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Surgical news

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Open doors

The College showcases its fascinating wares to the public. PAGE 26

The College of Surgeons of
Australia and New Zealand

ON THE COVER:
Crowds gather to see inside for Melbourne Open House

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Longitude 131 degrees

Important issues debated at the NT/SA/WA Annual Meeting

Uluru at dusk, courtesy of Charlotte Jennifer Padbury.

Ian Civil
President

Like most Fellows of the College I have flown over it many times. However, in the past I had not been truly aware of its significance. Longitude 129 degrees or as it is frequently called the 129th meridian east defines the border between Western Australia and South Australia/Northern Territory. Longitude 131 degrees passes through Russia, Japan, Island of Waigeo in Indonesia, the Dampier Strait, Melville Island and then continues through Uluru (formerly Ayers Rock) in the Northern Territory. It was a majestic backdrop to the Combined 2011 Annual Scientific meeting of our Northern Territory, Western Australia and South Australia regional committees.

It is not surprising that providing surgical workforce and building robust surgical departments as well as the contemporary issues of indigenous health were major components of the meeting. There was a vigorous debate over the College involvement in surgical endeavours away from the 'big smoke' of the major metropolitan areas. There is no doubt that in the awesome breadth of the outback, with its particular health needs, more resources from various governments and more endeavours from all health professionals are needed.

In this meeting the balance of generalism versus specialism was particularly felt. I have spoken recently of all the tensions in the health systems that are accentuating the issue of increased specialism. Although specialism is not all bad because extended knowledge in a particular area and expanded technical expertise provides benefits to society in general and patients with relevant problems in particular, we need to be particularly alert to some of the downsides.

Surgery has the particular problem ▸

Outback flowers, courtesy of QASM Clinical Director John North FRACS.

Society has given us the right to be regarded as a profession with key elements of;
- > An exclusive right to practise in a defined area of endeavour.
- > A right to professional autonomy.
- > A duty, individually and collectively to put the interest of patients ahead of our own interests, and of our profession.

“There was a vigorous debate over the College involvement in surgical endeavours away from the ‘big smoke’ of the major metropolitan areas”

of increased technical specialism where surgeons could become increasingly irrelevant to the care of patients as a whole, effectively marginalising our contribution in medicine. Our clinical decision making could be left in the hands of non surgeons and our range of expertise only confined to an operating theatre. Without doubt, the position of surgeons as influential contributors to the healthcare universe would diminish. From those of us who still believe we are “physicians who operate” that distinct advantage of a broad perspective would be lost.

However it does go deeper than that. Many surgeons that I have spoken to have read and re-read the words of the Hon Geoffrey Davies that have been printed in the *ANZ Journal of Surgery* about the challenges of professionalism that confront our College.[1] His clearly stated view and one that I support is that when a societal need, such as care of acute and emergency problems is not met then we are sacrificing our professional responsibilities as surgeons.

It is on this last element of clearly needing to meet patients’ needs across the breath of surgical presentations that we need to focus and ensure it is satisfied. Not doing so is unprofessional. The consequences will eventually be the privileges of professionalism are challenged and withdrawn. We are already seeing that with increased government intervention in all aspects of our clinical endeavours, the nationalisation and bureaucratisation of regulatory authorities and health service governance without our input. As Geoff Davies stated: “While individually you may decide, for whatever reason, to restrict your practice to only a narrow field, you cannot do so collectively and still retain your collective rights. Your collective field of practice is defined for you to some extent by the public perception of the role of a surgeon[1].”

There is no doubt that we have a collective responsibility to provide a broad scope of surgery in each discipline, but also a professional requirement to ensure high quality timely generalist surgery is readily available. At Uluru there was much to challenge ourselves as individuals, employers – be they hospitals or health department – and the College to continue to provide this meaningfully into the future.

Reference

1. Davies, G., *Professionalism of surgeons: a collective responsibility.* ANZ J Surg. 81 (4): p. 219-26.

Training and reform on the agenda

Keith Mutimer
Vice President

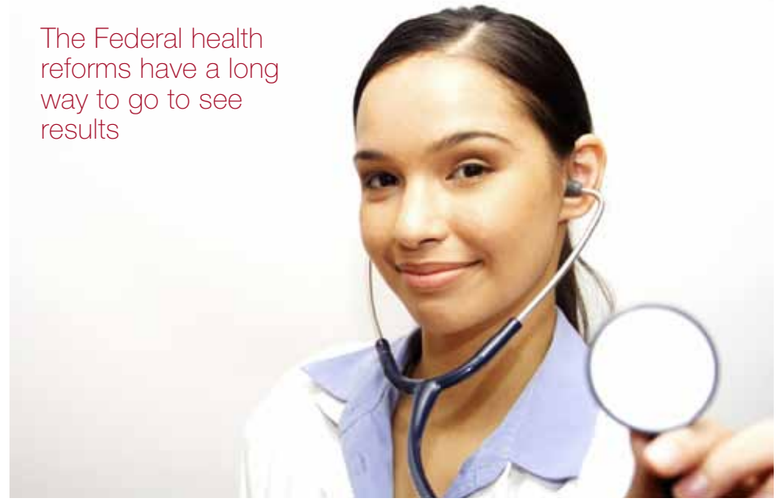
There have been interesting developments on both sides of the Tasman recently.

The College’s National Board in New Zealand issued a media release on 4 August expressing its concern over reports that the proposed elective surgery unit at the North Shore Hospital in Takapuna will operate with specialist medical staff only. The release noted that if this is to be the case it will seriously reduce the opportunities for Trainees to get the vital surgical experience they need.

If the North Shore Hospital elective unit arrangements mirror those at Waitakere Hospital, the already considerable difficulties in accessing sufficient elective surgery for training in a number of specialties will only be made worse. The growth in New Zealand’s population and the shortage of trained surgeons requires an ongoing increase in Trainee numbers. Limiting Trainees’ access to elective surgery will have exactly the opposite effect.

With the College and Health Workforce New Zealand already looking at what opportunities exist for training in the private sector, it makes no sense to remove opportunities for training in the public sector. At the time of writing, the College’s New Zealand National Board is seeking an urgent meeting with the Waitemata DHB to clarify the situation and its potential impact on training.

The Federal health reforms have a long way to go to see results



Meanwhile in Australia, after nearly four years of negotiations and political stand-offs, the nine Australian governments have now signed on to new funding arrangements for the Australian public health system.

A far cry from the scheme first proposed by then Prime Minister Kevin Rudd in 2007, the new system will see federal funding of the public hospital system rise to 50 per cent of new expenditure. This is hardly the revolutionary initiative to “end the blame game” which was originally promised. The College maintains the position it held throughout the period of negotiations – that the single funder model alone can achieve this goal.

While we obviously welcome the new spending contained in the agreement, we remain sceptical about the capacity of Australia’s already overstretched public

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"With the College and Health Workforce New Zealand already looking at what opportunities exist for training in the private sector, it makes no sense to remove opportunities for training in the public sector"

hospital system to meet the ambitious targets set by government. Even with new investment, the target of performing 100 per cent of elective surgery within clinically recommended timeframes is probably unachievable.

Significantly, what was once an "elective surgery guarantee" has become an "elective surgery target", so one suspects that the politicians quietly consider 100 per cent unachievable as well.

Of particular concern is the agreement's commitment to the four hour rule. Ninety per cent of patients presenting at public hospital emergency departments will need to be admitted, discharged or transferred within four hours of triage. Experience in the UK, New Zealand and Western Australia has demonstrated that time-based targets, applied artificially and inadequately resourced, run counter to the principle that emergency care should aim at the timely assessment and appropriate management of the patient. Time-based targets make the fundamental error of placing promptness of care before quality of care.

The precipitate implementation of such rules, particularly without a corresponding commitment to more beds in wards, more nursing staff and better diagnostic services, simply forces more patients – many of whom have not been properly diagnosed – into already overcrowded wards.

In place in Western Australia since April 2009, the four hour rule was significantly watered down in October last year. Despite this modification of the rule, Fellows report that it continues to lead to premature diagnoses, inappropriate admissions, exacerbated overcrowding in the wards and unsustainable pressure on surgeons – many of whom are called repeatedly through the night as the deadline for a decision on a patient approaches. These surgeons are then returning to work the next day significantly sleep deprived. There are also reports that the rule is being circumvented by way of imaginative record keeping and number juggling.

The College has been very vocal in its opposition to this chaotic state of affairs and the retiring Regional Chair in WA, Jessica Yin, is to be congratulated for the effectiveness of her advocacy. An opinion piece written by Jessica appeared in the *West Australian* in late June, prompting a letter of support from the AMA and a less than supportive letter from the WA health minister.

Interestingly, however, the four hour rule is now being reviewed by the WA government. That begs the question why, when the rule is under such a dark cloud in Western Australia, have all other Australian jurisdictions just signed up to it?

In short the agreement sets targets without really identifying the means of achieving them. Money alone can't solve systemic problems. There needs to be root and branch reform of the whole system, ensuring patients are receiving appropriate care in appropriate facilities.

The elderly and frail who currently occupy beds in the wards of our public hospitals should be moved to dedicated facilities for the aged. This would free up beds in public hospitals and go some of the way to addressing elective surgery waiting lists and relieving pressures on emergency departments.

The College believes that pressures on the public hospitals of Australia and New Zealand can also be alleviated by the separation of the elective and emergency surgical streams. Where such separation has been implemented, particularly by way of the establishment of consultant-led acute care units, there has been a marked improvement in the efficiency of both emergency and elective work. Significantly, no hospital which has implemented the reform has ever reversed it.

A position paper documenting the reasons for, and proven success of, the initiative was recently sent to health ministers and senior departmental figures in both nations. It is one example of how to achieve efficiencies in our public hospitals by drawing on the experience and ideas of clinicians rather than the prescriptive and unrealistic targets of bureaucrats. Fellows can read the paper on the advocacy page of the College website.

Poison'd Chalice

My contract is up for renewal

"our remedies oft in ourselves do lie"

Professor U.R. Kidding

This means a number of things – including a performance appraisal interview with the CEO and the Medical Director – an opportunity to assess my relationship with the organisation and to hear what the organisation thinks of my contribution. The latter is an interesting issue – neither the CEO nor the Medical Director has been in their respective roles for very long.

In fact, I am now into my fourth CEO and, counting acting Medical Directors, my sixth Medical Director. I have the advantage of "corporate knowledge" – whatever value that confers. Alas, good ideas are beginning to recycle. Administrators come and go, governments come and go, but senior clinicians persist – the backbone of the organisation, the culture of the organisation. The words of Helena in "All's well that ends well" (1, i, 231-232) come to mind – "our remedies oft in ourselves do lie".

So has the organisation moved on over the past couple of years? Sure our debt is a little bigger, but we have treated more patients than ever before. Have we treated the patients well? Our quality indicators have shown improvement, but there are constantly adverse events, analyses of which have led to demonstrable changes. Peer review has improved.

There was a time when if I uttered 'oops' during the operation, it would cause the anaesthetist to 'peer' over the drapes and by lunchtime, the whole hospital would be 'reviewing' the case! We have improved the pre-admission process with registrars attending the clinics, we have begun separating emergency surgery from elective throughput and possibly most importantly, we have begun employing full-time surgeons.

This is a new development for us. I was brought up in an era of VMO's. Of course there were a few full-timers attached to academic departments, but by and large they didn't operate a great deal – dabbled really. I remember Alf – a professorial appointment – great academic brain, hopeless surgeon. He went by the name "lucky Alf" because he was the only person who could be totally secure in the knowledge that he wouldn't end up on the wrong end of Alf wielding a scalpel. VMO's were the real surgeons – their skills honed in the cut and thrust of the turmoil of private practice.

So what has changed? I suppose I have to a large extent. I have become an advocate for some full-time surgeon appointments. I pushed hard for the hospital executive to fund these positions. In our institution, full-time equates to six patient contact sessions and three non-contact sessions. Without these surgeons, we would never have got emergency admission wards off the ground and I would not have been able to backfill unexpectedly vacant operating sessions.

More importantly audit, teaching and research have flourished. I still need VMO's – they provide the numbers to fill rosters, especially the emergency rosters, but interestingly, the feedback from the VMO's has been that the full-timers have made their involvement with the hospital much more satisfying and worthwhile.

When I began surgical practice, no-one would have thought of applying for a full-time position as a surgeon in a public hospital. Now, whenever we advertise, there are lots of applicants – both newly graduated surgeons, but more experienced surgeons as well.

Why is this so? For the newly graduated surgeons it is perhaps more understandable. In the past they might have gone overseas for a year or two before entering surgical practice proper – that is more difficult now. The jobs are scarce and their spouses seem to be professionals with careers of their own.

But why are the more experienced, seemingly established surgeons attracted to full-time employment? Has generation Y thinking affected surgeons? Or is the sheer cost of private practice taking its toll – constant staff challenges, indemnity uncertainty etc. Or is it that patients themselves have become part of the problem? Have they become so demanding, so suspicious, and so ungrateful that dealing with them on an individual basis, without the back-up of a major organisation is unappealing? Or maybe it is just the certainty of a good income, defined hours, paid holidays and study leave?

Whatever, I am just grateful for the applicants. But I am also grateful for the VMO's who choose to work in the public system – who choose to impart their knowledge, experience and example to the future generation of doctors and trainee surgeons – all for a sessional payment that barely covers their costs.

Now how do I fit all of that into my contract renewal? None of these issues had boxes for ticks next to them in the 360 degree assessments! Hopefully they will just look at me and mutter those great lines from Kylie Minogue (with all apologies to the Bard) – "Better the devil you know". Great song – came out 21 years ago. The year I started at the hospital. I wonder where the CEO and the Medical Director were then ...

Knowing when not to *operate*

Professor Mohamed Khadra felt that to promote end of life discussion, it needed to be played out on stage, with help from David Williamson

Professor Khadra caught the attention of playwright David Williamson at the Brisbane Writers Festival

After having published three books exploring perspectives of the health system – both as a surgeon and as a patient – Professor Mohamed Khadra recently entered new artistic territory when he co-wrote a play with Australia's most famous playwright David Williamson.

Titled *At Any Cost?* the work investigates end of life issues that are becoming increasingly complex and controversial in first-world high-technology medicine and is based on his most recent book Terminal Decline which comprises a series of interviews with the politicians, bureaucrats and administrators who have shaped Australia's health system.

Professor Khadra said he wanted to understand and then shift thinking about the social belief that doctors and surgeons must do anything and everything to maintain life no matter the quality of that life or the cost to the system.

"This is not about euthanasia, but about the everyday decisions health professionals are asked to make to prolong life just because we can and the difficulties facing family members if they don't know the wishes of their loved one," he said.

