group of conveners and the evaluation report from each Congress is sent to all conveners. There does seem to be reluctance amongst conveners to schedule such sessions in their programs, possibly because they are not sufficiently 'scientific'.

Consider integrating medico-legal sessions into other scientific programs

This issue is at the forefront of thinking in the Medico-Legal section. The Sydney convener of the ML program has indicated that he will endeavour to thread the medicolegal aspects of practice through the other sectional programs. Success will depend upon the interest of the ML convener, but also the interest of the conveners of the other sectional programs. The ML convener and the ASC co-ordinator can ask, but the other conveners have to consent.

Be mindful of the specific interests of Trainees and International Medical Graduates

Beginning with the 2005 Congress and rapidly expanded thereafter, the Masterclass program was instituted with these specific interests in mind. In addition, the Trainees Dinner (commenced 2006) and now, the Trainees program consisting of two sessions (commenced 2009) are designed to address these interests.

Continue to include presentations on non-technical topics e.g. lifestyle

Two elements to the program address this comment: the Senior Surgeon program and the 'Expand Your Horizons' program. The Senior Surgeons program commenced in 2008 and has grown from one session to three. The second element ('Expand Your Horizons') began in 2007. The 'Horizons' program has suffered from variable audience appeal and may need to be rethought. The speakers give their time pro bono and a small audience is no recompense for the time taken to prepare a presentation.

This may be the first year that the evaluation forms have not contained numerous complaints regarding lack of discussion time in the sessions. The Perth conveners are to be congratulated on reserving 30 minutes of discussion time in each relevant session and this has satisfactorily addressed this complaint.

Bearing in mind that two years of planning go into each meeting, it may not be possible to institute a change for several years. Change is constant and improvement is always the intention. Fellows may not be aware of these within the programs they attend. The College's purchase of audience polling units has allowed audience voting to be introduced at the 2010 meeting and several Perth conveners availed themselves of the technology. Following a small successful trial in 2009, the Trainee Research Prize program was expanded to 13 section programs this year and these will continue to be offered.

All recommendations whether from individuals or from the evaluation forms are reviewed and discussed at the ASC Planning and Review committee with a view to instituting improvements to increase the appeal of the Annual Scientific Congress, now in its 80th year.

The Professional Development Committee welcomes all feedback from the Fellowship about the format of future ASC evaluations. We are willing to 'think outside the square'. Please contact Merrilyn Smith on +61 3 9349 1106 or merrilyn.smith@surgeons.org with your comments and ideas.

Poison'd Chalice

Are committees a surrogate for democracy and is democracy an effective management style?

Professor U.R. Kidding

Sisyphus was a great King who irritated the Gods. According to Homer, he was taken from mortal life by Mercury and condemned for eternity to pushing an enormous boulder to the top of a mountain whereupon it would roll to the bottom under its own weight and the process would be repeated – endlessly. The Gods had reasoned that ceaseless, futile and hopeless labour was the most soul-destroying punishment that they could devise. So as I attend yet another management committee meeting, I am forced to wonder which God I might have angered.

I find that I attend a great many committee meetings. By and large, I regard them as a cross I must bear – but I am in a minority. Much to my chagrin, most committee members regard attendance as a "badge of honour", an affirmation of their importance, a break from their daily routine, a delusion that something is being done. The last is the most insidious – a problem is identified, "let's form a committee" – problem solved! If only it was that simple! Of course we could always form a committee to oversee implementation!

I am slowly coming to the realisation that committees are a pathological entity. They have a habit of reproducing and if left unchecked will stifle the host organism, in this case the hospital, with inertia and indecision. This indecision deserves further comment. Everyone knows that hospitals are complex and that any decision has ramifications – hence the need for committees to consider the ramifications. But considering them doesn't make them go away, indeed it expands them! Furthermore, there is usually no incentive for a committee to make a decision – to do so would remove the reason for the existence of the committee!

Committees, hospital committees in particular, are designed to function at an "average" level. They are necessarily devoid of innovation and focus primarily on maintaining the importance of their existence by being negative. Like many other clinicians, I generally attend committees to prevent bad things happening rather than achieve positive results. For hospital administrators, they have two major advantages – firstly, they ensure the value of the administrator – "just look at my timetable, not a minute to spare, I have meetings to attend!" And secondly, they avoid the need for anyone to actually make a decision and thus take responsibility.

So how do you judge the importance of a committee? There are two variables that need to be considered – firstly, the standing and importance of the members of the committee and secondly, how many committees report to the committee itself. You can see where I am going with this – every committee worth its "salt" will try to create more committees! And every committee wants the Director of Surgery on it!

Imagine trying to perform an operation by committee. There are lots of decisions that have to made during the course of an operation, but fortunately surgeons know how to make decisions and take responsibility. Surgeons are good at indentifying the problem and instituting the solution. These characteristics are rightly valued, but make committee participation frustrating.

A little while ago, I used my position to form a committee whose express purpose was to "rationalise" i.e., terminate, committees. We identified two types of committees within the health service – working committees that had been formed for an express purpose to solve a problem, and monitoring committees. Working committees were allowed a maximum of three meetings of one hour's duration. Monitoring committees were allowed to meet monthly for one hour, but no individual was allowed to be on more than one monitoring committee.

It worked for a while, but the tide was too much to withstand – we now have more meetings than ever. In more ways than one, I am reminded of the three witches of Macbeth: "When shall we three meet again, in thunder, lightening, or in rain."

There are some fundamental questions with regard to committees that we need to address since we live in the era of committees. The first of these is, "are committees a surrogate for democracy and is democracy an effective management style?' and secondly, "does committee participation encourage stakeholder buy-in to the problem?" As I become more experienced, i.e. cynical, I fear the answer to both is negative.

Consumer information

Visit to the Malaysian Department of Health Technology Assessment (MaHTAS)

Guy Maddern
Surgical Director, ASERNIP-S

Last year the Malaysian Department of Health Technology Assessment (MaHTAS) invited a staff member from the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) to present a workshop in Kuala Lumpur on the preparation of consumer information from systematic reviews.

Staff from ASERNIP-S had met the MaHTAS director, Datin Dr. Rugayah Bakri, and Assistant Director, Dr Junainah Sabirin, earlier in the year at the Health Technology Assessment International conference and the International Network of Agencies for Health Technology Assessment (INAHTA) annual meeting in Singapore. Datin Rugayah had said that MaHTAS was interested in preparing short summaries of their health technology assessments which were easy to read. In Malaysia, there is no adequate legislation in place to prevent untested devices being brought into the country, and those making decisions on the introduction of health technologies need to be informed of the latest research. I had suggested during a visit to MaHTAS that consumer information would help get the message across to policy makers and consumers.

An ASERNIP-S senior project officer, Eleanor Ahern, visited the MaHTAS office in Kuala Lumpur in the first week of December, 2009. She met Datuk Dr Noor Hisham bin Abdullah, Deputy Director General of Health (Medical), who was interested in the ASERNIP-S consumer summaries and enthusiastic about the upcoming workshop. He had also trained in Sydney and Adelaide as a breast endocrine surgeon.

Inspiring speech

The workshop was opened by Dato Dr Azmi Shapie, Director of the Medical Development Division, who gave an inspiring speech about the need to inform policy makers and consumers of the MaHTAS research. The 35 workshop participants included surgeons, researchers and members of the press; no consumers were present, although representatives of the National Consumer Association had been invited. Topics covered in the workshop included how to prepare a consumer summary in a multi-disciplinary team of surgeons, researchers and consumers, and how to write in plain English.

At the end of the workshop, possible future directions for consumer information at MaHTAS were suggested, starting with forming bonds with the national consumer organisation. The need for resources to do this work was also discussed.

The trip was an exchange of ideas and an opportunity for the College to share its knowledge internationally. We hope that in the future MaHTAS will be able to use consumer information to help get their message across.

Process Communication Model Course

The College is investigating how PCM can assist Fellows and Trainees to improve their communication skills.

Marianne Vonau
Chair, Professional Development

In today's busy clinical environment, effective communication is a prerequisite for positive patient outcomes. Patient care is a team effort. A functioning team is based on effective communication. The Process Communication Model (PCM) is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. PCM can also help to detect stress in yourself and others as well as providing you with a means to re-connect with individuals you may be struggling to understand and reach.

PCM has an interesting background. In 1971, Doctor Taibi Kahler observed a process by which people interacted with one another both in positive and negative ways. He discovered that human behaviour could be identified objectively as being either productive (communication) or non-productive (miscommunication). He believed that both patterns were sequential, measurable and predictable. In 1978, NASA used this theory to develop PCM in the selection, placement and training of astronauts. PCM has since been modified to provide people with a tool that can help them understand, motivate and communicate more effectively.

More recently PCM has been used in medical settings in the US as well as Australia and New Zealand. Recently College Councillors Spencer Beasley and Hugh Martin participated in a PCM course and both have been able to apply what they learnt in their hospitals, in College meetings and in their personal life.

"The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful."

PCM can help you to:

- Understand your preferred communication channel and manage your stress.
- Understand your colleagues' modes of communication and behaviours under stress.
- Develop an improved working relationship with trainees and supervisors.
- Improve the effectiveness of your communication with patients and their families.
- More effectively communicate with hospital management about workplace issues.
- Better manage conflicts and step in to prevent situations from escalating.

The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the six different personality types; each person represents a combination of these types, but usually one is dominant. If these needs are met positively, individuals are happier, healthier and more productive. If needs are not met positively, individuals can exhibit signs of 'distress' and do things consciously or subconsciously to get their needs met negatively.

One of the most powerful aspects of PCM is that it can allow you to step back and recognise that a particular behaviour – from a patient, a clinician, a nurse or hospital management – is often not targeted at you, but a behaviour driven by distress. More importantly you can develop the skills to do something about it.

The College is investigating how PCM can assist Fellows and trainees to improve their communication skills. Two courses for rural Fellows, Trainees and their supervisors are planned for later this year; Brisbane, 17 – 20 November and Sydney, 29 – 31 October 2010. The College has received funding through the Dept of Health and Ageing so is able to offer this course for $110 (incl GST) to rural surgeons. Registration is limited to 18 participants per course and participants will need to cover their own accommodation and travel costs.

Two half day 'Keys to Me' seminars will also be offered at the 2011 ASC for surgeons wanting to find out more about PCM.

For more information, please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org

The 8th Cowlishaw Symposium

THE SPEAKERS ARE:
Mr Wyn Beasley,
Mr Felix Behan,
Mr Ross Blair,
Mr Geoff Down,
Hon Prof Sam Mellick,
Mr John Royle,
Mr Phillip Sharp,
Prof Alan Thurston,

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

Saturday 6 November 9:30am

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

Fee: $120.00 inc.

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

For further information contact geoff.down@surgeons.org +61 3 9276 7447

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

Fellowship Survey 2010

Helping Your College Work for You

Mr Graeme Campbell
Chair, Fellowship Services Committee

Fellows will have the opportunity to shape the future direction of the College and provide feedback on the services and activities currently offered as part of the 2010 Fellowship Survey. The survey will be issued shortly to all active and retired Fellows to assist with identifying areas for improvement, strengths and the potential path Fellows wish the College to take in the coming years.

The College last gauged the views of the Fellowship in 2006. Almost 60 per cent of the Fellowship participated in the 2006 Fellowship Survey and provided valuable feedback on areas including communication, publications, professional development, member benefits and the College's name. The results have informed College strategic planning and since 2006 the College has worked hard to improve in a number of fields. Communication has been strengthened, a stronger focus on standards has resulted and we have strengthened relations with Specialty Societies and Associations. Support and resources for clinical audit and the Continuing Professional Development (CPD) Program have also been improved.