"It has seemed to me for a long time that the technology, expertise and money now available in first world medicine have outstripped the social discussion about how best to use them for the good of both the majority and the individual patient.

"More than 40 per cent of the health budget in countries like Australia is spent on the last month of life and although it may seem hard-hearted to ask the question, still it does have to be asked if this is the best use of resources."

Professor Khadra, Head of Urology at the Nepean Hospital in Penrith and Professor of Surgery at the University of Sydney, said he thought a play would be the best artistic vehicle to promote that discussion and when he saw David Williamson at the Brisbane Writers Festival, he pounced.

First he went up to the playwright and introduced himself, suggested they collaborate on a play, ducked off to a bookstand to grab two of his works and ran back to present them with security staff chasing him believing him to have taken the books without paying.

"It was funny at the time and I think he thought I was a nut but I certainly got his attention," Professor Khadra said.

"I wrote my phone number in one of the books and then about six weeks later he called back while I was operating and I talked to him while my registrar held the phone up to my ear."

Professor Khadra explained his interest in the issues and Williamson saw the dramatic potential of a family dealing with death and the two began the collaboration with Professor Khadra focusing on the medical voice while Williamson developed the characters of the family coping with the terminal illness of an aged parent.

"I felt like a finger painter working alongside a master," Professor Khadra laughed.

"At one stage we spent a day together at the Nepean Hospital talking to social workers about aspects of the human drama that play out at such times – anger, fear, abuse – along with staff in the intensive care unit to get a feeling for how the staff dealt with such times.

"He was wonderful to work with, considerate, respectful and it was a wonderful experience."

Finally, after 15 drafts and countless phone calls between the two, the play opened in July at Sydney's Ensemble theatre following its world premier at the Noosa Longweekend Festival in June.

With considerable black humour and the involvement of such well-known actors as Martin Vaughan, Tracy Mann and Kate Raison, the play has received glowing reviews and could soon be set to tour the nation.

But it was, perhaps, the views of his medical colleagues that had Professor Khadra most anxious.

> *"It has seemed to me for a long time that the technology, expertise and money now available in first world medicine have outstripped the social discussion about how best to use them"*

A scene from the play at the Ensemble theatre; Inset: Martin Vaughan in *At Any Cost*.

"One night we had about 60 doctors in the audience and I was as nervous as a kitten, but the reaction was positive, which was a great relief," he said.

"However, it is the general public I am most wishing to reach with this. We doctors are well aware of these issues, but still we need guidance from the person in the bed and the people around the bedside if the patient cannot communicate.

"I would hope that the one message that audience members would take from the play is to have the discussion with each other about what they want, the quality of life they want or don't want, the use of organs for transplant.

"With medical technology as it now is we can do almost anything to extend life for a very long time, but should we?

"I can remember a mentor of mine saying once that a good surgeon knows when to operate, but a great surgeon knows when not to operate."

Professor Khadra said that while surgeons and doctors should always concentrate on alleviating suffering, patients can be made comfortable to allow nature to take its course.

Doing otherwise, he said, could not only cause unnecessary suffering, but also affect the doctors, surgeons and nurses caring for the patient.

"It has been estimated that more than 30 per cent of health professionals experience at least one disabling anxiety episode throughout their working lives and I think that at least some of that is due to feeling compelled to do things based on medico-legal grounds, rather than acting solely in the best interests of the patient.

"That is not the way to practice medicine and not what most of us signed up for, and until this changes we all pay a price."

With Karen Murphy

Part of the big picture

Scholarships from the College have helped David Chang pursue better outcomes for patients and become a part of a project hoped to revolutionise cancer treatment

A previous recipient of College research Fellowships was recently awarded the Cancer Institute New South Wales Premier's Outstanding Cancer Research Scholar award for 2011.

Mr David Chang, a Pancreatic and Upper GI Surgeon, received the award in July for PhD studies that could help surgeons and clinicians make more informed decisions to optimise an individual's management.

That work was part-funded through the College's Sir Roy McCaughey Fellowship in 2009 and 2010 and was undertaken under the supervision of Professor Andrew Biankin, Head of the Pancreatic Cancer Research Group at the Garvan Institute of Medical Research in Sydney and Professor Rob Sutherland, Director of the Cancer Research Program

Mr Chang said his research investigated how tumour biology can be used to predict outcomes and treatment responses of patients with pancreatic cancer.

"At the moment we do a Whipple's procedure which is a major operation of the pancreas, which means that patients take a long time to recover," he said.

"We know it helps about half of patients and cures about a quarter, but we just don't know who they are ahead of time.

"We wanted to know that if we were to do such a large-scale operation, there would be a definite benefit to the individual patient. With a better understanding of the molecular pathology of pancreatic cancer, we can potentially define an optimal personalised treatment plan."

Mr Chang said that while pancreatic cancer was not one of the most common cancer types, it was the fourth most common cancer-related death with many patients suffering a recurrence of the disease within six months of surgery.

He said such patients are perhaps better treated in other ways given how little benefit they received from such a major procedure. However, more aggressive surgery may be justified in patients with a good prognostic tumour.

The clinical importance of this work was recognised by the American Society of Clinical Oncology in 2011 through a Merit Award and featuring the findings in ASCO Post.

David Chang with his supervisor Prof Andrew Biankin after the award ceremony.

Now with his PhD thesis almost complete, Mr Chang is operating one day a week at the Bankstown Hospital in Sydney while continuing his research work as part of a major international effort to deeply define the genomic aberrations that characterise pancreatic cancers.

This effort, the International Cancer Genome Consortium (ICGC) has been organised to elucidate the genomic changes present in the majority of cancers that contribute to the burden of disease worldwide.

Australia is a member of the ICGC and will contribute by sequencing pancreatic cancer in a project primarily incorporating the Garvan Institute of Medical Research in Sydney and the Institute of Molecular Biosciences (UQ) in Brisbane. The project, estimated to cost over $80 million, was initiated by the award of the largest single peer-reviewed grant of $27.5 million by the NHMRC.

"Our project is called the Australian Pancreatic Cancer Genome Initiative and is led by pancreatic surgeon Professor Andrew Biankin and Professor Sean Grimmond in Brisbane," Mr Chang said.

"It's really the next step after the Human Genome Project and a very exciting endeavour to be part of.

"This project will revolutionise the way we study and treat cancer, shifting paradigms and inducing dramatic changes in the clinical practice of oncology," he said.

"There have been major breakthroughs in cancer therapy, particularly in breast cancer, that has improved outcomes. We are hoping to achieve similar results through the sequencing project."

Mr Chang said he was honoured to have been chosen as the Outstanding Cancer Research Scholar as well as having received such strong support from the College.

"Having the opportunity to undertake a PhD was invaluable because I think research helps me understand disease biology and make better clinical decisions while conversely, my clinical work helps guide research questions and how to translate my bench findings," he said.

"The work we're now doing as part of the Australian Pancreatic Cancer Genome Initiative is cutting edge and having the support to contribute is a once in a lifetime opportunity for me."

With Karen Murphy

Participants at the workshop; Dr Marcelino Correia and President Jose Ramos Horta at the eye centre opening;

New vision for East Timor

The opening of a new eye centre in Dili will mean treatment for more people

The provision of eye care to the people of East Timor reached a landmark in July with the official opening of the National Eye Centre in Dili and the arrival a month earlier of a new ophthalmologist, Dr Andreas Kreis.

Funded through AusAid and the Fred Hollows Foundation in Australia and New Zealand, the Centre was opened by the President of East Timor, Mr Jose Ramos Horta who used the occasion to urge for the elimination of the backlog of cataracts.

More than 13,000 people in East Timor are needlessly blind, with the vast majority of them suffering from cataract blindness, a disease which places considerable social and economic strain on the developing nation.

"We can free thousands of people from having to look after people who have a very simple eye disease, cataract, so that they are cured and they are treated and the people who have to look after them are released into active productive life," Mr Ramos Horta said at the opening ceremony.

"I hope that working together in the next few years to come, that the backlog of cataracts is eliminated."

The head of the RACS-managed East Timor Eye Program (ETEP), Dr Nitin Verma said that while the building was funded through the Fred Hollows Foundation, it had been equipped through funding provided to the College through AusAid.

He said more than 50 people a day could be treated at the centre which comprises consulting suites and a theatre with the facility being jointly run by the ETEP and the Ministry of Health in East Timor.

"This does represent a significant milestone in our efforts to provide eye care to the people of East Timor," he said.

"Not only will it be equipped to undertake more complex surgeries such as corneal transplants, perhaps more importantly it creates a focus for co-ordinated national eye care efforts.

"Having our own operating theatre also means that we won't have to fight for theatre time, which means of course that we will be able to treat more patients."

Mr Verma said that the Eye Centre, which is yet to be commissioned, would predominantly service the people of Dili with team visits by Australian and New Zealand Ophthalmologists still necessary to treat the people in regional areas.

"All our surgical teams are now seeing more patients because the word has gone out; because more people are starting to understand what we can do and because the screening and outreach programs are working so well," he said.

"Now we are going deeper and deeper into the sub-districts so that people don't have to travel to Dili and we are in the process of putting eye care services into health centres that would represent the next level down from regional hospitals."

The opening of the National Eye Centre in Dili in July was also used as an opportunity to bring all stakeholders together for a workshop run by the RACS to discuss the current eye health situation in East Timor, identify key challenges and plan for the future.

The meeting was held under the banner of V2020, an advocacy group that helps direct resources and attention to blindness and seeks to eradicate avoidable blindness by delivering eye health and vision care to areas of need.

Held at the Hospital Nacional Guido Valadares in Dili and facilitated by Dr Marcelino Correia, national ophthalmologist, the workshop drew together members of a variety of organisations including representatives from the Ministry of Health, the RACS and ETEP, the East Timor Blind Union, AusAid, the Optometrist Association of Australia and Foresight.

The challenges listed by workshop participants included the cataract backlog, the lack of education and training in the early diagnosis of such conditions as conjunctivitis and keratitis, the inadequacy of workforce numbers with only four full-time ophthalmologists in East Timor to service a population of more than one million people and the lack of eye services in the regional areas.

In response, the workshop established specific goals to work towards including:

- The development of guidelines or manuals on identification, management and treatment of acute and chronic eye conditions to allow for improved education, training and up-skilling of local specialists, doctors and eye care nurses.
- Increased health promotion in communities to improve awareness and understanding of eye conditions and to encourage patients to visit their nearest eye clinic as opposed to seeking treatment using traditional medicine.
- Expanded outreach and screening activities to improve detection and identification of patients.
- Establishment of a comprehensive eye care service which includes treatment and management of sub-specialty cases, with sub-specialty clinics to be run by visiting teams to address more complex cases such as paediatric ophthalmology/glaucoma, ocular oncology and vitreoretinal disease as well as diabetic retinopathy.
- Ensuring that the appropriate infrastructure, supplies and consumable are available to provide a comprehensive eye care system able to treat disabling eye conditions in-country.

Members of the workshop also set as a goal the aim of having ten ophthalmologists working in East Timor by 2030, with 25 ophthalmic nurses and 50 primary eye care practitioners.

To date, the ETEP has performed more than 4,811 eye operations and treatments and provided eye consultations to over 46,000 Timorese. The program dispensed almost 30,000 spectacles, supported training of East Timor's first ophthalmologist and established sub-specialty ophthalmology programs including corneal transplantation and laser surgery.

With Karen Murphy

Swiss-Australian Ophthalmologist Dr Andreas Kreis, who trained in Switzerland and worked in Australia, took up his new position working with the East Timor Eye Program (ETEP) in June this year. Here he speaks to *Surgical News*

Why did you wish to work in East Timor?
I always had the desire to work in developing countries. This was one of the main reasons I chose to do medicine. Once I had finished my training in ophthalmology I was ready to tackle that big task. Also, I was born in Jakarta, Indonesia, so Timor was sort of like going back home. When Dr Verma told me about the project, I came to visit the place last year to see if it was workable in terms of my family. The decision was then made with my wife Julia to come here. It was an easy decision and for me the logical next step in our lives.

Where have you worked previously?
I studied in several places including Basel, Geneva, Paris and Montreal, but did my ophthalmological training in Lausanne, Switzerland, for four years and in Melbourne for four years. I started off in Australia as a research Fellow at the Centre for Eye Research Australia (CERA) under Professor Tien Wong. I was offered thereafter a Senior Registrar job at the Royal Victorian Eye and Ear Hospital (RVEEH), but kept my research activities going for a couple more years.

When will the new National Eye Centre in Dili be operational?
I hope in September. Although the clinic has been officially already opened, there is still a lot of work ahead, mainly in terms of managerial issues for me. Managing is about 40 per cent of my work here in Dili, which I deal with before or after my clinical and surgical duties.

What types of procedures do you expect to undertake there, apart from cataract surgery?
We are covering a broad field of ophthalmic operations. Starting with cataracts we will also be doing oculoplastic procedures, anterior segment surgery including Corneal transplants, filtrating glaucoma surgery and paediatric ophthalmology surgery for squints are just the most important ones. I should also mention the huge amount of ophthalmic trauma surgery undertaken that uses up lots of time and resources in our daily clinical life.


Andreas Kreis at work.

What does the establishment of the centre mean in terms of the provision of eye care ?
I think it is fair to say that eye care in Timor is the most advanced, best organised and most sustainable medical specialty in this country. We have a well-functioning general clinic in Dili and we will soon be starting a specialty clinic once a week for medical retina and glaucoma. We have a well functioning outreach program that not only covers the five referral hospitals in the main districts, but we have also started moving deeper into the country to screen patients and operate or refer in more remote places. This sounds all very nice and easy, but there are relentless and ongoing efforts from all sorts of people and organisations over the past decade to this day and hopefully in the future. The more intensified involvement of RANZCO over the last couple of years is certainly more than appreciated here.

How have you and your family found life?
After a very difficult first three months we have finally found a place that we call home now. My wife Julia and daughter Anais have found lots of new friends among locals and with other expat families and therefore have found a good balance, which, of course, is very important for all of us. People tend to have a lot of romantic ideas about working and living in the tropics and developing countries, but you quickly learn that life is difficult and often very frustrating under these circumstances, although often very rewarding too.

Reflections from South Australia

There are many important issues Fellows must consider over the coming months

Greg Otto,
SA Fellow

Things have been fairly quiet in South Australia (SA) over the last few months. There are four areas I would like to highlight.

The first is the State health budget brought down by Health Minister Hill in July. Ever the consummate politician, Minister Hill somehow managed to increase the health budget by $133 million despite these fiscally restrained times. Of surgical interest is the new investment of $42 million for digitisation of BreastScreen SA, a welcome initiative. The government is determined to push on with the reform of OPD services and the four hour rule, both of which the College has serious concerns about. We have expressed these concerns to the relevant individuals. The final outcome remains to be seen.