We recognise that Fellows may at times feel over surveyed and we are cautious not to overload you in this regard. It is essential nevertheless to our performance as a service organisation to get structured feedback on how the College is of 'real benefit' to the Fellowship. We hope you will get behind the Fellowship Survey as your views are critical to our further development as an organisation.

The survey will be released online and posted to all Fellows during September. Results will be made available on the College website and in Surgical News.

Fellows' feedback is essential and contributes to the ongoing success of the College. We look forward to receiving your feedback through the 2010 Fellowship Survey.

LEADERSHIP IN A CLIMATE OF CHANGE

19-21 NOVEMBER, MELBOURNE

Change provides an ongoing challenge to surgical leaders. Understanding your own style of leadership and adapting it to the situation and personalities of others in the workplace is crucial in today's dynamic world.

This workshop encourages a journey of self-discovery by undertaking a psychometric behavioural profiling exercise, indicating an individual's preferred leadership style. Group discussions identify alternative leadership styles, the value of emotional intelligence and a range of appropriate management styles that can enhance workplace relations.

According to Prof Clifford Hughes FRACS, CEO of the Clinical Excellence Commission who enrolled in the diploma and helped facilitate this workshop, "I was mightily impressed with the way the presenter worked with a group of clinicians, not known for their ready acceptance of some of the issues raised. It was great fun…. The informal discussions illustrate the way in which the presenter engaged each member of the group and developed their enthusiasm, including me. More importantly, I think there is still a lot to learn."

Please contact Professional Development Department. T: +61 3 9249 1106 F +61 3 9276 7432 E: PDactivities@surgeons.org

Australia's growing knife culture

Knife injuries are a preventable aspect of interpersonal violence

The College's Trauma Committee, with its distinguished history in advocating societal change to reduce avoidable death and injury, is now turning its focus toward tackling Australia's growing knife culture.

While studies in New South Wales (NSW) and Victoria show a levelling-off in the over-all incidence of serious stabbing injuries over the past decade, they often occur in clusters, leading to a perception among many that knife-related assaults are on the increase.

Yet despite the actual incidence of knife injuries, each one is distressing and many serious. Surgeons and other staff treating such injuries are among many who want to see a reduction in the incidence of knife-related harm.

In Victoria, a recent cluster of well-publicised stabbings led first to Victoria Police launching a knife amnesty followed by the passing of legislation giving police power to search for and seize such weapons.

In NSW there has been a slight decrease in stabbing injuries in the past five years, yet still 30 people are murdered each year with a penetrating weapon and more than 3000 crimes involving stabbing implements take place per annum, according to the NSW Bureau of Crime Statistics and Research.

Preventable injury

Now senior trauma surgeons are calling for public health campaigns to counter the trend. In particular they wish to see an improvement in the collection and sharing of data between hospitals, police and ambulance services to obtain a clearer picture of likely victims and perpetrators, contributing factors such as alcohol and location as well as school-based programs to warn young people of the potential severity of knife-related injuries.

Mr John Crozier, a NSW trauma and vascular surgeon and Deputy chair of the College's bi-national Trauma Committee said the use of penetrating implements including knives, swords, scissors and screwdrivers was a significant social issue.

He said that as with previous public health campaigns led or supported by the Trauma Committee such as the mandatory wearing of seatbelts and blood-alcohol testing of drivers, the core of the issue of knife injury was its self-evident preventability.

“Yet while we do believe there is a need for a public health campaign to combat the use of penetrating weapons, the challenge is to link the available data from police, from the ambulance service, from hospitals so we have the clearest possible picture of what is happening.”

“This is a totally preventable aspect of interpersonal violence,” Mr Crozier said.

“Yet while we have evidence of a slight downward trend in recent years in the use of penetrating implements, each incident is a preventable incident.

“Alcohol is a factor, gender is a factor, and youth appears to be a factor.

“We must address this if we hope to deal with the overall problem.

“The College has always had a deep commitment toward the reduction of preventable injury. It supports any legislative interventions that are effective and evidence-based and encourages a multi-faceted approach between governments, police and industry to change the alcohol culture that is clearly implicated.

“We also believe there is a need for focussed programs within the education system to teach young people how serious such penetrating injuries can be and of the risks associated with the growing culture of binge drinking.”

Mr Crozier, who works out of the Liverpool Hospital in Sydney, both treats and teaches the treatment of penetrating injuries. He said they were among the most difficult trauma cases to deal with both physiologically and emotionally.

“I have a saying when I’m teaching that: “One good stab deserves another”,” he said.

“And by that I meant that whereas in Australia most gunshot victims sustain injury from a single round, the emotion behind a stabbing is rarely abated with a single blow. The attacker most often stabs the victim repeatedly.

“Some of these wounds may not look too bad on presentation, masking the depth of underlying penetration and may be easily overlooked, so the body of the victim has to be very carefully searched for wounds that can easily jeopardise life.

“And I can say from personal experience working in South Australia, Tasmania and the Northern Territory that such trauma presentations have a great emotional effect on the staff of smaller hospitals because the injuries are both graphic and preventable and have the potential to cause a rapid deterioration and death in an emergency department with limited staff and facilities.

“The key to all of this, of course, regardless of statistics showing an increase or decrease in the incidence of penetrating trauma, is that all such injuries can be prevented.”

Mr Crozier said that the College’s Trauma Committee was keen to work with government agencies across Australia to reduce the use of knives in the community and while he would not specifically endorse particular police measures said any proven, evidence-based intervention would have the Colleges’ support.

“Penetrating injuries now represent a huge financial burden across the community from the cost to the victim, their family and friends and the financial costs to society,” he said.

“We can save most of these victims now, but that is a very costly down-stream method of dealing with this problem.

“It is clearly far better to prevent the injury than deal with it after the event, and the College is committed to doing what we can, in terms of using our expertise and support, to reduce or eliminate this preventable harm.”

Data required

Professor Russell Gruen, the Director of the National Trauma Research Institute and Professor of Surgery and Public Health at the Alfred Hospital and Monash University, said that while recent stabbing injuries in Victoria had given rise to fears of an outbreak of violence, more detailed data was required to fully understand the problem.

“We seem to be seeing clusters of activity which can seem dramatic at the time, but that can still average out over a year so that we need better data to fully understand the issue,” he said.

“There were four such presentations to the Alfred Hospital over a 24-hour period at

New Year’s Eve, for example.

“There we mostly see stabbings in association with other violence in an urban context, but that might not be fully representative of the situation.

“Yet while we do believe there is a need for a public health campaign to combat the use of penetrating weapons, the challenge is to link the available data from police, from the ambulance service, from hospitals so we have the clearest possible picture of what is happening.

“We need to know where the hot-spots are, who the most vulnerable to knife attacks are and what contributing social factors are in play such as alcohol abuse so that a campaign can be effectively tailored and targeted towards both the people at risk of harm and doing harm.

“Any such effort should be a multi-sectoral campaign between law enforcement, education and the health sector with the College playing a significant role, as it has always done, in promoting social change to reduce preventable injuries.

“These are very serious injuries to treat - people stabbed through the heart and dying in theatre, people stabbed through the spinal cord resulting in quadriplegia, stabbed through the neck and suffering massive blood loss - and they are distressing because they are all preventable.”

With Karen Murphy

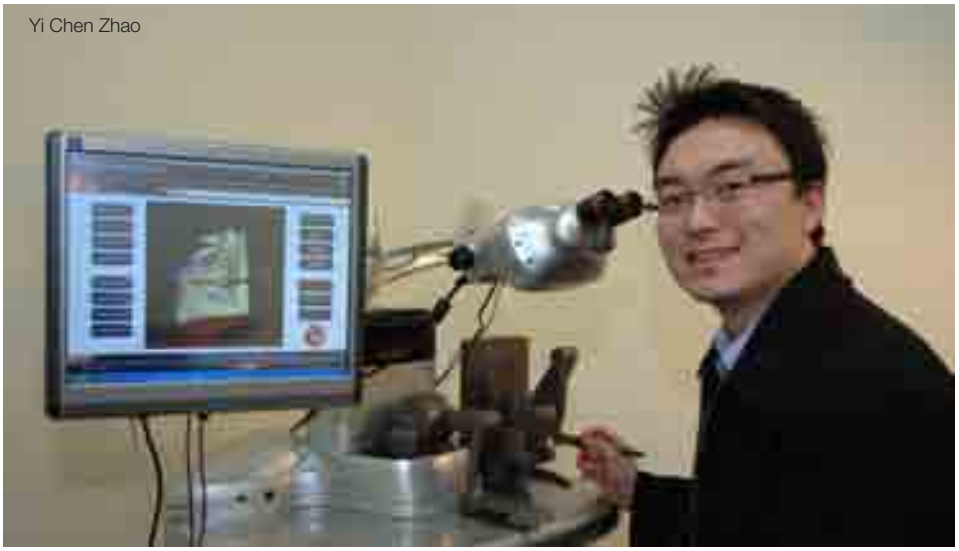
ASC Surgeons as Educators *Joint Prize Winner 2010*

Congratulations to Yi Chen Zhao and Ruth Prichard, joint winners of the ASC Surgeons as Educators Prize 2010

Jenepher Martin
Chair, Surgeons as Educators Committee

The Annual Scientific Congress (ASC) Surgeons as Educators prize is open to all Trainees and Fellows who present research papers during the Surgical Education Program at the (ASC). Dr Zhao, an ear, nose and throat (ENT) Trainee, received his prize for a paper entitled 'Does virtual reality simulation training improve real life performances? - Results from a randomised control trial' and Dr Ruth Prichard, who is an overseas Fellow who worked with the University of Sydney Endocrine Surgical Unit, received a prize for a paper entitled, 'Training surgical residents increases mental strain: A prospective study of heart rate variability in endocrine surgery.'

Please see below for a summary of the articles written by the prize winners themselves.


Yi Chen Zhao

***'Does virtual reality simulation training improve real life performances? - Results from a randomised control'* by Dr Zhao**

With an increasing number of Trainees and an ageing population, surgical education and training is a critical issue for the future of surgery. Dr Zhao focused on one critical aspect of surgical education, the use of simulation to improve surgical performance and training. In ENT surgery, cadaver temporal bone dissections have been the cornerstone in the teaching of temporal bone surgery; however with a worldwide shortage of cadaver temporal bones, as well as the exponential growth of computer technology, virtual reality simulation is currently being investigated for its role in temporal bone surgery.

At the University of Melbourne a virtual reality temporal bone simulator has been developed. The simulator consists of a desktop PC, which generates a 3D volumetric model of a temporal bone from a CT scan. The user sees this virtual model through a simulated microscope, which provides 3D vision. The user can move the model in 3D space as well as dissect it using virtual drills. These virtual instruments are controlled by a pair of haptic or force-feedback devices which provides the tactile feedback to the user when the instruments are in contact with the bone. Thus the user is immersed in this virtual 3D environment where not only can they see the temporal bone model, but also drill it away with tactile feedback as well as auditory feedback. Having developed this system our aim was to investigate whether supervised training on this VR system would be any better compared with traditional teaching techniques of using operative videos, lectures and CT scan.

In order to investigate the research question, a randomized blind control trial was conducted with 20 novice trainees to compare the cadaver temporal bone performance of Trainees who had either traditional teaching or Virtual Reality (VR) training. After receiving the same didactic teaching they were randomised into two groups. The traditional group were to receive additional teaching via traditional teaching methods such as small group tutorials, videos and models. The VR group received supervised teaching on the VR simulator. At the end of their teaching they were asked to perform a cadaveric temporal bone dissection and have their performance videoed and assessed by blind assessors. The assessors judged the videos on four domains of assessments: the end product, injury size, overall performance and technique. These assessments were based on the Welling's scale and OSATS.

The study found that supervised training on a virtual reality temporal bone simulator would improve cadaver temporal bone dissections compared with traditional teaching methods. Future direction of this research would be to investigate the role of self-guided learning in the VR simulator as well as role of surgical rehearsal using the VR simulator with real patient CTs.

***'Training surgical residents increases mental strain: A prospective study of heart rate variability in endocrine surgery'* by Prichard RS, Oucharek J, O'Neill CJ, Delbridge LW, Sywak MS**

Measuring stress

The objective of the research was to determine whether instructing surgical residents in technically demanding surgical procedures causes alterations in heart rate variability (HRV) and mental strain in supervising surgeons.

A prospective study of HRV in surgeons undertaking elective endocrine surgical procedures was performed. Two attending surgeons and three Fellows in an endocrine surgery tertiary referral centre participated. HRV data

was collected in elective total thyroidectomy procedures. Of these, Fellows and attending surgeons performed 50 cases as primary operator and 50 as assistants in a cross over design. HRV was measured during dissection around the recurrent laryngeal nerve, using the Polar Heart Rate monitor.

Overall heart rate, time and frequency domain parameters of HRV as a measure of cardiac and mental stress were correlated with the surgical role performed, in particular the teaching of surgical fellows at critical points within a thyroidectomy.

Research results

HRV data were collected prospectively in 50 total thyroidectomies in the period October 2009 to March 2010. Of these 50 lobectomies were performed with the attending surgeon as primary operator and 50 with the trainee as primary operator. There was no statistically significant difference in the mean heart rate for either group of participants regardless of role. However, energy expenditure was greater for fellows when operating compared to assisting (163kJ versus 129 kJ; p = 0.03). Fellows also demonstrated a higher LF/HF ratio when acting as the primary operator (118 versus 105; p=0.02). All time domain parameters of HRV increased when attending surgeons were operating, denoting more cardiac relaxation. Similarly, the LF/HF ratio was significantly greater for attending surgeons when teaching when compared to primarily operating (140 versus 87; p= 0.05), suggesting an increase in mental strain.

In conclusion, the teaching of complex but common endocrine surgical procedures is associated with a measurable increase in mental strain in attending surgeons, as determined by HRV. Fellows demonstrated increased levels of stress when acting as primary operators.

These papers are an example of the quality research that is being undertaken by Fellows and trainees. I would encourage you to consider submitting a paper for next year's ASC in Adelaide.

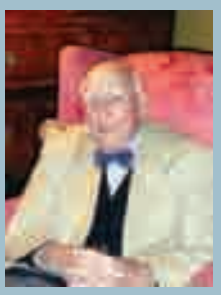
Foundation for Surgery

Passion. Skill. Legacy.

Invitation

Former College President, Mr Durham Smith AO is delighted to invite friends and past colleagues of Mr Douglas Stephens AO to attend a reception in honour of Douglas during his 98th year and to help support the fund for

The Douglas Stephens Paediatric Surgery Research Prize



Douglas is internationally renowned for his work on congenital abnormalities in infants and children, and he trained many surgeons at the Royal Children's Hospital. He is also highly regarded for his numerous books on paediatric surgery and urology.

Douglas served the College for many years as a Councillor, Treasurer and as Editor of the ANZ Journal of Surgery.

He is also an outstanding watercolour artist and many of his prized paintings will be for sale at the reception with all proceeds donated to the Research Prize Fund.

We look forward to welcoming you to this important event.

Date: Monday, 25 October 2010

Time: 5.30pm to 7pm

Venue: Royal Australasian College of Surgeons
College of Surgeons Gardens
250-290 Spring Street
East Melbourne

Drinks and canapés

RSVP: by Friday, 8 October 2010 to foundation@surgeons.org or +61 03 9249 1110.

Foundation for Surgery Research Scholarship

The science Australia produces should be a source of national pride

The current recipient of the College's prestigious Foundation for Surgery Research Scholarship, Dr Adam Fowler, is undertaking a PhD research thesis investigating possible genetic solutions to control the growth of the brain tumour known as glioblastoma. In particular, he is looking at the role of microRNA 124a in regulating the gene IQGAP1, a cytoskeleton regulator which is frequently over-expressed in the tumour.

"IQGAP1 is a protein in the cytoskeletal scaffolding which plays a role in enabling cells to change their shape. It is part of the invasive machinery that drives the development of tumour growth and has been well-described in a number of human cancers such as colon and ovarian cancer," Dr Fowler said.

"Now we are getting a deeper understanding of the effects of such an over expression of this protein on tumour growth and the role of microRNA 124a in controlling that over expression.

"I have found, by working on a number of different cells lines, that glioblastomas have little if any microRNA 124a which means there is limited regulation of the IQGAP1 gene that is driving tumour growth.

"That means that we now know that glioblastomas have a marked increase in IQGAP1 during the process of tumour invasion, so now the search is underway to determine whether it may be possible to develop delivery systems of microRNA 124a directly into the tumour to control its spread and growth which could then allow for better surgical treatment options and patient outcomes.

"I think I have proven that if we can do that, we stand a good chance of controlling the invasion of this tumour.

"Glioblastoma has been listed by the World Health Organisation as a Grade Four glioma which means it is one of the most lethal primary brain cancers so it is exciting to work in an area that could potentially save lives when we crack the delivery aspect of microRNA 124a."

Dr Fowler is undertaking his PHD at the University of Sydney in collaboration with the Kolling Institute located on the grounds of the Royal North Shore Hospital in Sydney.

He is working under the supervision of Dr Kerry McDonald, the Head of the Adult Cerebral Tumour Research Unit at the Frank Lowy Institute, Professor Bruce Robinson from the University of Sydney and Dr Carolyn Scott at the Kolling Institute.

Along with the Scholarship, Dr Fowler's work has also attracted funding from the National Health and Medical Research Council and the Neurosurgical Society of Australasia.

Last year he won the College's Young Investigator Award while he also won the 2009 Best Oral Presentation as awarded by the University of Sydney, the Kolling Institute and the University of Technology.

"I am optimistic that this research can make a difference, yet while I think the work is strong, Mother Nature is very cunning in how she controls the human population," Dr Fowler said.

"In some ways, given the enormous advances made in recent years in our understanding of the human genome, particular those strands once thought silent, we are now bumping up against technological limitations in what we can do with the knowledge.

"Yet still we are making incremental gains and there will no doubt be further technological advances that will move this science forward."

A source of national pride

He said that while medical research in Australia received much less financial support than that provided in the United States and Europe, we were still able to undertake scientific research of the highest calibre.

"I believe that the science we produce here is among the best in the world even though it must be done with less money and fewer people and that should be a source of national pride," he said.

"I also personally feel great satisfaction in working in this field because patients suffering a neurological disease are considered one of the most vulnerable sub-sets of patients because of the stigma of brain disorders and because of the assault such diseases can cause to a person's sense of identity and dignity.

"That is one of the reasons I chose neurosurgery, not only because it is a fascinating area of scientific research, but because, as a surgeon, I wished to advocate for and assist these patients."

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South Australian News

The main impediment to the public hospital system in Australia is lack of beds

Greg Otto,
South Australian Chair

I was fortunate enough to attend the June Council meeting. This reiterated for me the relevance of the College. There was a large time commitment by committee members. Discussion was robust and thoughtful and the College is clearly alive and well with the interests of all surgeons at heart. I would encourage all Fellows to attend a Council meeting and see for themselves.

The Surgical Leaders Forum also proved to be most interesting with four excellent speakers. For me the stand out was the presentation by Dr J Sammut. He gave some excellent insights into why some medical issues are difficult to get political traction on. In the light of what he had to say I would put two simple messages to politicians in the lead up to the election.

Although the recent College 2010 election strategy is an excellent and complete manifesto, I think it is too complex for politicians to read, let alone understand. The two simple messages I would advocate would be firstly that the College is the guardian of surgical standards and safety in Australia and secondly that the main impediment to the public hospital system in Australia is lack of beds. A simple message repeated often may stand a chance of getting through.

While in Melbourne I was surprised and a little disappointed to learn that South Australia was one of the states which had not paid the College for accreditation of training posts. I mentioned this to the Minister for Health at our recent meeting. His response was that other states had also not paid and that there were no plans to pay while this remained the case. I pointed out to him that the College may decide at some stage in the future to withdraw accreditation or decline to accredit new posts.

One of the issues that has concerned me greatly over many years is the disparity between the complexity of the surgical services provided and the backup services (i.e. Intensive Care Unit (ICU) oncology and others) provided in that institution. I have worked in a mid-sized suburban public hospital for the last 20 years. During that time there have been various ICU models used, mostly satisfactorily. During those years I think that public expectations have changed. The public nowadays expect a surgeon to operate only in a safe environment that gives appropriate backup if something unexpected happens.

Since 2006, when the government took the hospital back from the private sector operators, ICU services have ceased. This has meant that if there was a postoperative problem, arrangements had to be made to transfer the patient. This process sometimes took hours, valuable time wasted in the care of critically ill patients. Obviously, this is unsatisfactory from all points of view. Firstly, surgical complications are bad enough, but the stress they cause is amplified considerably when management is abrogated to another team, and in addition no one likes to manage other surgeons' complications. Secondly, the whole process causes high stress levels for medical and nursing staff and for the patient and family, not to mention the medico legal implications.

Emergencies select you

The problems can be minimised, to a certain extent, in the elective surgery setting, by careful selection of cases, but one cannot foresee every circumstance. In the emergency setting the situation becomes more problematic. One does not get to select the emergencies - they select you depending on expediency and proximity.

I think the College should come up with some guidelines and recommendations regarding the acceptable ranges of co-morbidities, surgical acuities and emergencies in relation to on site facilities. I think sites which don't or cannot comply should face losing accreditation of training posts.

Over the last year in South Australia a trial was run on the use of physician's assistants in the public hospital setting. Several highly experienced physician's assistants were brought in from the USA. They carried out various tasks such as pre-admission assessment and rectal bleeding clinics including flexible sigmoidoscopy.

Impact on training

The trial report was recently released. Although the trial was of relatively short duration and the report was largely subjective and anecdotal, it was hailed as a success. The physician's assistants were able to take on many of the mundane and repetitive tasks usually undertaken by our junior medical staff. It was hard to know if this translated into increased productivity or learning for the junior doctors. More of interest to the College is the impact such individuals could have on training. Anecdotally the assis-

tants were felt to have had a beneficial effect, but impact on surgical training was never really addressed by the report. Whether less experienced individuals would do so well also remains to be seen. Despite these limitations the trial was successful enough to initiate the development of a university degree course to train such individuals. Although discussions are in the early phases, the course could commence as early as 2012 and will probably be based on the American training model.

During the last couple of weeks I have been contacted by the Department of Health requesting a projection of the number of surgical training posts required from 2010 to 2014. I am reluctant to give bureaucrats figures without some factual basis, as these figures might just come back to haunt you. In the hope of getting some useful information I read through the College workforce survey document. The survey does provide some excellent information and indicates that the current training is keeping up with population growth. There is not much information about future requirements however. I think we need to project the training requirements against factors such as likely retirements, population demographics, shorter working hours, feminisation, subspecialisation and likely casemix and co-morbidities. These factors are a little complex for me to sort out. I know that the College of Anaesthetists recently commissioned a consultant group to go through exactly this exercise. I think our College should do the same if we haven't already. It is critical that we get the numbers right both for the current and future generations of surgeons and the general public alike.

SURGICAL RESEARCH SOCIETY ANNUAL MEETING

The Surgical Research Society
47th Annual Scientific Meeting
will be held in Adelaide on Friday 19th November 2010

This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers and scientists. It is being held in the Basil Hetzel Institute at the Queen Elizabeth Hospital.

JEPSON LECTURER:
Professor Michael Solomon
"Attaining Quality in Surgical Outcomes Research"

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

CALL FOR ABSTRACTS: The call for abstracts opened on Monday 2nd August 2010 and these must be submitted no later than Wednesday 29th September 2010. Abstract forms are available from the email address below.