I have also raised the issue of nonpayment of the College accreditation fee for the various sites. I brought this up with the Chief Medical Officer, Professor Paddy Philips. He indicated that the government was not intending to pay. Apparently this position had been adopted by all Health Ministers and was unlikely to change. It might be time for stronger action from the College.

SAIMET, the SA medical training organisation has voiced an interest in accrediting posts for surgical training. They have indicated that they want to accredit some basic generic attributes of facilities, thus saving the College some time and effort in the accreditation process. SAIMET have had some problems with intern post allocation this year, causing some issues for sixth year medical students whose career paths often depend on Intern postings. Hopefully SAIMET's processes will improve before they get involved in accreditation of College training posts.

Conflicts of interest abound in the medical profession. Some of you may have seen the Four Corners program on an alleged conflict of interest related to hip replacements. Discussions around these issues convinced me that the College should take a leadership role in minimising these conflicts of interests. A good start would be to automatically reject all scientific articles with declared or suspected conflicts. This is a matter requiring vigilance.

I am also of the view that all industry funding of conferences and workshops should be phased out, in favour of a user pays scheme. These conflicts are an anathema to our credibility as scientists, and as a group in general. The College could easily address these obvious conflicts starting with the College journal. A research fund could be established in order to supply alternative funding to worthwhile projects. I would like to see the College taking the initiative in this area.

I have recently become interested in the problems of alcohol in the medical workplace. It seems that this may not be an insignificant problem. If worldwide figures are to be believed, there may be as many as two per cent of the workforce affected by alcohol or drugs at any one time. I would expect the medical workplace in Australia to be no different. It may even be an underestimate, given that in this country we enjoy the dubious distinction of the largest per capita consumption of alcohol in the world.

Recent workplace experience has demonstrated how powerless institutions are to act, when allegations of intoxication are made against an individual. It seems the jurisdictions, the Medical Board and indeed the College are unable to act effectively. The difficulties relate to lack of concrete evidence. It seems that in the current legalistic environment of disciplinary hearings, hearsay evidence just won't cut it. I think that it is time to revisit the idea of random drug and alcohol testing in the medical workplace.

Some safety critical industries such as aviation already have such regimes in place for protection of the public and the workers. This has resulted in considerable reduction of workplace intoxication rates, and consequently improved safety. Surely our patients deserve and expect an alcohol and drug free medical workplace. Surgery is inherently a much more dangerous activity than air travel.

If random testing proves to be too expensive to introduce, then empowering the workplaces to demand an immediate blood alcohol estimation for any employee accused or suspected of drunkenness, would be an alternative strategy. This would be a useful, cheaper, but probably just as effective alternative to random testing, as it would provide evidence on one hand and protect the wrongly accused on the other hand.

The power to compel an individual to have a blood test could be conferred by legislation, bylaw or contractually, but it would need to be formalised in some manner. Offending individuals could then be dealt with in an appropriate fashion by counselling initially, up to dismissal for recidivists. I urge the College to grasp this nettle and give our patients the level of confidence they deserve.

The imminent apparent departure of the Orthopods from the College has also been a frequent topic of discussion among my colleagues and me over recent weeks. I learnt a lot about the motives behind this move in discussions. It seems that our orthopaedic colleagues wish to have complete autonomy in many of the areas currently run by the College.

To a certain extent, these views are shared by many other specialties and seem to be at the centre of dissatisfaction with the College, expressed to a greater or lesser extent by many. The current College structure has stood us in good stead for 80 odd years and in that time the College has tried to be all things to all Fellows. I think the time when this might have been even remotely possible could be coming to an end. One only has to look at the 1,000 pages of documents to be read for each Federal Council meeting to realise that this has become an onerous, thankless and seemingly impossible task.

It would indeed be a great shame if the Orthopods departed. I believe that united we stand, particularly in the areas of relationships and advocacy. In order to address the issues, I think that the College needs to reinvent itself in a leaner form. Many of the current functions should be devolved to the specialties by Memorandum of Understanding or similar instrument.

Core functions currently done well, such as library journal, relationships and historical archive, would be retained centrally as a glue to bind us together. In this way the College will survive the next 80 years as a strong united voice for surgeons and surgical standards. Rather than be all gloom and doom, the orthopods stand may have just shown us the way ahead as a united, but evolving group. We just have to be bold enough to accept the challenge.

Children and cosmetic surgery – the legal position of the doctor

There are important issues to consider when treating children

Michael Gorton AM
Principal – Russell Kennedy Solicitors
and Kate Hannah

There are many situations where cosmetic surgery for children is beneficial and clinically indicated (for physical and psychological health reasons).

However, news reports indicate a growing trend for elective cosmetic surgery being sought for children – under pressure from both the child and their parents. In some cases, the surgery was not "medically necessary" and accordingly exposed the child to the risks of unnecessary surgery.

What are the risks and potential liability of the doctor in such cases?

This is an area of practice which can create tension between the interests of the child, parents, the state and the law. It involves issues of consent, the autonomy of the child and questions of the best interests of the child (a child being a person under 18 years of age).

The Queensland Government examined this issue some years ago, and altered the law within that state to "ban cosmetic surgery on children", requiring doctors to have regard to the best interests of the child, after balancing the risks with potential benefits.

Queensland Health noted in the paper "Have Your say: Children and Young People Using Cosmetic Surgery and Solariums in Queensland" (2007): "There is some evidence that there may be an increasing number of children and young people in Queensland and Australia who are using cosmetic surgery... The media have explained the trend for cosmetic surgery as being caused by young people's obsession with celebrities, aggressive marketing by cosmetic clinics and some doctors, and the promotion of having the perfect body... At the moment there are no statistics collected on what and how much cosmetic surgery is performed in Queensland and Australia, or how old the people are that are having the surgery."

This is an area of interest, whether it is an area for substantial concern in Australian and New Zealand we don't really know.

States other than Queensland do not have a statutory limitation, but other considerations are still required at law. However, the doctor's principal professional obligation continues – to require the doctor to consider the best interests of the patient (child), even despite consent or insistence of the parents.

Cosmetic surgery can be defined as "reshaping normal structures of the body using surgical and non-surgical techniques... Initiated by the consumer to improve their appearance and self esteem" as defined by the "Cosmetic Surgery Report: Report to NSW Minister for Health Oct 1999"; quoted by Tina Cockburn, QUT, Children, Competency and Consent to Cosmetic Surgery.

Or as the NSW Medical Council, (NSW Medical Council, Cosmetic Surgery including cooling off period for persons under 18 years of age, June 2008 – www.mcnsw.org.au/page/317/resources/policies) has defined it; "Procedures undertaken by a qualified medical practitioner to revise or change the appearance, colour, texture structure or position of normal body features with the sole intention of improving the patient's appearance of self esteem".

Procedures such as rhinoplasty ('nose job"), otoplasty (ear pinning), and removal of prominent birth marks could be considered within the definitions, but appear to be outside the area of controversy or rising concern. It is accepted that these are performed to prevent embarrassment and social issues. For this reason the Queensland study excluded any procedures done for medical reasons to correct physical conditions which cause problems for medical, psychological or social welfare.

This does not mean any procedure with a similar aim is automatically acceptable.

> *"This is an area of practice which can create tension between the interests of the child, parents, the state and the law."*

Consent and Autonomy

It is a general principle of law that a person must consent to health care before it can be lawfully provided. A practitioner who treats someone without first gaining a valid consent for the treatment exposes himself or herself to legal liability. In order for a person to be able to give a valid consent to health care (that is, one that can be legally acted upon), that person must have the legal capacity to consent, and give the consent voluntarily.

For young people, however, capacity to consent is a real issue because the law has traditionally assumed that young people lack capacity to make health care decisions by reason of their immaturity. Parents have generally been given the responsibility of making those decisions on their child's behalf. The law has developed to a point where it is willing to recognise that young people may have sufficient maturity to be given decision-making responsibilities in relation to their own health care. But, unlike adults, the law requires something more than a broad understanding. In order to recognise a young person's competence, the young person must have sufficient understanding and intelligence to enable him or her to understand fully what is proposed, including the risks and benefits ("NSW Law Reform Commission Report 119 (2008): Young people and consent to health care").

This position is set out in two main cases. The first is Gillick. (Gillick v West Norfolk & Wisbech Area Health Authority [1986] 1 AC 112).

The mother of five girls sought a declaration that provision by the Department of Health of contraceptive advice to her daughters, under 16, without the parents' consent was unlawful. The question was whether the girls themselves could give that consent. Lord Scarman (p189) said a young girl was able (competent) to consent to the advice and treatment when she: "achieves a sufficient understanding and intelligence to enable her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances".

So from birth it is the parents' responsibility and right.

The child will gain capacity to give consent to procedures at various stages depending upon their own development and the issues involved in the procedure.

The second case is known as Marion's case: (Secretary, Department of Health & Community Services v JWB & SMB, (1992) 175 CLR 218).

There, the parents of an intellectually and physically disabled girl wanted her to be sterilised. There was no doubt the girl did not have the capacity to understand the issues or to consent, but could the parents do so?

The Court found that other than where the sterilisation would be an incidental result of surgery, which was otherwise necessary to cure a disease or correct a malfunction, the parents did not have the power to authorise the procedure. Because of the seriousness of the procedure only the Court could give approval.

The Court went on to say that the power of parents (in the ordinary course) to offer consent on the child's behalf diminishes as the child grows in capacity and maturity.

Informed consent can be given by a child when he or she has sufficient understanding and intelligence to understand fully what is proposed, the consequences and risks of the proposed treatment, and the consequences of non-treatment.

The physician, parents and the patient must consider the type of treatment, the effect, other options, the child's ability to understand the problem, the expected outcome, the risks, general maturity, age and schooling before commencing any such surgeries.

Consent to the treatment is one way of looking at it. Increasingly we find people talking about their rights, their right to treatment, children's rights or parent's rights.

If a child is not able to give consent, then the parents can decide on the treatment, but they must act in the child's best interests. In the area of elective cosmetic surgery, the circumstances may be rare where the procedure is clearly within the child's best interests. The Court in Marion's case did specifically refer to cosmetic surgery as being within the ordinary scope of a parent to consent to (p49). Whether the Court was using the same definition, excluding any medical requirement, is not clear. It was also noted that determining the child's best interest is a difficult and subjective task. If there is no medical requirement for cosmetic surgery, it is difficult to see why it is not something best left until the child reaches competency – also a factor to be considered under the Queensland legislation limiting elective cosmetic surgery for children.

(I am grateful for the assistance of Kate Hannah in the preparation of this article.)

Consider:

Before undertaking unnecessary or elective cosmetic surgery on children, consider:

1. The best interests of the child – warn of the risks.
2. Consent issues. Is the child mature enough to consent or is parental consent required? Is the consent rational?
3. The Queensland legislation gives some guidance on matters for review:
   - **a.** the views of the child, if sufficiently mature;
   - **b.** the views of the parent;
   - **c.** the health of the child, and whether the procedure has clinical merit;
   - **d.** the risks of the procedure;
   - **e.** the psychological health of the child, and whether the procedure will be beneficial;
   - **f.** the timing of the procedure, and whether waiting for adulthood would be better.

ANNUAL SCIENTIFIC CONGRESS
Coordinator

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

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

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

The Position Description, the Person Specification and an application form are available from the College's HR department (deborah.jenkins@surgeons.org). Potential applicants may contact the current Co-ordinator (campbell.miles@surgeons.org) for information regarding the role.

The closing date for applications is 30 October. The start date is negotiable but it is envisaged that the new Co-ordinator would begin the role two months before the 2012 Annual Scientific Congress.

NOTICE TO RETIRED FELLOWS

Thank you to
Mr Ian Valentine Lishman and Mr Graham Sinclair.

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

RACS ASC 2012

Royal Australasian College of Surgeons
81st Annual Scientific Congress

Kuala Lumpur Convention Centre, Malaysia

6 – 10 May 2012

Convocation/Workshops: Sunday 6 May
Scientific Sessions: Monday 7 - Thursday 10 May

W: asc.surgeons.org

Programs:

- Bariatric Surgery
- Breast Surgery
- Burn Surgery
- Cardiac Surgery
- Colorectal Surgery
- Craniomaxillofacial Surgery
- Endocrine Surgery
- General Surgery
- Head & Neck Surgery
- HPB & Upper GI Surgery
- International Forum
- Medical Student Program
- Medicolegal
- Military Surgery
- Neurosurgery
- Paediatric Surgery
- Pain Medicine
- Plastic & Reconstructive Surgery
- Rural Surgery
- Senior Surgeons
- Surgical Education
- Surgical History
- Surgical Oncology
- Thoracic Surgery
- Trainees Association
- Transplant Surgery
- Trauma Surgery
- Vascular Surgery
- Women in Surgery

For more information contact:
Conferences & Events Department
Royal Australasian College of Surgeons

T: +61 3 9276 7406
F: +61 3 9276 7431
E: asc.registration@surgeons.org
W: **asc.surgeons.org**

Royal Australasian College of Surgeons

Writing Medical Reports in a Brave New World:

Writing medical reports can be made easier if you understand the process

Leigh Atkinson
Chair, Medico Legal Section Executive Committee

From time to time, all surgeons will be required to provide medical reports to various jurisdictions throughout Australia. Twelve months ago, legislation was passed introducing national medical registration. As a result, the medical expert witness is now free to provide medical reports to jurisdictions in any Australian state or territory.

This national medical mobility however is compromised by the variations in the use of the American Medical Association's (AMA) Guidelines to the Evaluation of Permanent Impairment; the 5th Edition is accepted by the courts in Australia, the 4th Edition is relevant in some cases, the 5th Edition in others and modifications of the 5th Edition are also used.

As surgeons, at times we will receive a request from a solicitor to provide a medical report with respect to a plaintiff. On occasions this solicitor requires only a preliminary discussion on the documents submitted. More frequently, a written report is requested following an examination. Usually extensive documents from the solicitor are accompanied by an extensive list of specific questions regarding the plaintiff. In addition, the solicitor will identify that he or she is responsible for payment of the report. At this time, the solicitor will also forward material regarding civil procedure rules introduced in specific jurisdictions early in this decade.

Now the surgeon can proceed with a consultation and examination prior to providing the final document. In doing this, it is important to conform to the rules for expert evidence for the relevant State or Territory. What follows are general guidelines for producing a good report.

The surgeon will be required to identify his or her name, qualifications, and the material reviewed, together with the history provided by the plaintiff, the relevant examination and investigations, the facts and assumptions on which the opinion is based and a summary of conclusions with references if indicated. Finally, the medical report must acknowledge that the surgical expert witness has read the Code of Conduct and agreed to be bound by these rules.