CONVENOR: Professor Guy Maddern

PRESIDENT: Professor John McCall

FOR FURTHER INFORMATION CONTACT:
Sue Pleass, Scholarship Co-ordinator
T: +61 8 6363 7513 F : +61 8 82162 2077
E: scholarships@surgeons.org

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Operative Management of Liver Trauma

A multidisciplinary course

Auckland, 8 October 2010

CLINICAL SKILLS CENTRE

Convened by:
Mr Jonathan Koea

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Ideally a surgeon attending will bring a member of the theatre nursing team.

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Registration fee, $1158.75, GST inclusive. Registration closes on 7 September 2010. A course manual and full catering are provided. Please register online at: www.acsc.auckland.ac.nz

Accommodation
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The 2010 Hamilton Russell Memorial lecture

Delivered by Allan Skirving at the 79th Annual Scientific Congress, Perth

Allan Skirving

I received the invitation to present this Hamilton Russell Memorial lecture with a great deal of pleasure and pride. I must say though, at the time and it is almost one year ago now, I was not at all nervous. After all, much of my professional life has been spent giving lectures and presentations, although none as prestigious as this.

However, as part of my initial curiosity and preparation I then visited the College's website and found the list of previous Hamilton Russell lecturers. It was then I became distinctly nervous. It is a veritable Hall of Fame of surgical and non-surgical legends beginning with the inaugural lecture in 1935 delivered by Ernest W. Hey Groves with the delightful title, "The Romance of Surgery".

I can think of very few reasons why I might have been thought to be deserving of this honor; I am scraping the barrel, but firstly, like Hamilton Russell, I did my pre-clinical medical training at Kings College, London. Secondly, I finished my orthopedic training program in Bristol, which is where Hey Groves was the Professor of Surgery. Thirdly, like Hamilton Russell, I too emigrated to Australia and, like him, never regretted it. If these seem too insubstantial then I might have to consider whether, being from Perth, it has something to do with travel expenses.

Subjects chosen by previous speakers have been both impressive and eclectic, but have added to the challenge of choosing an appropriate theme. Understandably, many have chosen to speak of their clinical or research work, but any thought of doing the same and choosing an orthopaedic clinical or research subject was influenced, in part, by knowing that my audience would be composed of specialists from different disciplines; more particularly, that Carole, my wife would be in the audience and I am reminded of occasions in the past when, not able to sleep, she would tap me on the shoulder and say "Allan I can't sleep - tell me about your research."

I then realised that, at this stage of my career the consequences of a poor choice of theme was unlikely to be severe and this was a rare opportunity to be very self-indulgent and perhaps also vicariously indulgent on your behalf.

I have been fortunate to have practiced through perhaps the most prolifically innovative period in medical history but the technological progress which has underpinned recent extraordinary advances in medicine are, of course, not confined to medicine and have initiated change across all facets of Western society. Partly as a result, Western society is in transition and one of the features of all historical transitional periods is a challenging of social values and a challenging of established knowledge and intellectual frameworks (ref.1). Many of these events are healthy, but with these challenges invariably comes rejection of some of society's dominant institutional and organisational structures and there is no doubt that, currently, one of the structures in the firing line is the medical profession.

We are under siege on many fronts:

- By our politicians and government agencies such as the Australian Competition and Consumer Commission who resent our independence, autonomy and license to self-regulation.
- By the legal profession which, sometimes, becomes predatory and fails to recognise its own unprofessional behavior. Perhaps it needs an equivalent of our Hippocratic oath.
- We are pilloried in the press for whom the story is everything and who frequently seem to care little for accuracy or fairness.
- We are questioned by the new consumer society and its advocates who are armed only with superficial understanding gleaned from the media and the Internet. There is no quality control on the internet and certainly no peer review.
- We are also in competition with the alternative medicine industry which in the United States of America (USA) now consumes as large a component of the gross domestic product (GDP) as does conventional medicine.

Of course, none of this is new. The medical profession has constantly been criticised and reminded of our faults and deficiencies. Society seems to ignore the monumental accomplishments in medicine of the last 50 or 60 years. In surgery, complex operations which transform the lives of patients have been introduced by all our specialties and are performed with such frequency and success that they are now regarded as being routine and are taken for granted.

Paradoxically, even though our status in the eyes of society seems to have slipped, we remain, with nurses, the most trusted profession and the one that most parents would want their children to join. But we should not be complacent and remember that society in general does not want medicine as a calling to be destroyed .The public still expects its medical profession to be skilful, knowledgeable and

– "In Praise of Surgery"

"they recognise that most doctors and nurses will be doing their best for sick and injured people in the dark hours of a Saturday night or National holiday whilst the hostile critics of the profession are chattering away at their dinner parties or safely tucked up in bed."

well-trained, but also caring and compassionate even though in society as a whole these caring features are perhaps becoming less obvious.

As beautifully put by Professor Raymond Tallis in his book Hippocratic Oaths, 'they recognise that most doctors and nurses will be doing their best for sick and injured people in the dark hours of a Saturday night or National holiday whilst the hostile critics of the profession are chattering away at their dinner parties or safely tucked up in bed '.

That's enough of my 'my grumpy old man' impersonation, but the point I'm trying to make is that we do need, on occasions, to remind ourselves of the good work that we do and I intend to do just that. But before I do, I unreservedly acknowledge that much of this progress has piggybacked on the work of medical colleagues and a multitude of scientists from different disciplines.

The theme of this lecture therefore has being entitled 'In Praise of Surgery' and I have had great fun and learned a great deal in choosing operations which I regard as being the most praiseworthy and which I hope will support my case, but unfortunately, from just some of the surgical specialties. My selection has been not always objective, but frequently subjective, emotive and probably on occasions, lacking in evidence base. Nevertheless, I have used these guidelines as my criteria,

Criteria for selecting
- Life saving operations which restore a good quality of life
- Life transforming operations
- Operations which restore function
- Operations which alleviate pain
- Age of patient
- High success rate & low complication rate
- Cost effectiveness

Having set these guidelines I immediately, but disappointingly see that I had to exclude surgical procedures such as the recent separation of Trishna and Krishna which was, to me, one of the great events in Australian surgery, not so much because of the challenge or complexity of the surgical procedure, but because of the obvious willingness of so many Australians from so many disciplines to contribute to the care of these two little girls from Bangladesh. This inspiring event reassured me that, as a society we are moving in the right direction even though our progress often seems to be a matter of two steps forward and one step back.

Ophthalmology

Let us start with ophthalmology, which is perhaps unique in having the singular purpose of preserving or, where possible, restoring eyesight and surveys have shown that sight is the sense that people most fear losing. There are a number of outstanding contenders - one could choose the correction of refractive error disorders or perhaps an even stronger case could be made for the advances in the surgical management of diabetic proliferative retinopathy, which has so improved the outcome that the risk of blindness in diabetic patients with this complication can be reduced by about 95 per cent. Nevertheless, impressive though these may be, I cannot go further than choosing the surgical management of cataracts which are still the commonest cause of blindness in both developed and developing countries, responsible for almost 50 per cent of the world's total blindness. Cataract surgery is almost certainly the most frequently performed operation in the developed world.

The history of intervention for cataract is as ancient as any surgical procedure and much of it is shrouded in the mists of time, but fascinating though this history is, it is the advances in cataract surgery and the improved results over the past recent decades which I wish to emphasise for they have been nothing short of outstanding. Indeed, cataract surgery should now be regarded as one of mankind's greatest achievements of the last millennium

Sir Harold Ridley was the first to implant successfully an intra-ocular lens at St Thomas's Hospital, London, in 1950, but it did not find widespread acceptance in cataract surgery until the 1970s and 1980s.In 1961, Krawicz of Poland introduced the use of cryosurgery, which freezes the lens with liquid nitrogen and allows its extraction. Cryosurgery was the favoured form of cataract extraction from the late 1960s to the early 1980s. The most significant change in the modern era followed the introduction of phacoemulsification surgery in 1967 by Dr Charles Kelman, an American, but this too was slow to be accepted. An ultrasonic probe that emits high-frequency (44 kHz) sonic energy is combined within an irrigation and aspiration handpiece and the sonic energy is used to break up the hard cataract into minute fragments which can be aspirated. Today, this instrument can be inserted through an incision less than 3 mm long and, with the introduction of fine sutures, greatly enhances the safety and quality of results. Initially the lenses were made of polymethylmethacrylate, but later from silicone and acrylic both of which are soft and foldable inert materials. More recently, multifocal intraocular lenses and accommodating lenses have also been introduced.

Currently, phacoemulsification and the insertion of a foldable intra-ocular lens via a small two to three millimetre incision is the procedure of choice in most developed countries and can be performed as a day case or even in an outpatient setting. About 95 per cent of patients report that their vision is substantially improved following the surgery and although the complication list is quite long, the frequency of vision impairing complications is very low. Unfortunately, because of the high cost of a phacoemulsification machine, an extra capsular cataract excision remains the most frequently performed procedure in most developing countries. To effect similar outcomes in the developing world is simply a matter of resources.

In 2002 in Australia, approximately 9000 per million cataract operations were performed, i.e. approximately 180,000 per year. If, as is likely, some 50 per cent of these may have had operations on both eyes, it still suggests that had this surgery not been performed for the past 10 years then we would have approximately 1,000,000 severely visually impaired or blind members of society.

To be continued next month

Alcohol and Injury

The Alcohol and Injury workshop will feature during the College Trauma Week

Daryl Wall
Chair, Trauma Committee

Each year the Trauma Committee runs a workshop in November during College Trauma Week to explore topical and challenging issues surrounding injury prevention and trauma care. The topics chosen are those where it is believed an outcome can reduce the incidence of trauma or lessen the devastating effects of injury. Past workshops have included Trauma Verification, the Cost of Trauma, Injury in Indigenous Populations, Hospital Disaster Readiness and Outcome Analysis in Trauma. This year's workshop will mark the Trauma Committee's 40th anniversary – 40 years since the formation of the Committee that pushed for seat belts and later, important initiatives involving drink driving and mandatory helmet wearing. It is also the 40th anniversary of mandatory seatbelt-wearing in Victoria (a world first).

At the end of last year I wrote in Surgical News of the unacceptably high level of interpersonal violence linked to alcohol and, sadly, there is no sign that the tide is turning. In fact the flood of concern, and cries for action, about the rise of violence and its association with alcohol are picking up momentum from all corners including politicians, the media, Fellows, and the community at large.

All surgeons who manage injured patients experience first-hand the devastating effects of alcohol, especially on the young.

Policy reform

The College has spearheaded important initiatives, in the past, which have reduced harm from alcohol in the Australian community, and which have subsequently been adopted internationally. The College's Trauma Committee is committed to sustaining College leadership and advocacy in this major health issue, and has therefore dedicated this year's Trauma workshop to 'Alcohol and Injury'.

Articles appearing in the Medical Journal of Australia April 2010 included - Alcohol policy reform in Australia: what can we learn from the evidence and How can we reduce alcohol-related road crash deaths among young Australians? These articles stimulated wide debate and prompted the following response from the Trauma Committee.

"The College of Surgeons supports any measures that have been proven to successfully reduce death and injury in young drivers. Raising the minimum legal drinking age (MLDA) has been shown to significantly decrease road crash deaths in the US – as highlighted recently in a Medical Journal of Australia article ("How can we reduce alcohol-related road crash deaths among young Australians?). The College agrees with the authors that there would be major political obstacles and very little public support in Australia to increasing the MLDA, however should the politicians and the public see first-hand the devastating effects of alcohol on the young people our surgeons see on an all-too-regular basis – the mind set would change significantly. The authors state other ways that we can achieve further reductions in road crash deaths – extending the zero-tolerance laws for young drivers until aged 22 years as it is in Victoria, or 25 years for even further reductions. The College certainly supports this particularly as there is building evidence that the physical maturation of the part of the human brain that assesses risk and controls impulsive behaviour is not complete until aged 25 years in the human male."

John Crozier, Deputy Chair Trauma Committee, is Convenor of the Alcohol and Injury Workshop. A surgical lifetime providing care to injured patients, where alcohol is implicated, drives his desire to minimise this form of preventable harm. John was involved with the New South Wales Summit on Alcohol 2003. Important recommendations are contained in the report from that broad based consultative Summit which can be immediately implemented to minimise alcohol related harm, and which will be a key reference for the workshop.

The day-long workshop will be held at the College on Thursday, 18 November, 2010. There will be a wide representation from stakeholders including researchers, statisticians, police, politicians, media and representatives of the alcohol lobby. A College communiqué will summarise proceedings of this workshop, and inform the College Policy on Alcohol and Injury.

If you are interested in participating in this important workshop, pencil this date in your diary or pass this information on to any interested colleagues.

'Trauma week' at the College is always a busy time. It is a time of great energy and focus when trauma surgeons from Australia and New Zealand – and overseas - can gather together to discuss, review and draw up guidelines to improve the care of the injured patient and reduce the incidence of trauma. The timetable for Trauma Week will be:

16 NOVEMBER: DSTC course – Epworth Hospital [sonia.gagliardi@sswahs.nsw.gov.au]
17 NOVEMBER: DSTC course – Epworth Hospital
18 NOVEMBER: Trauma Committee workshop – Alcohol and Injury
19 NOVEMBER: Morning – Trauma Sub-Committees meet - DSTC, Disaster Preparedness, Regional Trauma Chairs, Road Trauma, Rural Trauma, Trauma Education Development, Trauma Quality Improvement, Trauma Verification
Afternoon – Trauma Committee meeting
19 & 20 NOVEMBER: Trauma Melbourne [NTRI – R. Gruen

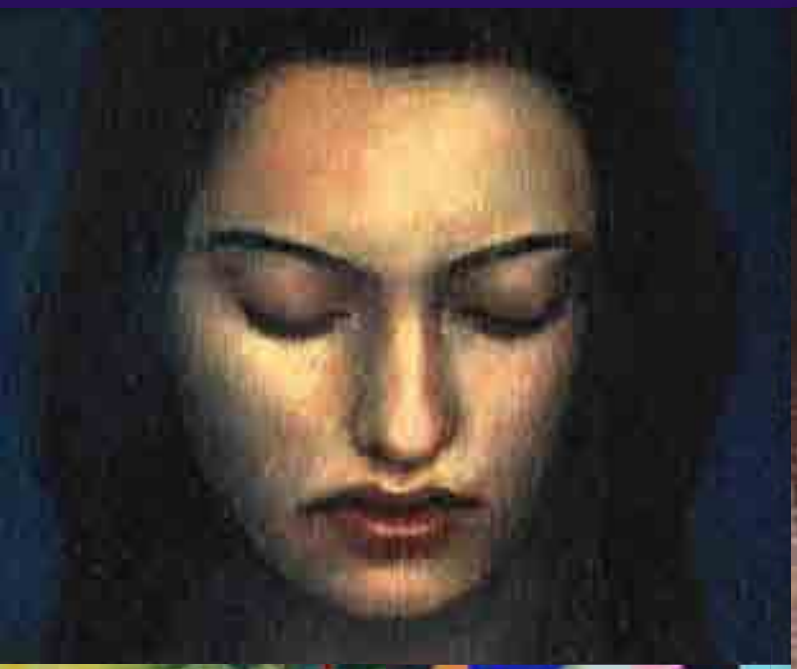
For further information about the Trauma Workshop or any of the trauma activities at the College, contact Lyn Journeaux at the College Trauma office on +61 3 9276 7448 – email: lyn.journeaux@surgeons.org

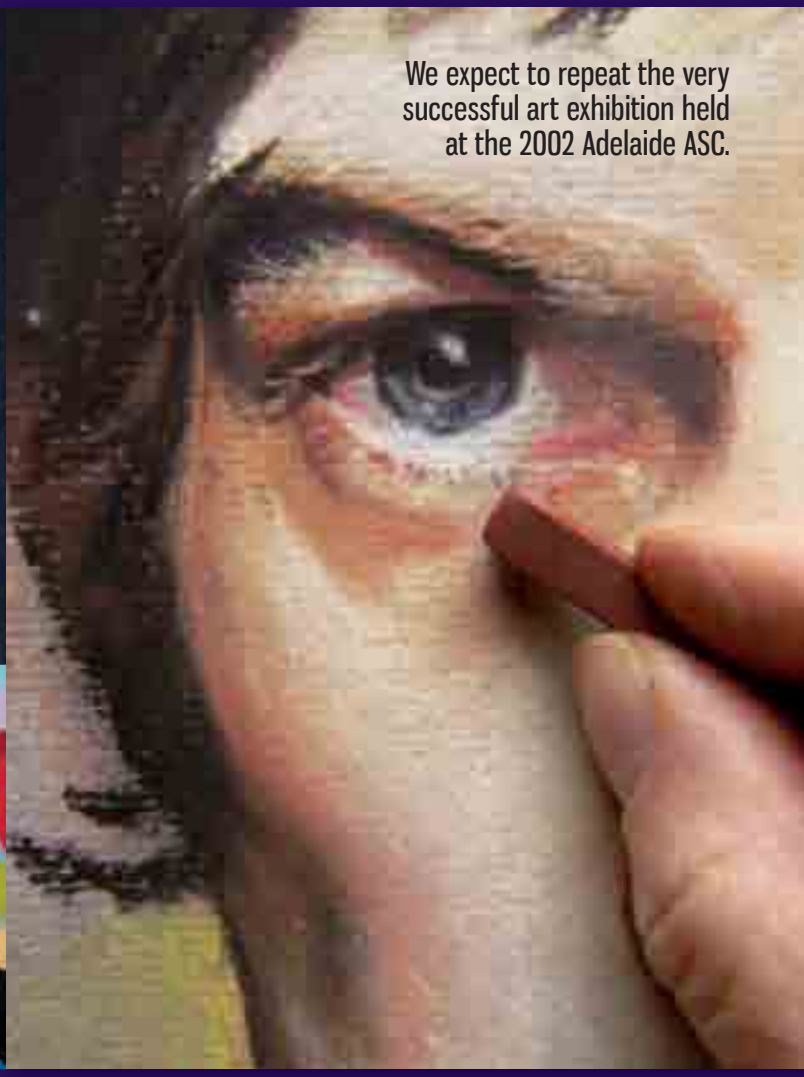
CALLING CREATIVE SURGEONS

Do you have an *artistic* hobby?

Like painting, photography, glass blowing, sculpture, woodwork, ceramics or jewellery making. If so and you'd like to take advantage of this opportunity please contact Lindy Moffat

lindy.moffat@surgeons.org





We expect to repeat the very successful art exhibition held at the 2002 Adelaide ASC.

Space has been reserved at the Adelaide Convention Centre for Fellows to display artworks for purchase or for display.

THE ASC RETURNS TO ADELAIDE IN 2011 – *a city with a fine reputation for the arts.*

ADELAIDE ASC & THE ARTS

INVENTORS CORNER

The Miller's Visceral Retainer

It had struck me for a number of years, during the course of numerous laparotomies that there was a better way

Brian Miller
Queensland Fellow

My background as a consultant in General Surgery in Brisbane has been at the Princess Alexandra Hospital (PAH) in the University of Queensland (UQ) since 1988. I started at PAH as a senior lecturer, and joined the fledgling Colorectal Unit under the chairmanship of Dr Jon Cohen in 1998. Over the last 20 years the unit has grown, and now with the acquisition of our best registrars, three of whom have returned as consultants, the unit has become laparoscopically oriented for elective colorectal work.

My particular responsibilities are to administer and teach the surgical terms for the third year graduate UQ students at PAH, and to supervise the twice weekly training sessions for our general surgical registrars. Another major clinical interest has been with annual charitable outreach general surgical visits to West Timor and Flores since 2005. I was also fortunate enough to have been involved in the inception of the Early Management of Severe Trauma (EMST) program in 1988, and I continue to instruct each year. My little red book "General Surgical Lists and Reminders", which is a revision tool for registrars, is now in its sixth edition and has recently become available on e-Books at www.ebooks.com/ebooks/book_display.asp?IID=334350

It had struck me for a number of years, during the course of numerous laparotomies, that the accepted way of controlling protruding bowel during abdominal closure by progressively withdrawing damp abdominal packs was inefficient and unnecessarily traumatic to the viscera. And this was particularly the case during difficult circumstances late at night with tired staff, perhaps typified by the conclusion of an arduous open operation for a complex bowel obstruction.

I had seen older surgeons use a variety of ad hoc devices to mitigate the problem including malleable metal retractors and even sterilised portions of car tyres. It was this situation that led to my idea for a smooth, shapely device to control the intra-abdominal viscera in a less abrasive and less risky manner while suturing the linea alba. Also considering that the device would only be in situ during each operation for a few minutes, to make it re-usable would be an advantage.

I then made some enquiries of local engineers in the immediate vicinity of the PAH in South Brisbane and soon met a versatile mechanical engineer who was prepared to manufacture the original steel mould for my idea, based on a wooden model that I had constructed. The steel mould contains multiple heating elements to cure the silicone uniformly for ten minutes at 180degC.

The Miller's Visceral Retainer (MVR) was first manufactured in 1998 as an autoclavable radio-opaque silicone device by Mr Fred Howie at Howie Engineering in Stones Corner, Brisbane. The barium that was originally mixed into the silicone was kindly donated by the PAH Radiology Department. The MVR went through several early prototypes where more longitudinal rigidity was given to the spine of the device by altering the steel mould.

The MVR has been produced for sale in its present form by Howie Engineering under my supervision for the last ten years. Its particular features are the firm spine and soft wings to keep protruding bowel gently under control, the incorporated handle for ease of removal, and its capacity for re-sterilisation by autoclaving or by the Sterrad method.

The device was on display at the Abdominal Compartment Syndrome conference at the Sheraton Hotel in Noosa in 2004, and the Australian trade mark "M.VR. (m)" was secured in 2005. The MVR has been marketed by the Elite Medical Co. Ltd. in Bulimba, Brisbane since 2008.

The latest version of the MVR is the 'MVR overslip' which is moulded using a mixture of blue, yellow and white silicone for a distinctive look. This device is latex-free and has become quite popular with general surgeons throughout Queensland, and to an extent elsewhere in Australia and New Zealand. Very little actual advertising has been done, but for past ten years I have given each of my registrars at the end of their six month term on the Colorectal Unit at the Princess Alexandra Hospital an MVR, to encourage some 'word of mouth' promotion.

I see the device as being valuable during closure of the abdomen after laparotomy

1) to reduce inadvertent injury to bowel

2) to reduce needle-stick injury to staff by allowing a proper grasp of the linea alba with toothed forceps.

Whilst the need for a visceral retainer has decreased with the advent of laparoscopic general surgery, it is now considered an essential piece of equipment for the open case as advocated by the College of Surgeons in their Supervisors and Trainers for the Surgical Education Training (SATSET) program video.

Inventors Corner

Dear Editor

The article in the July edition of Surgical News (Vol:11 No:6, page: 34) featuring Brian Miller's 'visceral retainer' reminds me very much of the 'Ferguson Fish', invented by Ian Ferguson, the founding head of the Vascular surgery unit at The Alfred Hospital, Melbourne. Ian invented his retainer to assist with mass closure of the abdomen following aortic surgery. The device was in regular use at The Alfred when I joined the unit in 1981.