At the time of the consultation, a careful history of the medical incident is required with additional background information on the current symptoms, the past medical history, the family history and recreational and employment activities prior to and following the incident. An examination is required and, in the case of a female plaintiff, it is recommended that a nurse or secretary be present during the examination and that this is documented. It is useful to document the length of the consultation and it is usually necessary to identify the plaintiff with such documents as a driver's licence. As a medical expert witness, the surgeon is not entitled to take over the management of the case.

The surgeon should then review the detailed material that has been provided. This will include medical reports from other expert witnesses, primary care physician records, investigations and reports from physiotherapists, occupational therapists and psychologists. With this extensive information, the surgeon can now proceed to develop a report in his or her area of specialist expertise, for example Urology or Orthopaedic surgery.

The opinion should be expressed in language that is concise and that is understandable to the common man. There is a place to carefully recognise the issues in the case and to recognise the losing person's position as the report is developed. In particular, a final impairment rating under the AMA Impairment Guidelines used in the specific jurisdiction should be then developed.

On occasions, the medical expert witness may decide that there is inadequate information or investigations and, in providing the report, it may be necessary to identify that a supplementary medical report will be required. In some cases, the plaintiff may not have reached maximum medical improvement.

Usually the final report is only applicable once the plaintiff has reached maximum medical improvement. In providing the report, the medical expert should identify the causation for the injury. In addition, in the event of previous injuries, an apportionment with respect to the impairment is indicated. In that case, the reasons for the opinion regarding the impairment need to be clearly identified.

Increasingly, the occupational therapists are providing reports on the impact of the impairment on activities of daily living and future employment expectations. The surgical expert witness will also be required to report in this area.

The impact of the impairment following the incident on care and maintenance of the plaintiff will be required, together with ongoing aspects of the need for care and additional treatment and possibly physical adjustments to the home and employment site. The surgical expert should carefully address these issues as they have additional impact on the assessment by the courts.

Having completed the report, it needs to be dictated, typed, edited and personally signed. Increasingly the courts are requiring expert witnesses to provide concurrent medical reports. This has some advantages in that it allows clarification of the issues and resolves areas of borderline conflict. Still, it can be time-consuming.

The courts require the combined experts in an area of special expertise to outline their areas of agreement, their areas of disagreement, and the reasons for this position. In completing reports, it is useful to develop a tight executive summary highlighting the specific issues in the case, ideally on one page. This is provided at the front of the report. A detailed CV of the surgeon should be attached.

In some cases, additional medical information may subsequently be provided and then a supplementary medical report is required. These days most cases are resolved by mediation and it is increasingly uncommon for the surgical expert witness to be required to attend court. However, if one is required to attend court, it is to be remembered that the expert witness cannot be expected to know all the details of a case that come before the judge.

Finally, it has to be accepted that very often the surgical expert does not hear the final outcome of the case.

For more information, contact the Professional Development Department at +61 3 9249 1106 and PDactivities@surgeons.org or visit www.surgeons.org.au

Occupational Medicine Course; getting patients back to work

A visit to GMH in Adelaide in May this year showed the integration of health services

Edward (Ted) Schutz,
Convenor

The latest workshop was at General Motors Holden (GMH) in South Australia, held in conjunction with the ASC in May. Organised by Erik Eriksen, together with great support from RACS and GMH staff, including the occupational medical team, the 13 participants were able to view much of the production line of vehicles.

The workshop opened with an interactive session on occupational health and safety and medical challenges faced by GMH and their measures over recent years to reduce injury-related time off work. GMH has developed a system whereby medical services are an integral part of the design of work stations and modified duties, especially for injured workers returning to work.

This session was followed by an extensive tour of many sections of the factory, starting at the assembly line where pressed steel components are welded together by robotics to form the chassis and body. We then observed the initial fitting and removal of doors, the paint shop, and the sequence of fitting all of the components which make up the car, including the wiring harness, seats, dashboards, refitting of the doors toward the end of the production process, and installation of the engine and drive train. We also saw part of the plastic injection moulding section. Due to time constraints the metal stamping section was not included.

We were able to see a wide variety of tasks performed, including many workers with lighter duties suitable for return to work. There were many stops during the tour to view particular activities and have lively question and answer discussions. A robust discussion of matters of interest arising from the tour completed the visit.

During the site visit we had the enthusiastic support of management, supervisors and medical team comprised of an occupational physician, hand therapist, physiotherapist, and Health Services Manager.

Health services are integrated with factory management and production and with great trust and everyone cooperating, the system has produced low injury rates and enviable return to work results.

A future visit to the GMH Engine Plant in Fishermans Bend in Melbourne is proposed; most likely combined with a visit to an adjacent large industry.

Forthcoming events for your diary:

Sydney, Friday, 4 November, 2011: A visit to the Qantas heavy maintenance area combined with either another section of Qantas or a visit to the container port to make a whole day program. Registrations from interstate are most welcome.

Sydney, Friday 25 November to Sunday 27 November, 2011: AOA/RACS combined Medico Legal Section meeting at the Masonic Centre, Sydney, following similar innovative and highly successful meetings in Melbourne, 2009 and Gold Coast, 2010.

For more information email PDactivities@surgeons.org or call +61 3 9249 1106

YOUNGER FELLOWS LEADERSHIP EXCHANGE FEBRUARY 14-16 2012, LAS VEGAS

Each year our College and the Association for Academic Surgery (AAS) in America exchange delegates as part of a leadership exchange. The purpose is to two fold; firstly to provide professional development for a Younger Fellow, particularly in relationship to leadership and secondly to promote an exchange of ideas and possible solutions for common issues affecting Younger Fellows in both organisations. The exchange also aims to identify opportunities for our Younger Fellows to access International Clinical Fellow positions in the US.

The Exchange covers airfares, accommodation, transfers and conference attendance expenses for the RACS representative. The 7th Academic Surgical Congress is from February 14-16, 2012 at the Encore at Wynn, Las Vegas

Interested Younger Fellows are encouraged to apply by 30 September 2011.

Contact Professional Development Department. Ph: +61 3 9249 1106 Fax: +61 3 9276 7432 Email: PDactivities@surgeons.org

Professional Development WORKSHOPS

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

>Building Towards Retirement
1 October, Brisbane
Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. The program covers key issues including maintaining health and well being, job opportunities after surgery, superannuation and legal advice, community involvement and building relationships and networks.

>Practice Made Perfect; successful principles in practice management
3 October, Brisbane
This whole day workshop focuses on the unique challenges of running a surgical practice. Learn more about the six principles of running a surgical practice. Practice managers, practice staff and Fellows are encouraged to join these workshops for a valuable learning experience.

>Writing Medico Legal Reports ***NEW redesigned evening program****
19 October, Brisbane
This half-day (evening) workshop uses lectures, activities and practical demonstrations to help improve your skills in preparing medical reports for use in legal matters and giving evidence as a medical expert witness effectively in court. It is an opportunity to gain understanding of the legal rules covering admissibility of an expert report and how to prepare and set out an expert report to ensure compliance with court rules.

>Polishing Presentation Skills
21 October, Perth
This whole day workshop helps to advance your presentation skills and provide you with a step-by-step presentation planning process and practical tips for delivering your message. It is equally applicable to presentation sessions in hospitals, conferences and international meetings.

>Occupational Medicine: getting patients back to work
4 November, Sydney
This workshop focuses on the knowledge of task adaptation and communication strategies that will enhance patients' successful return to work. A tour of QANTAS heavy maintenance and another site visit are being planned. Interstate visitors are most welcome.

STEP (Surgical Teacher Education Program)
>Keeping Trainees on Track (KToT) ***NEW***
23 Sept, Hobart, 19 Oct Sydney, 21 Oct Wangaratta Vic
This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

>Sustaining Your Business
18-20 November, Brisbane
Effective business and financial planning is important for both private and public clinical practices. This 2½ day workshop provides the foundation for the development and implementation of business plans to sustain business growth and performance. It explores financial management; from the preparation and analysis of responsible budgetary plans, decision making, management and reporting to the development of estimates and capital investment proposals.

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

2011 DATES:
SEP – NOVEMBER

ACT
>9 November, Canberra NEW
Keeping Trainees on Track (KToT)

NSW
>19 October, Sydney ***NEW***
Keeping Trainees on Track (KToT)
>20-22 October, Sydney
Surgical Teachers Course
> 4 November, Sydney
Occupational Medicine: getting patients back to work
> 25-27 November, Sydney
AOA/RACS combined Medico Legal Section meeting

QLD
>1 October, Brisbane
Building Towards Retirement
>3 October, Brisbane
Practice Made Perfect
>19 October, Brisbane ***NEW***
Writing Medico Legal Reports
>18-20 November, Brisbane
Sustaining Your Business

TAS
>23 September, Hobart ***NEW***
Keeping Trainees on Track (KToT)

VIC
>21 October, Wangaratta ***NEW***
Keeping Trainees on Track (KToT)
>12 November, Melbourne
Communication Skills for Cancer Clinicians

WA
>21 October, Perth
Polishing Presentation Skills

Reminisces of the Rowley Bristow Hospital at Pyrford

The Rowley Bristow Hospital in Pyrford, UK, was established in 1907 as a home for poor and crippled children by the Waifs and Strays Society. Over the years it developed into a hospital and special school and later became a centre of excellence for the practice and teaching of orthopaedic surgery until its closure in 1990

Reginald Magee
Queensland Fellow

In the 1950s and 60s, many young medical graduates desirous of a career in surgery made their way to the UK to take advantage of the teaching offered by the Colleges and hospitals. Also, there was the opportunity to gain operative experience.

One favoured hospital was The Rowley Bristow at Pyrford, Surrey where a three weekend cram course in the management of orthopaedics and fractures was run by Mr A Graham Apley. The FRCS was the basic qualification for all branches of surgery and aspiring surgeons, especially those with little orthopaedic experience, found these lectures invaluable.

This hospital had its beginning in 1907 as one of the homes established by The Church of England for the care of poor and disabled children many of whom suffered from such conditions as tuberculous bone disease, the effects of poliomyelitis, rickets, other bone diseases and deformities; all of which necessitated long stays in hospital. Because of this The Board of Education in1918 insisted that a school should be added to the home and provided with teachers trained to teach disabled children.

In 1922, Mr. Rowley Bristow, orthopaedic surgeon at St Thomas' Hospital, London, came to live in West Byfleet. He took an interest in the welfare of the inmates of the St Nicholas and St Martin's homes and became the honorary surgeon. Any children who required surgery at that time were transferred to St Thomas'. The establishment gradually developed into a hospital and became known as the St Nicholas and St Martins Hospital and Special School, with Rowley Bristow taking over its direction.

The hospital acquired its own operating theatre in 1928 and further enlargement took place in 1936. In 1937, a decision was made to admit adult patients and two wards were adapted for this purpose.

With the outbreak of war, the children were moved to other homes and the hospital further adapted to take war casualties. When the orthopaedic department of St Thomas' Hospital was destroyed in an air-raid, the whole department was moved to Pyrford.

Rowley Bristow died in 1946 and in memory of his services, the hospital was named after him.

In its functioning days, The Rowley Bristow had seven wards including babies and children. The consultant surgical staff were Mr F.A (Sam) Simmonds, A.G. Apley and R.J Furlong.

The hospital retained a liaison with St Thomas' from the days of Rowley Bristow and George Perkins and members of the Rowley Bristow staff would attend St Thomas' each week to assist with the outpatient clinic

The hospital continued to work with the National Health Service until 1962 when it was joined to the Woking and Chertsey Group. It later passed to the control of the North West Surrey Health Authority.

The Rowley Bristow Orthopaedic Hospital finally closed its doors on 21 December, 1990 and its services transferred to St Peter's hospital Chertsey. The area became derelict for some years and the grounds were used for paint-ball war games. Finally it was redeveloped into a residential estate named as the St Nicholas Crescent and St Martins Mews.

The Pyrford Course

Alan Apley was appointed to the staff of The Rowley Bristow Hospital in1947. He enjoyed teaching and organised a series of lectures on orthopaedics and fractures, which developed into a special course for the final Fellowship examination. The lecture material was very well organised and requests were made for printed notes.

When these were seen by Ian Aird, the Professor of Surgery at Hammersmith, he suggested to the author that they be published as a book. The first soft bound edition appeared in 1959 and additions and revisions followed. For the sixth and seventh editions, Apley enlisted the aid of Louis Solomon as a co-author in their production.

In the preface to his book, published in 1959, Apley says that many students were not lacking in factual knowledge so much as a methodical approach, and the form of his presentation was designed to overcome this handicap and to inculcate method.

This was to be done by describing physical signs in a constant sequence using a standard series of headings for both orthopaedic conditions and fractures. The headings he used throughout his lecture series were; Look, Feel, Move, X-ray.

The lecture room at Pyrford was set up with a stage and examination couch, above which was a large mirror so that the audience could see the patient, and the physical findings being demonstrated. A large number of patients were available for the display of pathological conditions and for candidates to examine. Also, there was a large display of X-ray films illustrating pathological conditions.

Nearly all the lectures were given by Apley himself, with some assistance from other members of the staff. He was most meticulous in the preparation of the contents and this would have been done in the same way as he believed papers should be produced – the drawer method. Material would be put aside to be reviewed later, revised and polished, probably many times. The result was that they were given with great clarity, an air of spontaneity and with the flair of a professional actor.

Memorable phrases and jokes were orchestrated into the substance of the lecture and held the attention of the audience. After delivery, a lecture would be reviewed, improved and rememorised for the next occasion.

At the end of each day, those who had booked on the 'full' course and had been allowed to examine patients were invited to discuss their cases, demonstrate their findings and be questioned. On the final day, a trick case was offered to the last candidate. This was a patient with Charcot's joints and while the findings were being presented, Apley would surreptitiously alter the physical signs a couple of times. Although this caused some confusion to the candidate and mirth to the audience, it was a good example of the mobility of the Charcot's joints.

With the closure of the hospital, the Pyrford course shifted to the orthopaedic unit at St Peter's, Chertsey. In a letter in 1992, Apley said that although he enjoyed being involved with the course there, it lacked the magic of Pyrford.

Alan Apley died in 1996 but he will always be remembered as one of the finest teachers of his subject of all time.

So what began as a service for the welfare of waifs and strays became a centre of excellence for the practice and teaching of orthopaedic surgery.

The Rowley Bristow Hospital has gone. All that remains as a reminder is a grey granite stone at the one-time entrance to the hospital grounds which has the inscription, "nearby once stood the world renowned Rowley Bristow Orthopaedic Hospital, which began as a Waifs & Strays Home 1907 – 1990".

The rest is memories.

COVERSTORY

College opens doors to crowds in Melbourne Open *House*

A chance to showcase the historic building in Melbourne

Left to right: Barry King and John Royle talk of the history of the building. Top to bottom: Crowds lined up in the driveway by mid-morning; Curator Geoff Downe guiding a tour, Fellow Cas McInnes in the Library. A long two days: Tour guides Cas McInnes, Geoff Downe, Barry King and John Royle.

On a cool weekend at the end of July, the College's historic Melbourne headquarters opened its doors to become part of the Melbourne Open House (MOH) program for the first time.

The program began in 2008 as an opportunity for the public to see some of the architectural and engineering masterpieces of the city that are not often showcased. Despite only opening eight buildings in its first year, the day was a huge success with more than 30,000 visitors. The program has grown to the all-weekend event that this year saw 75 buildings open across Melbourne, and over 106,000 visitors.

College Curator Geoff Down liaised with the MOH organisers and opened the College both days from 10am until 4pm with the help of MOH volunteers, some College staff, and Fellows Cas McInnes, Barry King and John Royle.

As members of the College's Heritage Committee, the Fellows have always found the building fascinating, though even they were surprised to see the queue of people that formed outside and snaked up the driveway over both days of the program.

MOH volunteers allowed around 20 people in for each tour led by Geoff Down or one of the Fellows. They were shown the original front façade, the Foyer and Gallery, the Library, the Courtyard with the remnants of the Old Model School, the Museum and also the Hailes Room and the Council Room.

Visitors were enthralled by the stories of surgical procedures of times past as well as some of the better known characters in the College's history. There was also considerable interest in the role the College plays in the education of surgeons today and the maintaining of surgical excellence.

Fellow Barry King asked some why they had come to see the College. Many replied that it was such an interesting building in such a prominent position, they had passed by and wondered what it was used for and what it was like on the inside.

Both days were a great success in showcasing the College, with about 750 people coming through. Queues became so long on the Sunday that the wait to get in was up to 90 minutes and unfortunately some had to be turned away. This despite the best efforts of the tour guides who worked past 5pm to let as many people as possible into the building.

All involved are to be thanked for their efforts. The weekend will be assessed to consider whether we participate in next year's program.

THE HERITAGE GROUP

Speaker: Mr Nick Doslov
of Renaissance Bookbinding
Friday 23 September 12pm
at The Royal Australasian College of Surgeons,
250-290 Spring Street,
East Melbourne Hughes Room

$30 inc. GST per person and lunch.
For further
information contact
geoff.down@surgeons.org
or phone: 9276 7447

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PAYMENT OPTIONS
1.Pls make all cheques/bank drafts payable to the Royal Australasian College of Surgeons (payable $AUD)
2. The following Credit Cards are acceptable

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Amount (inc. GST) $ .....

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Competent surgical candidates

How the Minimally Competent Candidate is identified at the Fellowship examination

Spencer Beasley
Chair, Court of Examiners

The Fellowship Examination is an assessment tool used by the specialty training boards as part of their Surgical Education and Training (SET) programs to assess whether candidates are ready to practice unsupervised in the community as safe and competent surgeons. In addition, the Fellowship Examination may be used to assess the comparability of International Medical Graduates (IMGs) who wish to practice in Australia or New Zealand.

There is vigorous debate as to what should be the attributes and competencies of a competent surgeon on the first day of his or her consultant practice.

The challenge for the specialty training boards, the Education Board of the College and the Court of Examiners is to define an agreed standard that the candidate must reach to pass the Fellowship Examination. The intention is to pass all candidates who are safe to work unsupervised in their vocational scope.

One issue is that the Fellowship Examination in its present form is not designed or able to test adequately all nine of the College's defined surgical competencies. In reality, it is only able to test in any detail medical expertise, clinical judgment and, to some extent, communication. It relies on the other surgical competencies to be assessed during SET training (or, in the case of IMGs, during a period of supervision).

The assessment tools used in the Fellowship Examination include written tests and oral vivas. The actual types of written and oral assessments vary between the surgical specialties in both form and content. Each specialty mini-court has seven separate segments, and in general two of these are written segments and five are vivas. Each is marked independently by two examiners. The examiners are deemed to be experts in their field and careful attention is given to their own attributes and expertise before they are appointed to the Court of Examiners, to ensure they are capable of conducting this high-stakes assessment process to the level required.

It is the responsibility of the examiners in each surgical specialty to determine the pass-mark, cut off or benchmark for each segment of the examination. These are clearly defined to reflect what would be expected of a "minimally competent candidate".

The minimally competent candidate is defined as one who "just passes" the examination and has "just" reached the standard of being able to practice as an unsupervised consultant surgeon on their first day of practice. Of necessity, the Court and specialty boards ensure that the standard is set at the appropriately high level for this, primarily for the protection of the community at large.

In the viva segments of the examination, the specialty mini-courts look at the pre-prepared questions and examination material to determine, based on a consensus of expert opinion, what constitutes a candidate's minimum level of competency. There may be several sections within that viva that relate to different competencies: each will be assessed and marked separately.

If the pre-determined level is achieved, a pass mark is awarded. If the candidate's answers fall just below the required standard a borderline fail mark is awarded. If the candidate's answers are well below standard or there are concerns about patient or safety, a definite fail mark will be given for that segment or section of the viva.

On the other hand, where a candidate's answer is exceptionally good or outstanding this too is recognised. The close marking system (akin to the modified Likert) scale of marks is awarded for each marking point. The four possible scores range, in 0.5 increments, from 8 (equals a definite fail) to 9.5 (equals outstanding). Descriptors are used for each marking point to facilitate the award of an appropriate mark.

For the written segments of the examination, the marking may be different or modified to suit the type of written questions given. Like the vivas, the essay type questions are marked using the close marking system.

For multi item assessments such as MCQ or multiple short answer questions, the College prefers the "Angoff" method. The Angoff method of standard setting is criterion referenced: this allows all competent candidates to pass the examination, unlike the absolute or norm-referenced methods where a proportion of the candidates will fail. The Angoff method estimates the probability that a minimally competent candidate (i.e. the just passing candidate) would (not "should") answer that question correctly.

The examiners review the questions and estimate the probability for each question. The probabilities are averaged over a number of examiners and a number of questions to give a cut-off score or pass mark for that segment. The more examiners that can estimate the probability and the larger the number of questions the more statistically accurate the cut-off score is. Once a cut-off score is determined by the standard setting process then a norm reference method is used to convert the candidate's score into bands to match the close marking system.

The Angoff method is dependent on: a vigorous discussion of the definition of a minimally competent cohort of candidates, the expertise of the examiners estimating the probabilities, the validity and reliability of the questions and the number of examiners and questions. It takes into account the difficulty of individual questions so that different examinations can be appropriately comparable.

Once the results of the examination are available, poor questions with a low discriminatory value can be identified and excluded and the cut-off score recalculated, thus improving the validity of the process.

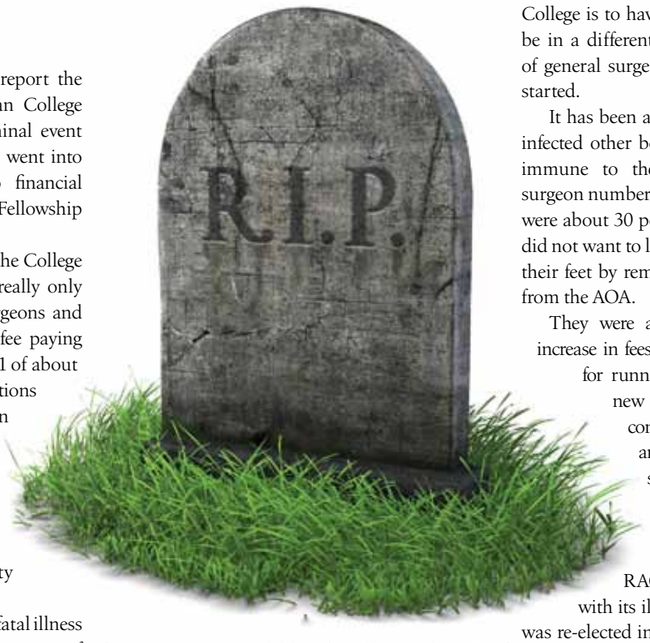
The Court of Examiners is very much aware that the ultimate aim of the Fellowship Examination is to ascertain whether a candidate who presents for assessment will be a safe and competent colleague.

With Mr Richard Lander, Deputy Chair (NZ) Court of Examiners

Death of a College

Glenn McCulloch is a former RACS Councillor and NSA President. The contents of these two articles are not necessarily the views of the RACS or NSA (or indeed possibly the author himself). They were written to stimulate thought and discussion.

Glenn McCulloch



It is with great sadness that I report the death of the Royal Australasian College of Surgeons (RACS). The terminal event occurred on 30 June, 2016, when it went into voluntary administration due to financial problems caused by a marked fall in Fellowship numbers.

Since the specialty societies left the College between 2012 and 2014, there has really only been support from the general surgeons and the vascular surgeons. The actual fee paying Fellows fell from the heydays of 2011 of about 5,500 to only 1,500. Their subscriptions did not maintain the organisation and many departments closed. The offices in the ACT, SA, NT, Tasmania and WA closed in 2014 as a part of the atrophic process. Oddly enough the NZ office has strengthened as the NZ specialty societies stayed with the College.

It is hard to see exactly when the fatal illness began. Nobody really saw the seriousness of the illness until it was too late. There were some symptoms in the orthopaedic department in about 2006. At first it was a niggling pain related to IMG assessment and trainee dismissals. In some views it started with a malaise in the SET Board of Training when reasonable changes to the SET Orthopaedic program were rejected by the Board of SET.

At about the same time this malaise spread to Neurosurgery. The exact aetiology of the illness is yet to be defined, but it does seem to be moderately infectious in the early stage and highly contagious in the later stage. In late 2012 it also infected Plastics and Urology and in 2013 ENT, Paediatric Surgery and Cardiothoracic.

It also proved to be a painful illness with great anguish in the Projects office as many good altruistic overseas aid projects had to be terminated early or not commenced due to lack of Fellows and staff. There were also staff redundancies and a lack of volunteers to do the many pro bono activities of the College. As well as the specific symptoms there were general symptoms of malaise and lack of interest in life. At first there was a vigorous immune response, but as the defence mechanisms of the body weakened, the reactions became sluggish.

As for the Finance section, there have been no persons doing a Great Depression style leap off the building, but some have been seen to stumble on their way down the front steps.

Final days

There was some hope of a financial saviour when IKEA put in a bid for the Spring Street building for its new central Melbourne showroom but they withdrew it when they found that Heritage Victoria would not allow the building of a 15 story car park on site. They were some unconfirmed rumours of a Funeral Director being interested.

The Administrator's doctors have given an infusion of a magic drug that might fix the problems. The prognosis is grave and if the College is to have a "Lazarus" moment it will be in a different body – probably as a body of general surgeons, which is how the RACS started.

It has been a strange disease as it has also infected other bodies that thought they were immune to the disease. The orthopaedic surgeon numbers in the AOA dropped as there were about 30 per cent of their members who did not want to leave the RACS and voted with their feet by remaining Fellows and resigning from the AOA.

They were also worried about the large increase in fees to the AOA that were needed for running the new body. Again this new variety of the disease seems contagious as Neurosurgery and Urology are seeing similar symptoms of dwindling numbers in the face of increased fees.

At the same time as the RACS corpus was struggling with its illness, the Gillard government was re-elected in June 2014 with an agenda of "fixing health". One of their first acts was to commit to building a $500 million Academy of Specialty Training in Canberra and employ a number of overseas academics to run the training programs in all surgical and medical specialties.

Many of these academics had been involved in the changes to medical careers in the UK (you remember that program that resulted in some of the finest UK graduates moving to Australia in the early 2000s). Last month the new Federal Minister of Health announced the hard-fought changes to tort reform would be reversed in the interests of "pluralistic equanimity". Already the Medical Indemnity organisations have announced rises of 400 per cent.

As for me, I am so gloomy about the future of surgery that I think I will stop my pro bono activities for the College and resign. I tried to do so on-line, but the website has closed. A resignation letter sent to Spring Street was returned "not known at this address". I am resigned to not being able to resign.

The *resurrection*

It is with great pleasure that I report that the resurrection of the Royal Australasian College of Surgeons (RACS) is nearly complete. The final triggering event occurred in late 2014 when all nine specialty societies agreed that starting in 2016 they would meet at the Annual Scientific Congress at least every second year.

The specialties that had been drifting away returned with vigour when they realised that surgeons of all flavours needed to stick together and that there were indeed matters of common interest to discuss.

The number of Fellows attending the last ASC in 2016 was the largest ever with more than 3,000 attending. One of the overseas guests commented that there was no equivalent meeting in the world as elsewhere the Surgical Colleges had splintered into smaller sub-groups.

It is hard to see exactly when the previously progressive illness started to improve. It may have been when far-sighted persons within the College realised that each of the SET Specialty Boards knew their own area well – orthopaedic surgeons were the best ones to run orthopaedic training, urologists knew about how to make urologists, and so on.

They did not need micro-management from the RACS in regard to how to select their trainees, how to assess their progress, develop the curriculum and similar educational matters. It was realised that each SET Board had to be self-reliant and run their programs in a fair and proper fashion using the Brennan principles (which have been mandated by the AMC); they were, after all, a group of professionals.

With this change came the need for fewer meetings and supervisory Boards. The Board of SET was disbanded as they had nothing to consider and the Education Board reduced in size.

In the view of some, the first treatment that began to reverse the debilitating illness was as early as 2011 when the composition of the IMG assessment panels was altered such that there were two specialty representatives on each panel.

This altered the dynamics such that the sole specialty representative was not a "voice in the wilderness" and the view of the specialty was noted and given greater weight. There were no longer the controversial decisions that had dogged this body in the past.

The Projects office was barely able to cope as there were a larger number of Fellows volunteering for the various projects. New good altruistic overseas aid projects were started and old ones expanded.

As for the Finance section, they were initially sceptical when the subscriptions were decreased, but as there were fewer meetings and committees and less travel costs the cost of running the College decreased. Maybe it was my imagination, but no longer did they stumble down the steps at the front but took them two at a time.

I have noticed a rather odd thing – the less involved that the College was in the Specialty Societies, the more involved the surgeons wanted to be in the College. Perhaps this was because the Fellows involved in Specialty Society and College matters felt that they were appreciated and their views taken notice of.

No longer were there meetings at which the Specialty Representatives felt that their presence was simply to say that there had been consultation when in reality no notice was taken of their views.

One can only speculate what effects the Federal election in June 2014 may have had; it was a close call. The Gillard government looked as if it may have be re-elected but two strong candidates who happened to be surgeons won their seats from the Independents with their clear and articulate policies on health.