As noted by Brian Miller in his article, the Ferguson Fish was indeed cut from a car inner tube. In its final version it was a large oval and incorporated a long tail that remained outside the lower end of the wound by some 20 cm. The tail was to prevent it being inadvertently left in the abdomen and it provided the handle (long enough for a two-handed grip) with which to extract the device. I found it of particular value with closure following repair of ruptured aneurysms, when the distended, Laocoön-like intestinal coils attempted to sneak under a loop in the mass closure suture.

A similar device was in use at the Royal Infirmary in Hull, UK when I trained there, again fashioned from a sheet of rubber, but without the tail. To prevent accidental retention in the abdomen and to aid extraction, a large Kocher's forceps was attached to the lower end. Some the surgeons thought the forceps were unnecessary until a patient at the first post-operative visit complained of an offensive discharge from the abdominal wound. A good light and inspection of the sinus confirmed black rubber in the depths.

A Ferguson Fish was also left in the wound when a young surgeon decided they preferred to close the wound from each end rather than from top down. To accomplish this, the tail had to be folded back into the abdomen. The review of the adverse event found that, as the Fish was not opened onto the operating table until requested at the commencement of the abdominal closure, the nursing staff did not include it on the pre-op count sheet; secondly, the nurses were distracted by the large pack and swab count at the end of a ruptured AAA repair; thirdly, Ferguson's carefully incorporated fail-safe of the tail had, in effect, been turned "off". It helped that the rubber showed on a CT scan. A change of protocol prevented a recurrence.

Campbell Miles
Victorian Fellow

Keystone Concept on Reconstructive Surgery

Dear Sir

Recently, I came upon a book by David Schwartz "Emergency Radiology Case Studies" and during one of my sleepless nights, I was browsing though this interesting case study book. I liked it so much that I am going to use that format for my forthcoming publication on the Keystone Concept on Reconstructive Surgery. But more interestingly, in one of the chapters, I came upon an interesting section on the silhouette sign in X-rays of the chest. There are four types; it describes an air space in the lungs filled with fluid forming a new air-fluid interface obliterating normal pneumonic markings. But what caught my eye was a little dissertation about silhouette and I quote: Etienne de Silhouette was the French Minister of Finance to Louis XV in 1759. He proposed budgetary restraints in those days (as we even experience today) and his fiscal policy was aimed at the wealthy including ministers in the court. The expensive cost of portraiture of these personalities in those days was something that had to be curtailed. The austerity measures were wide ranging, but he was eventually forced out of court. The fashion in those days was to use black paper cut-out portraits. He suggested this could be a substitute for more expensive portrait paintings.

He became ridiculed before he was ousted from office for having his name associated with this lesser form of art. But as history dictates, the name took hold and in 1835 the word "Silhouette" was entered in the dictionary of the French Academy. Perhaps this has relevance today.

(Perhaps the college administrators can take a leaf out of history and find a quick solution to the multiple portraits that must be in storage or damaged with mould of someone of past glory?)

Felix Behan
Victorian Fellow

Correction

The Order of Australia citation quoted in the article on Rowan Nicks (Surgical News, August, Vol:11 No:7 Page 39) should have read

For service to medicine in the field of cardiothoracic surgery and by providing training and education opportunities for young Indigenous health workers and international surgeons in Australia.

NOTICE TO RETIRED FELLOWS

Thank you to
Mr Mark Sheppard for the generous donation.

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

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve. We will acknowledge your donations and place your name on the gown if you approve.

If you would like to donate your gown to the College, please contact Katie Fagan on +61 3 9249 1248.

Alternatively you could mail the gown to Katie Fagan c/o Conferences and Events Department. Royal Australasian College of Surgeons. 250-290 Spring St, EAST MELBOURNE, VIC 3002

Welcome to the Surgeons'

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Lars Andersson, Karl-Erik Kahnberg and M Anthony Pogrel (Editors)

9781405171199 | Hbk | 1312 pages | September 2010

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Oral and Maxillofacial Surgery is a comprehensive reference for all trainees and specialists in oral and maxillofacial surgery, oral surgery and surgical dentistry. This landmark resource draws together current research, practice and developments in the field, as expressed by world authorities. The book's aim is to cover the full scope of Oral and Maxillofacial Surgery, incorporating recent technical and biological developments within the specialty. It provides an international and contemporary approach, reflecting the exciting developments of technique and instrumentation within this field, built on technical innovation and medical and dental research.

15% Discount

Emergency Surgery

Adam Brooks, Bryan A. Cotton, Nigel Tai and Peter F. Mahoney (Editors)

9781405170253 | Pbk | 228 pages | April 2010

~~AU$89.95~~ / AU$76.46

Emergency Surgery provides both a practical guide and an understanding of the issues that need to be considered in the management of emergency surgery patients. It presents a clear account of the key issues involved in the assessment, investigation, resuscitation and surgical management of patients who present to the on-call emergency team.

It considers the full breadth of issues encountered in these patients including anaesthesia, pre-op resuscitation/ optimisation, and initial post-operative care including preliminary high dependency/ critical care, as well as the complications and acute issues found in acute surgical patients on the ward.

It is ideal for surgical trainees as well as trainees from other specialties involved in the care of these complex and challenging patients.

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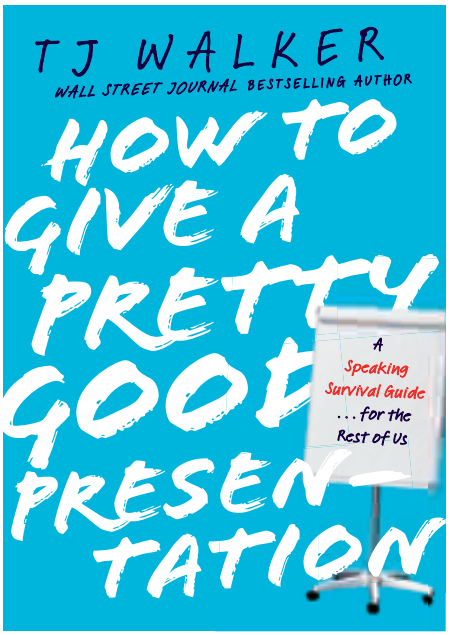

How to Give a Pretty Good Presentation: A Speaking Survival Guide for the Rest of Us

T. J. Walker

9780470597149 | Hbk | 163 pages | July 2010

~~AU$27.95~~ / AU$23.75

Whatever your job, if you need to give a presentation and are feeling overwhelmed by it, How to Give a Pretty Good Presentation is there for you. If you want to reduce the time and stress associated with your presentations now and pass all future presentation opportunities with flying colors, then pick up this fun and accessible guide; you'll no doubt like the resulting improvement in both your personal and professional bottom line. Although it does not promise the moon (or a standing ovation), this public speaking survival guide will help you:

- Appear confident (even while still feeling nervous!)
- Take the spotlight off of you and put it on your content
- Save time
- Not put people to sleep with your PowerPoint Presentation
- Produce better results
- Make better impressions
- Reduce the feelings of dread, sleeplessness, and procrastination associated with your presentations

BOOKCLUB

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

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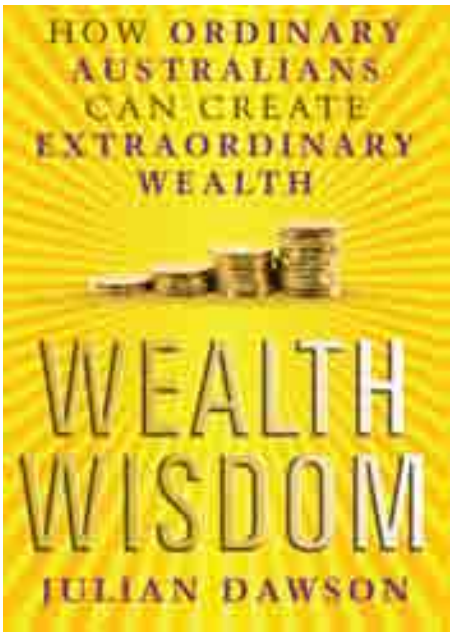

Wealth Wisdom: How Ordinary Australians Can Create Extraordinary Wealth

Julian Dawson

9781742468105 | Pbk | 280 pages | August 2010

~~AUS $29.95~~ / AU$25.46

The richest people in the world are not rich because of the salary they draw from the businesses they run; they are rich because of their investments. People such as Bill Gates, the Albrecht brothers who started ALDI, Ingvar Kamprad of IKEA fame and, in Australia, James Packer, Frank Lowy and Harry Triguboff, have all made money in their businesses, but it is their investments that made them super rich. Wealth Wisdom is the first wealth-generation book to show you how to invest like the famously rich by building up a portfolio of investments in both the sharemarket and property market. It includes usable, easy-to-follow 'invest by the numbers' assessment criteria for success giving readers a clear framework for choosing their investments.

- Julian Dawson already teaches his selection system to thousands of people around the country and has an existing database of more than 4000 clients.
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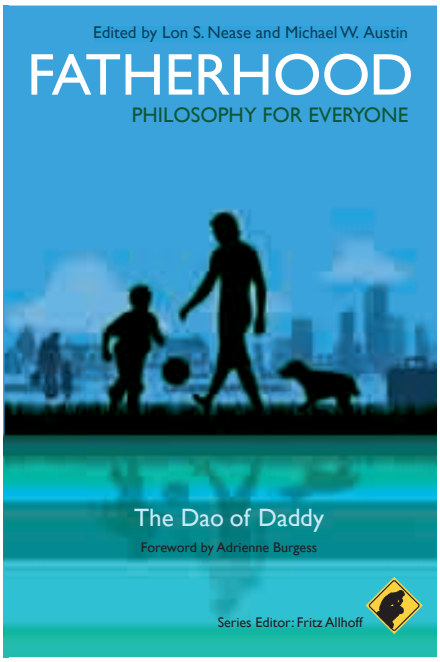

Fatherhood - Philosophy for Everyone: The Dao of Daddy

Lon Nease and Michael W. Austin (Editors)

9781444330311 | Pbk | 224 pages | October 2010

~~AU$29.95~~ / AU$25.46

Fatherhood - Philosophy for Everyone offers fathers wisdom and practical advice drawn from the annals of philosophy. Both thought-provoking and humorous, it provides a valuable starting and ending point for reflecting on this crucial role.

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Covidien Travelling Fellowship Grant

Overall the fellowship was invaluable and can only encourage colleagues to take time out for such experiences

Mark Porter
2009 Grant Recipient


Younger Fellow Mark Porter

I was the grateful recipient of the Covidien Travelling Grant in 2009 and it assisted in financing a fellowship at St Gallen Katonsspital, Switzerland, during the same year. The fellowship was supervised by Professor Markus Kuster, who is essentially, an Australian with a Swiss accent. He is very well known to the orthopaedic community in Western Australia, where he lived for several years. Professor Kuster has maintained his close association with Australia and offers a De Puy fellowship at his department to Australian orthopaedic surgeons. He encourages his fellows to soak up as much experience from their fellowship as possible, in those orthopaedic areas of greatest interest to them. His only firm rule is forbidding anyone from overtaking him during the annual department ski race. The Australian contingent in 2009 was no threat.

St Gallen is located in the German speaking region of Switzerland. However, Swiss German bears little resemblance to the standard German taught in schools, and hence I struggled to understand much of what was discussed in the outpatient department. Fortunately, the foreign language skills of the doctors within the hospital were exemplary and communication with them was easy. For this reason I concentrated on assisting and observing in the operating theatres during most of my stay. The large orthopaedic department covers all the sub-specialty areas and there was no shortage of operating.

The hospital, St Gallen Kantonnspital, caters for both public and private patients. Amongst the more famous surgeons that have worked there, Bernhard Georg Weber stands out. Dr Weber is responsible, in part at least, for the most universally accepted (and only memorable) classification of ankle fractures during the 1970s. He also designed the first body-exhaust suit in an attempt to reduce intra-operative infection rates. Some of his original suits are still being used in the hospital today.