As you would recall the Gillard government campaigned on a policy of "fixing health". However it was apparent that their commitment to building a $500 million Academy of Specialty Training in Canberra and the employment of a number of overseas academics to run the training programs in all surgical and medical specialties was "pie in the sky" ideology.

It was also apparent in the press material released by the College that the true cost of the proposal would have been a capital cost of $800 million and on-going running cost of in excess of $80 million per year for surgery alone.

After the election the new Federal Minister of Health announced there would be no change to the excellent Government medical indemnity support packages. She stated that she realised that without these measures the system of health provision in Australia would collapse.

As for me, when the illness was at its peak I was going to cease my pro bono activities for the College and retire from College affairs, but the College and the Specialty Societies seem to have a new vigour. As I mix with the younger surgeons and Fellows I feel a youthfulness that I have not felt for several years. I am sure that Dr Alzheimer will pass me by and that I can hand on my knowledge and experience to the next generation. The only problem is that there are so many persons interested and enthused that I may not be elected at the next election.

Fellowship Survey – Helping your College work for you

The results of last year's survey will help us with our strategic direction

Cathy Ferguson
Chair, Fellowship Services Committee

Fellows have provided valuable feedback on the services and activities offered by the College as part of the 2010 Fellowship Survey. The survey results identify areas for improvement, strengths and the path Fellows wish to take the College in the coming years. The survey and recommendations were considered at the June 2011 meeting of Council.

The Fellowship Survey was conducted between October 2010 and February 2011 with all active and retired Fellows encouraged to participate. A response rate of 45 per cent (n=2,929) was achieved. 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 the College will now reflect and build on the changes that have occurred during this time.

Importantly, Fellows who participated in the survey were a representative sample of the broader Fellowship in terms of specialty practiced, regions, age and gender. Active Fellows comprised 2,583 of the respondents, while 346 were retired.

Overall, Fellows are satisfied with the role of the College and the services provided with over two-thirds of active Fellows (68 per cent) and 84 per cent of retired Fellows reporting satisfaction. Seventy-six per cent of respondents consider the College to be of 'real benefit' as a Fellow. This meets a key performance indicator for the 2010-15 Strategic Plan.

More than 1,800 Fellows provided feedback on areas that the College could improve on, with key responses including the Surgical Education and Training Program, relationships with Specialty Societies and Associations, promoting collegiality and unity, lobbying and political negotiations with external groups and government, communication with Fellows, protecting the title 'surgeon' and promoting the value of 'FRACS'.

Fellows are satisfied with the range of communication and publications currently available. A high proportion of Fellows reported that they were satisfied with Surgical News (80 per cent). This was followed by the Australian and New Zealand Journal of Surgery (70 per cent), Council Highlights (65 per cent), Regional Newsletters (54 per cent) and Library Highlights (53 per cent). The College Pocket Diary received a mixed response with 50 per cent of Fellows indicating satisfaction.

Fellows are also satisfied with their recent contact with College staff with two-thirds of respondents reporting satisfaction. In addition, almost two-thirds of respondents indicated that they were able to make contact with the appropriate person to assist with their enquiries 'always' or 'very often'.

Of those active Fellows with a RACS CPD Program requirement, 72 per cent of respondents reported that they were satisfied with the College's efforts to assist Fellows to meet the requirements. In addition, 44 per cent (n=940) of Fellows indicated that they used CPD Online. This is a significant increase when compared to 2006, where only 20 per cent of Fellows reported that they had used CPD Online. Fellows provided a range of suggestions on how to continue to improve CPD Online.

Survey results show that Fellows continue to have an interest in a wide range of professional development activities. The strongest expression of interest (more than two-thirds) was for surgical teaching topics (e.g. assessment and feedback) and more than half of Fellows reported interest in managing adverse outcomes, leadership/managing people and business/practice management.

Workshops continue to be the most preferred delivery method, followed by presentations/lectures and online learning. Fellows wish to see professional development offered alongside scientific meetings, on weekends and as half day options. These results are reflective of the 2006 Fellowship Survey; however, in terms of topics, risk management and medico legal areas were the most popular in 2006.

Sixty per cent of Fellows (n=1716) reported that they contribute to the College in a pro bono role, an increase from 44 per cent in 2006. When asked about the type of pro bono roles undertaken, over two-thirds of respondents reported that they contributed to the College as a surgical supervisor and over half as an educational instructor/presenter. Other pro bono roles reported include examiner/interviewer, Council/board/committee member, international aid as well as a contributor to the ANZ Audit of Surgical Mortality and the ANZ Journal of Surgery.

Fellows are satisfied with the College library services and website. Active Fellows reported a higher use of the College library services (including journal article request service, literature searches, loans and the online library) than retired Fellows. This was particularly notable for the online library and contrasts with results from the 2006 Fellowship Survey. In terms of satisfaction, 60 per cent of active Fellows indicated that they were satisfied with the library services provided, compared with 44 per cent of retired Fellows.

Sixty-five per cent of Fellows (n=1,845) reported using the College website with strong levels of satisfaction being reported. A range of suggestions were made by Fellows on how to improve the website further, many of which are being addressed with the current website redevelopment and review.

Fellows consider the Annual Scientific Congress (ASC) to be equal to other scientific meetings in terms of relevance, registration and value, however a third of Fellows felt the ASC was below other meetings for relevance and value for money.

The survey results suggest there is limited use of the Member Benefits Program by Fellows, with 17 per cent of respondents reporting that they have accessed the program. The services Fellows would most like to see offered through the program are car hire, travel and corporate memberships. In addition to the options provided, other suggestions made by Fellows include New Zealand focused benefits (also the most frequent suggestion made in 2006), discount loan rates and credit card offers.

Fellows were asked to nominate one change they would like to see made by the College, with more than 1,200 Fellows providing feedback. The most frequent responses received were to reduce bureaucracy and ensure greater transparency, focus on strengthening relationships with specialities, encourage innovation and offer more interactive education, more direct support for surgeons and be more representative of all specialties and regions.

Further analysis on specialty and regional variations in the results will be featured in a future edition of Surgical News. A full report on the 2010 Fellowship Survey is available at www.surgeons.org.

The results from the Fellowship Survey are being reviewed by Councillors in key governance roles and College management, with a particular focus on improvements to the services and programs provided. Feedback will be instrumental in strategic planning for 2012 and beyond, to ensure that our services, communication and programs meet the needs and expectations of Fellows.

I would like to take this opportunity to thank the significant number of Fellows who took the time to participate in the survey. The survey has provided valuable feedback and gives Council confidence that decisions and plans for the future reflect the views of the majority of Fellows.

Elective or retirement?

Preparing for retirement can be daunting without the right knowledge

Fred Leditschke
Convenor

Retirement is an event we must all prepare for. It is far better to plan an elective retirement in five, 10 or 15 years than to ignore the inevitable and have to face the situation acutely.

A 'Building Towards Retirement' workshop is being held on Saturday, October 1, 2011, at the RACS Queensland Regional Office, 50 Water Street, Spring Hill. If you are considering retirement totally, partially or are merely in a contemplative mood, this all day gathering with presentations by your surgical colleagues John Quinn, Bill Coman, Errol Maguire, Ian Gough and Leigh Atkinson may appeal.

They have some understanding of winding down from surgical practice which can be of help to you and hopefully provide some assistance with your diagnostic dilemmas. Mary Cooney will focus on the partner's perspective of this potential radical change in life-style.

There will also be presentations by experts on the psychosocial implications; estate planning, wealth management and superannuation; medical indemnity and the legal obligations of closing down your practice. Dr Gino Pecoraro, the past president of the AMA, will expand on a topic with which he has been very involved – the implications of National Registration.

As medical professionals, we have been very involved in our varied leadership roles – as clinicians, administrators, teachers or examiners and assessors. The workshop will provide an opportunity to examine where these roles might take you in the future as you pare back surgical practice.

Come and join in the Q&A session with the speakers, sponsors and enjoy some social intercourse with your colleagues. Conveners Roger Wilson and Fred Leditschke look forward to welcoming you.

Tried and tested

A part-time position at the Royal Adelaide Hospital has proven its worth, and Susan Neuhaus would like to see more in the training landscape

The only 'stand-alone' part-time training position in general surgery currently available in Australia has now been shown to work successfully and similar models should be replicated across Australia, according to Associate Professor Susan Neuhaus.

Associate Professor Neuhaus, who works with the Breast Endocrine and Surgical Oncology (BESO) Unit at the Royal Adelaide Hospital (RAH), said the unit had provided the part-time training to three surgical trainees since 2007, all of whom have now passed their Fellowship exams and returned to full-time work.

She said the part-time training model not only worked to benefit the trainee, but also the unit with the position designed to cover peak activity days and with trainees able to cover for colleagues on leave.

She said the three-day per week stand-alone position was much easier to organise than job-share arrangements and more cost-effective for hospitals.

"There are currently two basic models of part-time training," Associate Professor Neuhaus said.

"There is the job share model based on a shared full time position, yet one of the key disadvantages of this model is the need to find an equivalent-level trainee wanting a part-time position in the same location at the same time and in the same sub-speciality.

"The employer also carries liability for two employees and contractual issues of overtime and superannuation.

"By contrast in 2006 we successfully lobbied the State Department of Health for funding to develop a 'stand-alone' position on the basis that our unit had sufficient excess capacity in teaching and training - not for a full-time resident, but sufficient for a half time position.

"The part-time trainee is employed alongside a full-time trainee and/or Fellow for 12 months in an accredited position, which gives them the equivalent of six months training while allowing for greater continuity and stability for both the resident and the unit."

Some successful part-timers: Eu Ling Neo and Bev Fosh with their families.

Associate Professor Neuhaus said the position offered in the BESO Unit had been designed to meet the needs of the unit and the trainee, and both RACS and hospital requirements. The trainee has two days off per week, but they have each achieved above 'pro-rata' exposure in terms of operative cases, outpatient exposure and after-hours on-call. There is also exposure to the private sector, which provides increased clinical exposure outside of the public hospital, mentoring opportunity and compensatory income.

She said that the role of the Board of Surgical Training was pivotal to selecting the most suitable candidates.

"This stand-alone position is of most benefit to more advanced trainees who are approaching their Fellowship because they have the increased clinical experience, patient experience, skills and maturity to be able to walk in and know where everything and everyone is up to," she said.

"At the same time, given that they are so close to completing their training, it is very important that they be given the opportunity to maintain their skill levels and not lose confidence by interrupting their training."

Since the stand-alone part-time position was first offered, the BESO unit has trained one trainee who returned after the birth of her second child, a trainee who needed time away from surgery to give evidence in a lengthy trial and another with a young family who had developed thyroid cancer during training.

Associate Professor Neuhaus said that now that all trainees had successfully passed their exams and returned to full-time work it was time for the Australasian surgical community to embrace similar models of flexible training.

"Other disciplines in medicine, such as obstetrics and physician training have embraced part-time training, but surgery has been more challenged in terms of implementation.

"While in the UK there is the aim of making up to 20 per cent of positions available on a part-time basis, in Australia there remain concerns about the adequacy of clinical exposure, the impact on patient outcomes and continuity of care issues.

"There are also mysteriously entrenched concepts that part-time training is only for women, or that it demonstrates a lack of commitment to surgical training.

"Yet we know now that far from demonstrating a lack of commitment, the ability to manage dual careers, the demands of training and family or other commitments requires a high level of motivation and organisational skill.

"In our current environment, we are all challenged to find creative ways to break the nexus between 'hours worked' and perceived competence, and this model achieves that.

"It is now clear that such stand-alone positions can benefit the unit, the trainee and the RACS by creating flexible training options to help overcome workforce shortages while increasing diversity with the surgical profession and helping retain our trainees. In addition it has effectively added a training position to the hospital.

"While not a panacea, this model has been proven to work, it meets all the regulatory requirements of the College and the hospital and we would strongly encourage more positions like this to be available across Australia and New Zealand."

With Karen Murphy

For the people

Barry Hicks has worked in Ethiopia on and off for more than 40 years and has seen the worst, but is drawn back to the people

Back home in Queensland after his latest stint working and teaching in Ethiopia, general and thoracic surgeon Barry Hicks speaks of his time there with an amused tone that mixes great affection with enormous frustration.

On the upside are the enthusiasm and learning capabilities of the medical students under his tutelage and mentorship at Jimma University, an institution educating 20,000 students based in the largest city in south western Ethiopia.

On the downside of the ledger he lists the uncovered sewerage pits that lie just outside the operating theatre, the lack of basic equipment and hygiene supplies and a cultural dynamic that encourages lateness.

Now with his latest teaching contract at Jimma University complete and a new one under negotiation, Mr Hicks has made it clear he will only return if basic standards are improved.

Mr Hicks, who was recently awarded the Member of the Order of Australia for his services to international humanitarian aid, now has to decide what to do in the future. At the moment, in his absence, there are only two surgeons teaching and training 270 medical students (increased this year from 150 per annum) and 17 post-graduate surgical trainees at the university hospital.

"My heart belongs in Ethiopia in a way, particularly with the poor people, but there are times when you have to ask if it is worth it to keep going when you keep facing problems every day that would be easily solved if there was the will to solve them," he said.

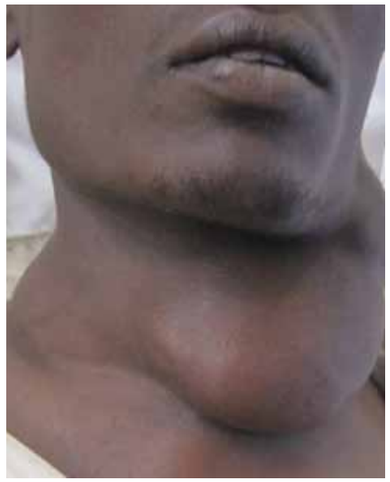
"The tertiary hospital I work and teach at in Jimma serves a population of 15 million people, but we are only doing about five elective cases per day because few people in Ethiopia turn up on time which means that we quite often have an 8am theatre list that cannot start until 10am when all the theatre staff are ready.

"That is a tremendous waste of time and extremely frustrating and when you add to that the lack of fly screens in the theatre and the sewerage pits outside – and the inability to scrub between every procedure because of a lack of water – it can become an extremely draining experience.

"There is so much exciting pathology to be seen in Ethiopia, so much to learn in terms of disease progression, yet there is no research conducted, a very limited range of laboratory tests in the hospital and some tests undertaken can take a month or more to finalise such as histopathology and they are still by no means always accurate.

"But at the same time, the students are very bright young people, usually keen to learn which makes it difficult to walk away, so this year I've stipulated certain changes I wish to see, in the hope of pushing change."