The strong research and educational tradition of the hospital lives on with Professor Kuster. There were regular weekly lectures (presented in my choice of English, German or French, and often by visiting surgeons) and clinical meetings. The department also has a number of on-going clinical research studies. I was able to contribute to one of the more interesting orthopaedic studies. This particular study was designed to determine the efficacy and cost effectiveness of the use of computer assistance for knee arthroplasty surgery (Computer navigation in total knee arthroplasty improves patient outcome. Kuster MS et al. 2009. Submitted for publication).

Since its inception, computer navigation has been adopted by some surgeons with great enthusiasm. The evidentiary base and cost effectiveness of this is not well established. More can be done to implement strategies to ensure that new technology is introduced appropriately. Joint registry data, although a crude measure of outcome following knee arthroplasty, does not demonstrate a cost-effective benefit from the technology. This study was an attempt to determine if there is a benefit, in terms of patient-scored outcomes, from the use of computer assistance during knee arthroplasty. The study is on-going, but interim data demonstrated that computer navigation improves patient satisfaction. However, the cost-effectiveness controversy remains unresolved. This study exemplifies the correct introduction of new technology and a similar approach might be prudent in other areas. The initiation of a well-designed study prior to the establishment of subjective confidence in new technology is essential. If this approach is not adopted, then it is only a matter of time before budget-conscious health providers will demand it. It was refreshing to work in a department that followed this philosophy.

Specific Swiss benefits

As well as the unquantifiable value of experiencing foreign medical systems and forging professional relationships with colleagues overseas, there were a number of other more specific benefits from my fellowship period in Switzerland.

- Attendance at the 12th Foot Surgical Skill Course in Oberdorf, BL, Switzerland. This course included scientific presentations by international experts, practical education in anatomy and surgical procedures of the foot and ankle, as well as clinical discussions of difficult cases and current controversies.
- Working with Doctor Christof Lampert and observing his skills in the use of partial ankle fusions or movement preserving fusions for the treatment of advanced joint destruction, foot and ankle osteotomies, soft tissue balancing of the ankle, as well as ankle ligament reconstruction, and delayed repair of the Achilles tendon ruptures.
- Witnessing the benefits that result from a

government system commensurate with long-term health planning. This is in stark contrast to the Australian system, which can only plan as far ahead as the next election. Although the Swiss spend 12 per cent of their gross domestic product (GDP) on health, as opposed to the Australian figure of 9 per cent, there seemed to be disproportionate benefits to this 30 per cent greater expenditure. The benefits include shorter waiting times and better funding for research designed to provide improved cost-effective health care.

Although acquisition of learning and clinical experience is central to any fellowship, it also provides invaluable life opportunities. The location of Switzerland in central Europe provides easy access to a mix of neighbouring cultures and adventures.

If you enjoy skiing the obvious time to do the fellowship is during the Northern hemisphere winter. With a train pass travelling to one of the many ski resorts anywhere in Switzerland was both easy and affordable. Each weekend the precise destination was based purely on ski conditions. Weekends in Wengen and St Moritz, were common, while the 16km down-hill run in Davos was well and truly worth the train journey.

Although the climate and proximity to the ski slopes has obvious advantages, the winter is harsh with temperatures of -15 Celsius not being unusual. This tested my resolve while preparing for the Rome marathon, especially during the longer training runs. However, the marathon was one of the most spectacular courses I have run and the weekend in Rome truly memorable.

Having now returned to Canberra, and established my sports orthopaedics practice, I have been able to apply much of the knowledge I gained while in Switzerland. The fellowship was complimentary to the other fellowships I have completed.

Overall the fellowship itself was invaluable and I can only encourage my colleagues to take time out for such experiences despite the financial repercussions. I would like to thank Professor Kuster and his entire department for their hospitality, Covidien for their grant, as well as De Puy who also provided monetary support for my fellowship.

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

Medics & Markets Gala Event

The Foundation is the charitable arm of the College

Kingsley Faulkner
Chair, Foundation for Surgery

With philanthropic support from Fellows and the wider community, the Foundation for Surgery raises funds to help deliver vital surgical care in underprivileged communities in Asia, the Pacific Islands, Papua New Guinea and Timor Leste, address indigenous health challenges in Australia and New Zealand, fund research into new surgical techniques and treatments and provide scholarships to nurture the surgical talent of the future

To help raise funds to support these vital programs, the Foundation has partnered with the ASX Thomson Reuters Charity Foundation (ASXTRCF) to hold the inaugural Medics and Markets golf day and gala dinner in Melbourne on Friday, April 1, 2011. The Foundation for Surgery and ASXTRCF will equally share the proceeds of the event with AXSTRCF distributing its share between Very Special Kids, Royal Melbourne Hospital Children's Diabetic Unit, Kidney Health Australia, SANE Australia, Post and Antenatal Depression Association (PANDA) and the Financial Markets Foundation for Children.

This new event on the Australasian philanthropic calendar features both morning and afternoon golf tournaments at the premier Huntingdale Golf Course in the heart of Melbourne's world famous 'sandbelt' region. It will be a challenging event with a full field of 64 golf teams of four including Fellows, financial market executives and colleagues from the medical industry playing an Ambrose Tournament. The winning team will be invited to represent Medics and Markets on an all expenses paid trip to Wairaki in Taupo, New Zealand to compete in the New Zealand Financial Markets Charity Golf Classic.

That evening, a black tie dinner for 600 guests will be held at Melbourne's Grand Hyatt ballroom and feature a charity auction with impressive items such as business class packages to the French Open Ladies and Men's Tennis Finals, US Open Golf and the Hong Kong Rugby Sevens, along with corporate hospitality, a Peugeot RCZ, jewellery, artworks, wine collections and gourmet dining experiences.

"Help support your Foundation for Surgery and other worthy charities and enter a team in the golf tournament or attend the dinner."

The Foundation's partner in this initiative, ASX Thomson Reuters Charity Foundation, has organised similar successful fundraising events in Sydney for the past 24 years, raising more than $21 million for medical and children's research charities.

Help support your Foundation for Surgery and other worthy charities by entering a team in the golf tournament or attending the dinner. We would also welcome support with sponsorships or contributions of goods and services for the event. Places are limited, so an early indication of your interest in playing golf or attending the dinner would be appreciated by 20 October, 2010.

For more information or to make a booking, please contact the Foundation for Surgery on +61 3 9249 1110, Medics & Markets on +61 3 9286 1449 or email foundation@surgeons.org

Osler and Cowlishaw

When he died in 1919, Osler had amassed a collection of 8000 works

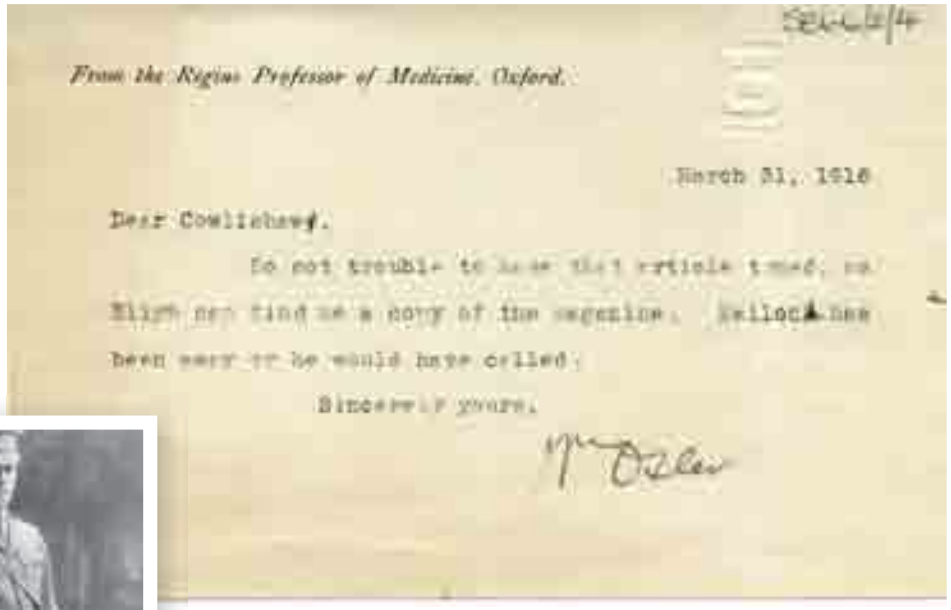
Mike Hollands
Honorary Treasurer

In 1915, Captain Leslie Cowlishaw of the First Australian Field Ambulance, Australian Imperial Force was in a position to visit an admired mentor, the Canadian physician and bibliophile, Sir William Osler (1849-1919).

Osler who was appointed Regius Professor of Medicine at Oxford in 1905 had been collecting books since the 1860s. Like his contemporary Oscar Wilde, Osler was a student of the Greek philosophers and was a keen reader of Benjamin Jowett's translations and the neo-classical author, Walter Pater. Also, like Wilde who anecdotally 'devoured' his books, Osler was in the habit of writing in his books. In Thomas Browne's essay 'Rab and friends', for example, he writes about how the manuscript was acquired for the Edinburgh College of Physicians.

In 1914 when Osler decided to catalogue his books and create the Bibliotheca Osleriana (completed after his death by Archibald Malloch, R.H Hill and his nephew, William Francis), he eschewed a dry listing of works and wrote notes about the books and authors on the index cards or in the volumes themselves.

When he died in 1919, Osler had amassed a collection of 8000 works. These included books and pamphlets relating to the medical profession, significant literary works such as those by Classical authors, Shakespeare, Browne, Milton, Shelley and Keats and editions of the great writers in science and medicine. Osler reputedly had a passion for Vesalius and distributed six copies of his De humanis corporis fabrica to various libraries. His book buying sometimes misfired and on one occasion he commissioned two bidders to go after the same set of Galen, effectively causing them to bid against each other.



From the Regius Professor of Medicine, Oxford.

March 31, 1916

Dear Cowlishaw,

Do not trouble to have that article typed, as I can find me a copy of the magazine. Malloch has been sorry if he would have called.

Sincerely yours,

W Osler

It is not clear when Leslie Cowlishaw met William Osler – he may have corresponded with him before he came to England and was certainly on friendly terms with him towards the end of World War 1. There are six pieces of correspondence written by Osler to Cowlishaw in the College archive – most are dated or partially dated and refer to the period of Cowlishaw's war service.

Dear Cowlishaw
Yours of Nov 14. reached here today. What a trump you are! I hope if you return it will be to stay for some months – but you will be delighted to get home again. I've kept well & busy. I made a good hand at the Dunn sale – tho. books went high. Garrison 2nd Ed. has only just reached England. There was a difficulty about the shipping. It is A.1 & v. useful for reference.
I will send a photograph – it's not very good, but good enough.
Yours sincerely,
Wm Osler (Dec 26)

Come here for a rest and bibliographic browse when you come back – I am struggling with my catalogue. A few good things come in now and then. Let me know if there is anything special I can find out for you – no difficulty – I think about the Charaka vol.
Wm Osler (dated 26th)

For Cowlishaw, the contact with Osler must have been inspiring, but clearly Osler whose literary son, Edward Revere was also in France, thought highly of Cowlishaw. He writes in August 1917 shortly before Revere's death:
I am devastated to miss you – just got back from Wales. Do come to us direct your next leave.
Best wishes William Osler (8 August 1917)

It is easy to speculate that Cowlishaw's contact with William Osler – a committed bibliophile, physician remembered for his contribution to medical teaching and an audacious and witty writer– under the pseudonym, Egerton Yorrick Davis, he contributed pieces such as one on the phenomenon of penis captivus to various medical journals – helped to stimulate Leslie Cowlishaw's own collecting and teaching interests and ultimately, create the Cowlishaw collection.

With Elizabeth Milford, College Archivist

Younger Fellows Leadership Exchange
2011 Academic Surgical Congress
1-3 February, Huntington Beach, California

Name: ----------

Year of Fellowship: ----------

Contact Address: ----------

Home Phone: ---------- Bus Phone: ----------

Mobile Phone: ---------- Facsimile: ----------

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Please attach a short professional biography indicating your current involvement and understanding of Younger Fellows' issues and what you would hope to gain from the J&J Leadership Exchange.

STATEMENT (please tick):

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

Signature: ----------

Date: ------ / ---- / ------

Submit your nomination to the attention of the Younger Fellows Secretariat by 30 September 2010

Royal Australasian College of Surgeons,
College of Surgeons Gardens
250-290 Spring Street,
EAST MELBOURNE VIC 3002

T: +61 3 9249 1122
F: +61 3 9276 7432
E: Younger.Fellows@surgeons.org

Thank you for your nomination for the 2011 Younger Fellows Leadership Exchange. Please note:

- Selection is finalised in October 2010. If your circumstances change and you wish to withdraw your nomination, please contact the Younger Fellows Secretariat.
- Airfares, transfers, accommodation and attendance at the AAS meeting are met by the J&J Leadership Exchange Program.
- Selection is based on understanding and involvement in College functions, understanding of Younger Fellows issues, leadership skills and experience.
- The successful applicant will be required to present a paper at the AAS meeting and prepare a brief report on their experience suitable for publication in Surgical News.
- More information (including the policy) is available on the College website **www.surgeons.org/YoungerFellows**

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Trauma inspection in Perth

The Royal Perth Hospital Trauma Service and Burns Unit welcomes foreign ministers from Australia and Cuba

Sudhakar Rao
Chair, WA Trauma Committee
Chair, Disaster Preparedness Committee

On 8 June, 2010, the Hon Stephen Smith, Minister for Foreign Affairs and Trade, and Mr Bruno Rodriguez, Cuban Foreign Minister, visited the Royal Perth Hospital. Dr Fiona Wood and I met with them as they inspected the state-of-the-art Burns Unit and the Major Trauma Unit facilities at Royal Perth Hospital to see first-hand Australia's expertise in responding to medical emergencies in our region, such as the Bali bombings and Jakarta air disaster. Dr Wood and I are members of both the College Trauma Committee and the Disaster Preparedness Sub-Committee (a sub-Committee of the Trauma Committee).

Cuba has a keen interest in medical assistance, medical technology and medical expertise and is internationally renowned for the medical assistance work that it does. Minister Rodriguez had recently visited East Timor, where Cuba, through a medical facility, trains up to 700 East Timorese in the medical profession. The importance of working together to improve health outcomes in the Pacific and the Caribbean was discussed and the potential was recognised for Australia and Cuba to collaborate in the Pacific on development assistance in the medical area.

Dr Sudhaker Rao, Director of Trauma Western Australia (right) meets with the Australian Foreign Minister the Hon Stephen Smith (left) and the Cuban Foreign Minister Bruno Rodriguez at the Royal Perth Hospital.

Mr Rodriguez also met the then Deputy Prime Minister, the Hon Julia Gillard MP. And, as we now know, it was not long after this visit that daggers flew and heads rolled in that Office – but that of course is another kind of trauma commonly called politics!

Chester Alan Troy

A generous bequest from an admired surgeon and raconteur

Kingsley Faulkner
Chair, Foundation for Surgery

A bequest is a significant and enduring way to support a cause that is close to your heart and a reflection of your values. The charitable arm of the College, the Foundation for Surgery, depends on bequests to deliver vital medical aid in underprivileged communities in our region, address indigenous health challenges and provide scholarships for research into new surgical technologies and treatments and to nurture upcoming surgical talent.

The Foundation is grateful for the generous bequest left to it by Mr Chester Alan Troy. The foresight of Chester to leave a bequest to the Foundation is inspiring and epitomises his munificent spirit and his passion for surgery. It is an important legacy that will help train and foster skilled surgeons of the future.

Chester was a well-respected Fellow, a talented general surgeon, an avid skier and a raconteur who sadly passed-away in Epworth Hospital after collapsing on the green at the Melbourne Cricket Club Bowling Club on 16 January, 2009. He was 76.

Chester attended Scotch College in Melbourne from 1943 to 1949 and Melbourne University from 1950 to 1955, overlapping at the Royal Melbourne Institute from 1952 to 1955 where he earned honours in obstetrics and gynaecology.

After gaining his College Fellowship he worked in London for several years. Returning to Australia in the 1960's he was appointed Acting Assistant Medical Superintendent and Specialist in General Surgery at the Repatriation Hospital in Heidelberg and later worked at the Dandenong and District Hospital and in private practice. He also taught at Prince

Henry's Hospital for 15 years and served as the Clinical Teacher in the Medical Faculty at Monash University from 1979 to 1994.

Chester retired from practice in 2003 and with his long-time partner Betty Marks, travelled the world and indulged his passion for skiing. Such was his medical knowledge and polished communication skills, when he suffered a heart attack on the ski slopes of Colorado, he instantly knew what was wrong and told other skiers how to care for him. His self-diagnosis saved him.

He also had a thirst for knowledge and could talk for hours on topics ranging from medicine and history to politics and was famous for his jokes, although he often forgot the punchline.

Chester is survived by his partner Betty and her children and grandchildren.

In Memoriam

Information about deceased Fellows

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

John Kevin Clarebrough, Victoria
Guy Justin Dowling, Victoria
Semesa Matanaicake, Fiji
Donald Wallace Fleming, Western Australia

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
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Robert Lusby's life of experience

The colours of the vines in autumn and the bud bursts in spring, are very good for the spirit

NSW vascular surgeon Professor Robert Lusby was recently invited into the studios of ABC radio for a chat with veteran broadcaster Margaret Throsby and asked to bring along some of his favourite pieces of classical music. In between the discussion of his working life (now at Concord Repatriation General Hospital) and his outside interests (a successful vineyard two hours from Sydney), they played that music.

The opening piece was the "Call of the Dairy Cows" from the third part of the William Tell Overture, amusingly chosen by Professor Lusby as a call to action and because William Tell, like a good surgeon, required a "good eye and steady hand".

Then followed the duet from "The Pearl Fishers" by Bizet, one of his wife's favourites, and then "Nimrod" from Elgar's Enigma Variations, chosen because Nimrod means Hunter and his vineyard, bought, cleared and planted 17 years ago, is located in the Hunter Valley.

Called Tintilla Estate, it is an entirely family-run business with Professor Lusby's son James, a trained viticulturalist who has worked in the United States (US) and the United Kingdom (UK), now the chief wine-maker with his other two sons helping at vintage. His daughter, as the licensee of a Melbourne hotel, promotes the wine in Victoria.

Vineyard refreshes him

In recent years it has attracted considerable attention not only for being the first winery to plant Sangiovese in the Hunter Valley, but particularly for the 2005 Patriarch Shiraz which has been placed by some wine writers between the glorious Grange Hermitage and Hill of Grace.

Professor Lusby said he decided on a vineyard not only because it was too hard for surgeons with a heavy roster to run a farm with livestock, but because he thought a vineyard could prove to be an enjoyable family endeavour.

"I have spent considerable portions of my career overseas, either in Europe or America and when in Europe, my wife and I greatly enjoyed visiting the vineyards of France and Italy," he said.

Bob Lusby in vines

"Later I worked in San Francisco at the University of California and one of our neighbours, a paediatrician, had a vineyard and I thought if he could do it, I could do it.

"So when we came back to Australia we looked around and decided on the Hunter Valley not only because my wife has family ties to the area, but also because it was within a reasonable travel distance from Sydney.

"It's given me more enthusiasm for my working life in the city to have that time up there and we go up every weekend when I'm not on call. As a vascular surgeon I tend to treat mostly the old or the very sick so that seeing the seasons on the vineyard, the colours of the vines in autumn and the bud bursts in spring, is very good for the spirit."

Professor Lusby said he decided on vascular surgery not only because he liked the physiology of it, but because it was a new and expanding field at the time of his choice.

Since that decision, he has been widely acclaimed for his pioneering work in the use of ultrasound technology in the diagnostic aspects of vascular disease and the repair and treatment of carotid artery disease.

"It was an exciting time in the 1970s and 1980s in vascular surgery because there were such rich opportunities for research applying new technologies to a growing field of surgery," he said.

"I studied under some outstanding surgeons including Justin Fleming, a pioneer of vascular surgery at St Vincent's Hospital in Sydney, who did the first aneurism repair in Australia, which meant that when I went overseas to further my training I had a pretty good idea of where vascular surgery was up to and where advances might be found.

"In the UK I devoted considerable time researching the use of ultra-sound to identify the characteristics of plaques so that we could use that technology to diagnose carotid artery disease.

"Later in the US, when I was at the University of California I worked with ultra-sound manufacturers to work out the changes we needed so the technology could be of greatest use in vascular surgery and brought back to

Surgeon Bob Lusby, anaesthetist Brian Puzzutti and Ramos Horta in the Australian Hospital East Timor

Australia the first Duplex ultrasound machine in 1983 when I was appointed the Professor Surgery at the University of Sydney.

"I feel very fortunate to have started my career at such a dynamic time and I always say that the carotid artery has been very good to me."

Rwandan atrocities

Yet while he could have basked in the professional accolades and relaxed on the vineyard, instead Professor Lusby joined the Australian Army Medical Corp, a decision which saw him posted to one of the most horrific conflicts in modern times – the genocide in Rwanda. He was posted to Rwanda as a member of the Medical Corp in 1990 to assist the UN peace keeping force.

"This was the first time since Vietnam that Australia had deployed such a significant number of defence force personnel including medical teams and it was still a very dangerous place when we arrived," he said.

"Oddly enough, one of my first cases involved a nine-year-old boy who had a false aneurism of the carotid artery caused by shrapnel so at least my first case involved something I was very familiar with."

Professor Lusby said the majority of surgery there involved the treatment of injuries caused by mines rather than bullets or machete, which he found confronting given that most victims were innocent non-combatants, mothers out walking and children at play. Some memories are the stuff of nightmares.

"We went to a church outside Kigali in which a slaughter had taken place, a bomb thrown in where all the people were sheltering, and there were bodies everywhere. When I walked in I thought I was standing on a step, but I was actually walking on a dead body covered in the mud and my foot went through the chest wall," he said.

"Winston Churchill wrote about the mud coming up to claim the bodies of the fallen in World War 1, but I didn't really understand what he meant until that moment.

"It was a shocking experience, but the army usually arranges people into cells of four and the surgeons and physicians I was working with were all pretty experienced, worldly people which helped. We talked about the things we saw there and that is important to your ability to deal with it over time I think."

He reflected on how fortunate we are to live in Australia and the Rwandan experience "only served to highlight our freedoms and opportunities". "Yet such experiences make the vineyard very attractive, and helped me put life into some perspective".

In later years, Professor Lusby was also sent as a member of the Medical Corp to support the peace efforts in Bougainville and the endeavours of Interfet, the peace keeping force sent to East Timor in the immediate aftermath of Independence.

"While there was a real dash of danger it did not seem as risky or as tense as Rwanda and the attitude of the people was entirely different with one nation desperately afraid with great uncertainty and the other very grateful for their hard won independence," he said.

"It was an amazing time to be in East Timor then because over weeks after liberation people began to dress in brighter clothes and the number of names read out in the banns of marriage at the church I attended grew and grew, as if the people had deferred such hope in the future until they had won their freedom.

"It was a very rewarding assignment and deeply moving."

Professor Lusby is now retired as the Colonel Consultant to the Army and the Australian Defence Force, but in characteristic fashion has taken on other roles such as the Head of the Clinical School at Concord General Hospital and as Associate Dean at the University of Sydney.

COVIDIEN TRAVELLING FELLOWSHIP GRANT

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

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

Application requirements

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

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

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

Applications close 5.00pm Friday 29 October 2010.

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