Mr Hicks has worked in Ethiopia periodically for over 43 years, arriving in Africa shortly after receiving his Fellowship in 1967. He began his life as a general surgeon in Shashemane working with Christian Mission groups in impoverished hospital theatres with his surgical text books opened on a violin stand beside him when dealing with situations he had not previously met.



Left: Barry with new graduates from the University in Jimma; with a baby rescued after the death of her mother. Above: A typical case.

> *"We treat an enormous number of patients … and it was a pleasure to share these cases with my colleagues at the meeting"*

Difficult times abroad

Forced to leave at various times through personal illness, political revolution and government decisions, Mr Hicks held a number of posts back home in Australia including as Director of Surgery at Townsville Hospital.

His autobiography published in 2009 and titled *Have Scalpel Will Travel*, describes his experiences treating everything and everyone from sick children to women in obstructed labour to men with gun-shot and spear wounds, sometimes working only by the light of candles.

He has known colleagues murdered, seen scores of the brightest young doctors leave the country for better pay and conditions elsewhere and also many sick people turned away from receiving medical care for lack of resources, yet still he keeps returning.

In July this year, he gave a presentation at the Queensland RACS' Annual Scientific Meeting focussing on the advanced pathology commonly seen in Ethiopia, but rarely found in Australia.

"People in Ethiopia tend to present very, very late which means we see some fascinating pathology," he said.

"We treat an enormous number of burns patients partly because of untreated epilepsy; we see an enormous number of intestinal obstructions and very advanced thyroid disease and it was a pleasure to share these cases with my colleagues at the meeting.

"Many people in the audience later said they found the combination of the conditions we treat and the conditions we treat them in totally unimaginable and I suppose it is from an Australian perspective."

Having suffered prostatic cancer some years ago, Mr Hicks said his PSA count was again on the rise and that depending on his health he would return in November to determine if the improvements he had insisted on had begun to be met.

"I felt that the only way to force change was to refuse to sign up to a new contract until I saw a desire to change," he said.

"All surgery was cancelled recently at one stage because there was no gauze in the country and when things like that happen it is easy to lose heart.

"I'm very grateful to my wife Robin who has stood by me in this work all these years and listened to my woes and when I received the AM recently I knew that 50 per cent of it belonged to her."

Mr Hicks said that while many Australian surgeons may wish to offer their services to improve the surgical services offered in Ethiopia, bureaucratic and complex administrative requirements made that difficult.

With Karen Murphy

New resources for the Online Library

The Library is continually growing and improving, but can always use your help

Cathy Ferguson
Chair Fellowship Services

Fellows and trainees frequently tell us how much they value the College online Library. However, there is always room for improvement and in last month's Surgical News I flagged that the resources would be expanded for all surgical specialties over the coming months. New journal titles recently added include Surgery, Injury, European Journal of Surgical Oncology and Seminars in Paediatric Surgery.

Other new resources include Access Surgery, an added-value multimedia product that supports lifelong learning and will assist trainees in their preparation for examinations by providing more than 1,400 questions and answers across the broad range of curriculum along with the ability to track and report scores.

Acland's Anatomy is a web streamed video atlas presents expertly dissected human specimens as three-dimensional objects, with intelligent search and navigation tools so you can easily find the content you need to teach, learn, or review.

A new initiative for the Library is a 12-month trial of Orthopaedic Knowledge Online, a substantial product from the American Academy of Orthopaedic Surgeons (AAOS). Orthopaedic Knowledge Online includes full text access to instructional course lectures, clinical topics, lectures, presentations, self-study quizzes and multimedia. Clinical topics are organised and searchable by all Orthopaedic sub-specialties.

Orthopaedic Knowledge Online is complemented by a new range of AAOS e-books available to the College for the first time. These include:

- AAOS Comprehensive Orthopaedic Review, 2 Volumes – 2009
- Essentials of Musculoskeletal Care – 4th Edition, 2010
- Essentials of Musculoskeletal Imaging – 2004
- Orthopaedic Basic Science: Foundations of Clinical Practice – 3rd Edition, 2007
- Orthopaedic Knowledge Update – 10th Ed., 2011
- Pathophysiology of Orthopaedic Diseases, 2 Volumes – 2006, 2009

We are trialling Orthopaedic Knowledge Online for 12 months and based on your feedback we will make a decision regarding the permanent availability of that resource. We very much appreciate your advice regarding the new resources.

The College has written to each of the nine specialty elected Councillors seeking ideas for how to further improve the online library. Their recommendations, together with feedback from other library users, will inform the development of the 2012 Library budget.

If you have suggestions for how we can make an already great library service even better, then send these to college.library@surgeons.org or log in to the College web site to complete the online feedback form within the online library section of the College web site.

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Seeing the value in research

Dr Henry To is grateful for the support of the College in valuable research

The current recipient of the College's Foundation for Surgery Research Fellowship, Dr Henry To, is using the attached funding to investigate the genetics of Barrett's Oesophagus (BO) and Oesophageal Adenocarcinoma (OAC) to give surgeons and clinicians the knowledge to allow for early detection and improved treatment.

Barrett's Oesophagus is a squamous metaplasia of the oesophagus and is the risk factor with the highest known association for Oesophageal Adenocarcinoma.

Working out of the Peter MacCallum Cancer Centre in Melbourne, Dr To is using Next Generation Sequencing (NGS) technology to identify the genetic mutations that cause both Barrett's Oesophagus and Oesophageal Adenocarcinoma.

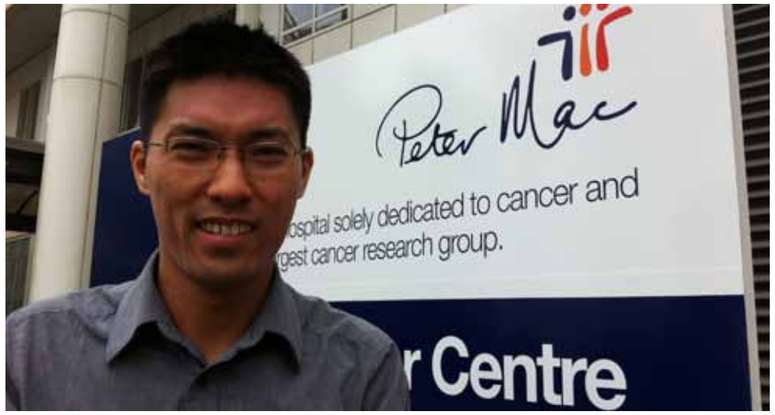
Dr To's investigation combines two research aims; using NGS to discover causative genes in Barrett's Oesophagus in familial settings to identify key protein changing (non-synonomous) genetic mutations, and using NGS to discover causative genes in a sporadic matched normal/tumour cohort.

"Oesophageal Adenocarcinoma is a cancer with very poor prognosis and limited treatment options and its incidence has been rapidly rising in the past two decades, with the percentage rise far greater than that of breast, melanoma and colorectal cancers," Dr To said.

"Yet while we know that Barrett's Oesophagus is a precursor to the development of adenocarcinoma it is difficult to identify which patients will progress to cancer so to help stem this rise we need to know more about the genetics of the disease.

"There are currently no treatments that completely reverse BO or reduce its predisposition to develop OAC, which means that understanding the cellular and genetic mechanisms of this disease will aid better risk stratification for screening and prevention and may even develop treatment options."

Working through the Familial Cancer Service at the Peter MacCallum Cancer Centre, Dr To has prospectively identified a number of Australian families with multiple first-degree relatives with



BO and/or OAC. He said sequencing had now been done on the affected individuals to perform genome-wide screening for inherited genes in the protein changing variations.

"It is exciting that we are finding genetic variations that may cause OAC in areas of the genome that we have not thought of before," he said.

"We remain hopeful of finding this key genetic driver for this disease which may have relevance for genetic screening and risk profiling while changing clinical practice."

Dr To, a general surgery trainee, is undertaking his research as part of his PhD and is working under the supervision of Associate Professor Wayne Phillips, Scientist and Head of Laboratory at the Peter MacCallum Cancer Centre and Surgeon Mr Cuong Duong.

He received the Foundation for Surgery Research Fellowships, which carry a stipend of $55,000 per annum, for both 2010 and 2011.

Already he has presented his findings at national conferences including the RACS Annual Scientific Meeting and the Australian Health and Research Medical Congress with publications in process in the Journal of Clinical Gastroenterology and the ANZ Journal of Surgery.

Dr To said he was honoured to have received such strong support from the College to concentrate on pure science.

"I feel that in today's era, the public demands surgeons and doctors that are at the forefront of scientific understanding, surgical practice and innovation," he said.

"Being involved in research gives me the foundation to continue my interest in scientific study and also gives me exposure to areas of treatment and technology that I would not have in the regular hospital setting.

"I am able to meet and collaborate with scientists, medical and radiation oncologists which are essential skills, particularly in today's era of multi-disciplinary care.

"Without the support of such fellowships, doing medical research is extremely difficult.

"You need the support of others to step outside the comfort zone of regular hospital work and to receive a Fellowship does not simply represent financial support, but also the moral support from the College that your research has real potential. I look forward to working closely with the College to complete this research and to being involved more in the future.

"Going through the rigorous application process and being accepted to receive this prestigious Fellowship shows that the College has interests that are aligned with my own – that is, investing both our time and money to support innovation to benefit patients in the future."

With Karen Murphy

President Ian Civil with the Gannon family at the 2011 Adelaide ASC.

Great *achievements*

Associate Professor Brendon Gannon PHD;
Award of the Heslop Medal

Citation kindly provided by Mark Stringer FRCS FRCSEd and Fiona Stewart MBBS BSc, RACS RACS Anatomy Discipline Committee

The posthumous award of the Heslop Medal to Associate Professor Brendan Gannon recognises his outstanding service to the Anatomy Committee at the Royal Australasian College of Surgeons over many years.

As an undergraduate at the University of Melbourne, Bren was an outstanding student and after completing his primary degree in Zoology, he went on to complete a PhD entitled "Comparative and biomedical studies of the autonomic nervous system (1972)". Bren then undertook a two-year post-doctoral fellowship at the University of British Columbia in Vancouver before moving back to Australia where, in 1974, he was appointed first to Lecturer and later to Senior Lecturer in the Human Morphology Unit at Flinders University.

In 1985, he was promoted to Associate Professor in the department that is now entitled 'Anatomy and Histology'. Except for temporary appointments as Visiting Professor in Physiology to several US universities (Arizona, Kentucky, and Louisiana), Bren remained at Flinders, becoming Assistant Dean in the School of Medicine in 2007.

Bren's main research interest was in the microcirculation and lymphatics. He published numerous scientific papers on these topics in leading scientific journals, achieving international recognition in the field. As a testament to his academic ability, Bren was a valued member of numerous national grant bodies including the Australian Research Council, the National Health & Medical Research Council, the National Heart Foundation of Australia and the Anti-Cancer Councils; most of these appointments spanned two decades or more. He was also a founder member of the Australian & New Zealand Microcirculatory Society and his contribution to microscopy was widely recognised, both at Flinders and beyond.

Bren joined the Anatomy Committee at the Royal Australasian College of Surgeons in 1997 and for six of the subsequent 12 years he was the Deputy Chair. He witnessed many major changes in the College examinations and proved to be a steadfast member of the group, developing many high quality questions for the multiple choice question bank.

Despite his ill health, he continued his commitment and service to the Anatomy Committee, attending meetings and giving fully until his untimely death in 2009.

The award was accepted by Professor Gannon's son on behalf of the Gannon family.

In Memoriam

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

>Ross Bohm, NZ Orthopaedic surgeon

>Ronald Eisner, VIC General surgeon

>Raymond Windsor, NZ Cardiothoracic surgeon

>Donald Urquhart-Hay, NZ Urologist

>Murray Ashbridge, NZ Ophthalmologist

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

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
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Surgical Plagiarism Part 1 –
Recollections and fragments from my own surgical experience

As Sophocles, the playwright in the 5th century BC, once said (and yes he was a friend of Aristotle): "I would prefer to fail even with honour then win by cheating"

Felix Behan,
Victorian Fellow

I was enjoying Tchaikovsky's Piano Concerto No. 1 (a favourite of mine) on the Queen's Birthday weekend when the ABC announcer Marian Arnold mentioned Rubinstein's critique of the first performance of this 1890's work. This director of the Russian Conservatoire said it was "tawdry, plagiaristic and non pianistic". Tchaikovsky was deeply offended, but stated "I will change nothing".

The word "plagiarism" stuck in my mind because it gave me some insight into the personalities, talents and criticisms of these times. Plagiarism is accepted in music and the arts and copying is almost routine (as we see at the Louvre). However, literary plagiarism, particularly since the time of Samuel Johnson, is frowned upon. Scientifically it is unacceptable. The term "plagiarism" originates from the Roman poet Martial and the Latin word plagiarus literally means a "kidnapper". Ben Johnson described plagiarism as "literary theft" and the Oxford English Dictionary (3rd ed) defines it as "taking someone else's work or idea and passing it off as one's own".

Navigating consciously through the realms of Freud (whose grandson, an eccentric multi-millionaire post-expressionist painter, died only recently), Jung and the alter ego, certain elements emerge about our own individual personalities based on our experiences. Some ideas subconsciously originate from an unknown source before their external manifestation. Could these experiences be the genesis of innocent or subconscious plagiarism or just co-discoveries? From the ideas of Jung (on this, the 50th anniversary of his death), the alter ego and the dawn of psycho-analysis in the early 20th century, we continue to explore such links to help explain innocent plagiarism or just blatant orchestrated deceit. Never forget the media is very quick to report such episodes.

I recall an ABC radio presenter, Dr Earle Hackett, from 1975 with a great example. He recounted then on his Thursday afternoon medical program an episode involving an Indian researcher, an American publication and possibly misplaced authenticity. In spite of arduous attempts to establish the specific accurate details of this story, I have been singularly unsuccessful (even with a Sherlock Holmes cape and magnifying glass – the image of a frustrated sleuth). My search has now come to an dead end, as the Hackett obituary appeared in the *Age* in April, 2010, when I first began to reflect on this issue.

Hackett was an interesting ABC personality and presenter – a man of the arts and a pathologist who helped establish the Blood Bank in South Australia. He was eventually Chairman of the ABC in November, 1975.

Quoting Hackett, the story concerned a young female medical researcher from India who submitted a paper to a prestigious American medical journal. It described for the first time the simple electrophoretic analysis of a blood sample on paper from a finger prick test to gauge a blood sugar level on a colour scale. Its clinical importance today is still resounding, yet her paper was rejected.

Some years later something extraordinarily similar appeared in a major medical publication in the United States with no acknowledgement. One of the listed co-authors was a senior consultant with editorial links to the very journal that had rejected it.

In riposte the Indian researcher cleverly forwarded her rejection letter to a major American newspaper. Not surprisingly, a legion of resignations followed.

On the local scene in 1984 I presented at the RACS scientific meeting the principle of the "Fenestrated Full Thickness Graft" – an alternative to the tie-over technique for Wolfe grafts for facial mitotic lesions. This idea came to me in the late 1970s when one of my patients dislodged the tie-over dressing on day 2 and the graft was fully viable beneath. I subsequently added drain-holes, creating what I thought of as a "holey" graft.

My RACS presentation needed a more formal title (without any religious ring) and I asked the late John Hueston (a wealth of information on international publication), for suggestions. Standing outside his rooms at the rear of 89 Royal Parade (now called Jageurs Lane) and resting against his Citroen DS23 (he was a Francophile) he looked at the trestle window of his Victorian terrace and suggested I use the French word for a window (la fenêtre) and title my talk the "Fenestrated Full Thickness Graft" – my idea, but John's eponym.

After this Melbourne RACS meeting, where international surgical figures were in attendance, a similar idea appeared two years later as an original paper on the European scene. How do I know this? John Newton (from Newcastle), just happened to be present on both occasions. Perhaps one could seek the specific details from his experience and recollections.

Now the stories get better. Tom Robbins (an international figure in breast reconstructive surgery), was initially reluctant to have his experience revealed, but was convinced when I told him that it is part of medical history and therefore should be in the public domain.

From the 1970s, Tom worked in partnership with John Hueston (who incidentally in those days would have had one of the largest aesthetic practices in Australia, thanks to the John Gorton $5 scheme). John always encouraged the publication of new ideas and Tom submitted his breast reduction paper to an American journal. It was rejected, I am sure with the usual tirade (or triad) of criticism of technicalities, statistics and demographics.

But truth will out – in the late 1970s, Tom just happened to be at a conference in North America when his very idea was publicly presented. I would have loved to have heard Tom, with his Scottish brogue, walking down the aisle, in stentorian style, then audience up to the dais, microphone in hand, letting all and sundry know what he thought about their presentation of "his very idea". Details could be obtained from Tom himself. Incidentally, he told me he had no problems subsequently with any publications.

The Scottish background

Tom and I did our Fellowships together and he told me that on emigrating from Glasgow to Australia, he initially worked as a builders' labourer. To go from this to an international surgical figure is no mean achievement. It reflects quality, like his surgical style, and that underlying Scottish surgical gene. Since the 19th century, Scotland has been the source of outstanding surgeons – my mentor in England, Ian Wilson, worked for five surgical knights from Edinburgh University. In Australia, Gordon Clunie and John Masterton carry on this surgical tradition of excellence. Tom – a Glaswegian with the usual inter-city rivalry – facetiously quotes, however, that "the best thing that comes out of Edinburgh is the train to Glasgow".

Let's revert back to these "plagiarists" and give them the benefit of the doubt. Was it merely a subconscious process? Did they review an article and then forget it – a case of facilitated amnesia? Was it a simple independent co-discovery, as Bob Goldwin said of my Bezier island flap submission to the PRS years ago? We may never know.

We should remember in all publications the notion is more important than the name, to quote John Hueston yet again. Gordon Clunie also taught during his academic years that if you have a new idea, launch it locally and then go international, as I did with the Keystone flap.

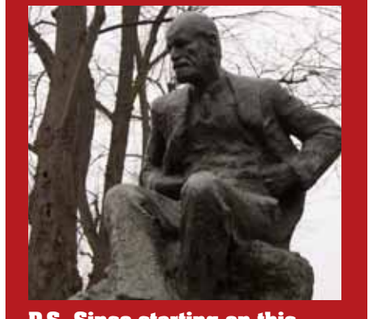
I originally called it an "arc" flap; Alan Breidahl called it a "keystone" when he saw it, incorporating architectural and philosophical precepts in this surgical variation. Alan, it is a "win-word" – merci.

In conclusion I hark back to the musical scene – a source of refuge in the wee hours of the morning. I recall once hearing one of Poulenc's pastorales plagiarised in an early Stravinsky sonata – before he entered his dissonance phase. Even Mozart at 14 is said to have transcribed the Allegri Miserere of 1620 after the second hearing encouraged by his father. Thankfully we can still hear it today, as few of us are ever likely to be invited to a pontifical mass in the Sistine Chapel; formerly the sole venue for its papal performances.

Surgically speaking we all encourage the apprenticeship model of surgical training. We are deeply indebted to our surgical mentors and all who have gone before; quoting Sir Isaac Newton "we stand on the shoulders of giants". We must acknowledge this debt, as I do to many, since my V.P.S.U. days, especially Benny Rank for establishment, and Don Marshall for refinement.

Don Marshall once mused that a person with ingrained talent, spontaneous artistic manifestations far exceed acquired skills, even when honed by repetition. Someone also said (was it Voltaire?): "Those with talent survive, and those without strive".

I will have more to say about this topic (the editorial red pen is approaching) concerning a late 19th century textbook on flaps including cross-leg flaps by the French surgeon Ombredame I recently found on the Left Bank in Paris. It was published years before the idea drifted across the Channel under the Gillies umbrella.



P.S. Since starting on this venture, more examples have come to light. I would encourage these "victims" to relate their experience in separate submissions (Letters to the Editor) and also allowing me to conclude with Freud, who said: "Flowers are restful to look at; they have neither emotions nor conflicts."

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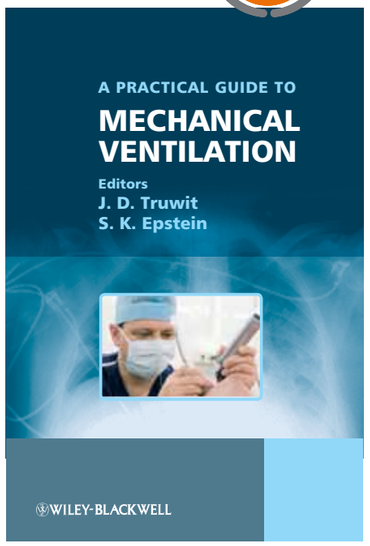

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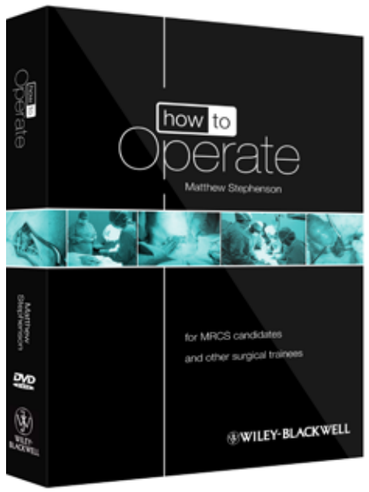

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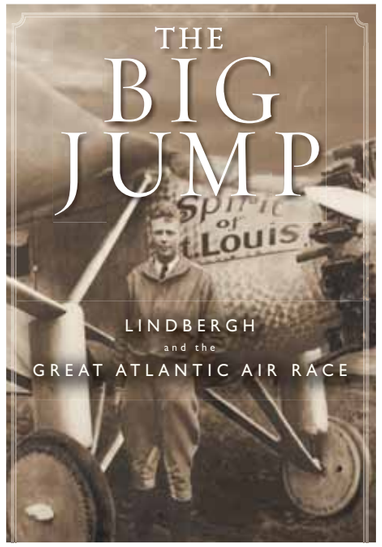

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Practical Guide to Mechanical Ventilation

J. D. Truwit and S. K. Epstein (Editors)
9780470058077 | Pbk | 366 pages | February 2011
~~AU$120.00~~ **/ AU$90.00**

Here is a practical introduction to the equipment, techniques, and protocols of mechanical ventilation. It is a comprehensive reference guide to both invasive and non-invasive procedures, together with detailed guidance on weaning from mechanical ventilation. Each section is accessible and clinically relevant, and each topic is illustrated by clinical cases and decision-making algorithms. The book is intended for medical postgraduates and professionals, as well as for trainees in respiratory medicine, critical or intensive care, and anesthesia in hospitals and medical centers.

- Concise, practical reference designed for use in the critical care setting
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- Flow charts and algorithms delineate appropriate treatment protocols

How to Operate: for MRCS candidates and other surgical trainees, includes 3 DVDs

Matthew Stephenson
9780470657447 | Pbk | 288 pages | September 2011
~~AU$150.00~~ **/ AU$112.50**

A unique blend of integrated video and book content, How to Operate provides a comprehensive, multimedia training resource for medical students, junior doctors, MRCS candidates and surgeons in training.

The three DVDs present over 40 of the most common general, urological, ENT and orthopaedic surgical procedures, complete with step-by-step commentary from experienced surgical consultants. At key points during each procedure, the frame freezes so that anatomical structures and pathology are 'drawn' onto the frame for clarity and to reinforce learning.

The 10 hours of video is supported by an accompanying book containing an introduction to each procedure, a thorough explanation of the operation mirroring the video with relevant video stills, and bullet point summaries which can be used as OSCE-style checklists.

Credibility: How Leaders Gain and Lose It, Why People Demand It, 2nd Edition

James M. Kouzes and Barry Z. Posner
9780470651711 | Hbk | 272 pages | July 2011
~~AU$34.95~~ **/ AU$26.22**

As the world falls deeper into economic downturns and warfare, the question of credibility (how leaders gain and lose it) is more important than ever. Building on their research from The Leadership Challenge, James Kouzes and Barry Posner explore in Credibility why leadership is above all a relationship, with credibility as the cornerstone, and why leaders must "Say what you mean and mean what you say." This first full revision of the book since its initial publication in 1993 features new case studies from around the world, fully updated data and research, and a streamlined format. Written by the premier leadership experts working today, Credibility:

- Reveals the six key disciplines that strengthen a leader's capacity for developing and sustaining credibility.
- Provides rich examples of real managers in action
- Includes updates to the applications and research

iPhone 4 Portable Genius, 2nd Edition

Paul McFedries
9781118093849 | Pbk | 352 pages | October 2011
~~AU$32.95~~ **/ AU$24.71**

A no-nonsense guide to getting everything your iPhone 4 has to offer

Designed for devotees of the Apple digital lifestyle, this guide presents key information for iPhone users in a hip, straightforward way. Packed with tips, tricks, and techniques to help you uncover and take advantage of every feature of the iPhone 4, this edition covers the newest features, including FaceTime video calling, HD video recording, the multitasking feature that lets you run multiple apps simultaneously, and much more.

- Portable Genius books cover key features of technology designed to support the digital lifestyle
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- Offers tips and tricks for working with the newest features, including FaceTime, HD video recording and editing, multitasking, and more

The Big Jump: Lindbergh and the Great Atlantic Air Race

Richard Bak
9780471477525 | Hbk | 336 pages | July 2011
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Treating practitioner reports

Orthopaedic surgeon Dr Gary Speck explores the art of negotiating the provision of treating practitioner reports. This article originally appeared in the August 2011 issue of the Australian Medical Association's magazine *vicdoc*

Gary Speck,
Victorian Fellow

We all receive requests from insurers and solicitors to provide reports on our patients. For many of us these requests are seen as a necessary distraction from healing the sick and injured, in the red tape war that schemes such as WorkSafe engage in.

However, in mulling over this article, I wanted to ensure I captured my passion for getting patients back to health, yet also my equal frustration that WorkSafe is perceived as mistrusting doctors and is cost-cutting.

So what options do I have? Should I:

- capitulate to the demands of a growing bureaucracy[1] and dominant purchaser and accept whatever price they determine reasonable for my work?
- skill my practice manager in the art of "shedding" WorkSafe claimants?
- suggest options to my colleagues to manage WorkSafe requests so that we can all continue to treat people who are badly in need of our help?

The last is the basis for this article.

As a reasonably busy practitioner, I receive requests for "treating doctor reports" too. These are not medicolegal reports, but reports regarding the treatment provided to my patients. Most requests come from those who are subject to a workers compensation claim.

Requests for treating doctor reports

When I receive such requests I always ensure that the patient has authorised provision of the information and report. I write to the insurer or solicitor and provide a quote based on the time it will take to complete, the complexity of the question, and an estimate of costs. I ask them to acknowledge acceptance of the quote or they may contact me if they have any concerns. I will always consider a request for review of the quote if either an insurer or law firm is experiencing "hard times".

At the same time I prepare a report. Otherwise my pile of requests backs up. I keep this report until the requestor pays the fee, if requested, accepts the quote or we agree on a price.

The timely preparation of the report is an important step as it is in my interest and the interests of my patient to ensure a report is prepared and available. The only issue that should be subject to debate is whether the insurance company will pay my fee, not my tardiness or refusal to write a report. Ensuring reports are prepared in a timely fashion is considered good practice by the Medical Board of Australia.[2]

Of course insurers being insurers and WorkSafe being WorkSafe will say that I am "charging more than the scheduled fee". Frankly, what position are they in to determine what my fees will be? A WorkSafe policy on fees is just that – a policy. Our patients have rights under legislation. WorkSafe is required to reimburse claimants the costs of reasonable medical and like expenses.[3] If the price in the WorkSafe policy is OK some of the time, then that is all well and good. However, policies provide an indication of how WorkSafe will react. Thankfully WorkSafe is unable to make laws. The Victorian Administrative Appeals Tribunal has stated clearly that just because the fees charged do not meet the schedule it does not mean that they are unreasonable.[4]

Requests for a patient's medical records from a lawyer or insurer

Should an insurer want a copy of my patient's history, I send a quote back based on the cost of reviewing the record, organising a package of information and forwarding the package in secure post quickly.

I make sure that I have contemporary consent from the patient. If not I will write to my patient asking if they consent to the release. The quote will include the labour and out-of-pocket expenses required to fulfil their request and the time to deliver. A quote is provided as the fee is greater than the statutory charge under the Health Records Regulations, but the service offered is greater than simply "allowing access" or "providing a copy" to a patient who attends my clinic.

However, if this quotation is not agreeable then I advise that the patient can come to my practice at an agreed time and read or make a copy of their record. In this instance I will charge only the statutory fee.

This practice means that I can continue to treat my patients in the way I think they should be treated. I also manage all the other "stakeholders" in the process without having to subsidise their insatiable desire for more information.

I hope that my practice helps your practice.

References

1. WorkSafe staffing increased by 20% in five years from 919 FTE in 2005 to 1105 FTE in 2010. See *VWA Annual Report 2005, 82; WorkSafe Annual Report 2010, 87.*
2. See Chapter 8, *Good Medical Practice: a Code of Conduct for Doctors in Australia*, Medical Board of Australia 2010
3. Section 99 *Accident Compensation Act* 1985 (Vic).
4. *Moore v TAC* (2002) VCAT 737 Aug 2002; *TAC v Moore* (2004) Supreme Court of Victoria April [2004] VSCA 60.

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