SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
VOL 15 NO 8 / SEPTEMBER 2014

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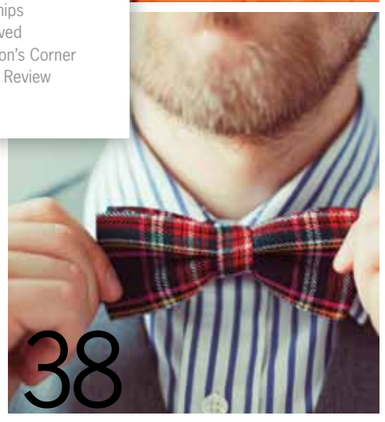

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REGULAR PAGES

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T: +61 3 9249 1200 **F:** +61 9249 1219
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ON THE COVER: Dr Wisam Ihsheish's humanitarian aid work

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2014

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

Safer Australian Surgical Teamwork

2 October - Bega, NSW

The Royal Australasian College of Surgeons (RACS) with the Australasian College of Anaethetists (ANZCA), the Australian College of Nursing (ACN) and Australian College of Operating Room Nurses (ACORN), is offering a combined workshop for surgeons, anaesthetists and scrub practitioners working in rural and regional Australia. The workshop focuses on non-technical skills which can enhance performance and teamwork in the operating theatre thus improving patient safety.

Keeping Trainees on Track (KTOT)

18 October, Newcastle; 22 October, Wellington

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.

Supervisors and Trainers for SET

18 October, Newcastle; 21 October, Wellington; 20 November, Melbourne.

The Supervisors and Trainers for Surgical Education and Training (SAT SET) course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues.
This workshop is also available as an eLearning activity by logging into the RACS website.

Training Standards: Interpretation and Application (TSIA)

24 October, Melbourne; 29 October, Brisbane

Training Standards: Interpretation and Application (TSIA) is a new course offering. This three-hour workshop expands on the concepts outlined in the Becoming a competent and proficient surgeon booklet developed by the College in 2012. The course aims to provide a baseline standard for College educators in Competency Based Education, ensure that College educators know the required standards for Competent and Proficient performance across the nine RACS competencies and increase awareness of Training Standards in the workplace, including the ability to interpret standards and use them to assess own and other's performance.

Clinical Decision Making (CDM)

24 October, Melbourne; 29 October, Brisbane

Clinical Decision Making (CDM) is a three hour workshop designed to enhance a participant's understanding of their decision making process and that of their Trainees and colleagues. The workshop provides a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling Trainee or as a self-improvement exercise.

Preparation for Practice

25 to 26 October, Brisbane

This two day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice. This activity is proudly supported by proudly supported by the Bongiorno National Network, mlcoa, Rooms With Style and MDA National.

Building Towards Retirement

15 November, Sydney

Work is an important part of life so when you stop full time surgery or are approaching retirement, you need to take time to plan for the next stage. It's crucial that as much thinking and planning are undertaken for life after surgery as was given to building your career in the first place. Surgeons who attend can expect to receive information about retirement and motivation to plan for retirement, share the experience of retired Fellows to stimulate interest in alternative careers and lifestyles and gain financial and legal management information and resources. This activity is proudly supported by proudly supported by the Bongiorno National Network and mlcoa.

Non-Technical Skills for Surgeons (NOTSS)

24 October - Launceston, TAS

The NOTSS workshop focuses on the non- technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you develop the knowledge and skills to improve your performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into elements or behavioural markers that indicate can be used to assess your own colleagues. This activity is proudly supported by AVANT.

Academy of Surgical Educators Forum

13 November - Adelaide, SA

The evening will be convened by Associate Professor Stephen Tobin, Dean of Education and Professor Julian Smith, Chair, Academy of Surgical Educators and will feature preeminent thought leaders discussing progressive topics in medical education. Attendees will enjoy a three course meal and drinks whilst workshopping questions at their tables and engaging in a Q and A session with the panel of experts.

workshop

September-November

ACT

10 October, Canberra
Keeping Trainees on Track (KTOT)

NSW

2 October, Bega
Safer Australian Surgical Teamwork
18 October, Newcastle
Keeping Trainees on Track (KTOT)
18 October, Newcastle
Supervisors and Trainers for SET (SAT SET)
23-25 October, Sydney
Surgical Teachers Course
15 November, Sydney
Building Towards Retirement

NZ

23 September, Auckland
Non-Technical Skills for Surgeons (NOTSS)
21 October, Wellington
Supervisors and Trainers for SET (SAT SET)
22 October, Wellington
Keeping Trainees on Track (KTOT)

QLD

25 to 26 October, Brisbane
Preparation for Practice
28 October, Gold Coast
Non-Technical Skills for Surgeons (NOTSS)
29 October, Brisbane
Clinical Decision Making (CDM)
29 October, Brisbane
Training Standards: Interpretation and Application

QLD

9 November, Gold Coast
Supervisors and Trainers for SET (SAT SET)

SA

13 November
Academy of Surgical Educators Forum

TAS

24 October, Launceston
Non-Technical Skills for Surgeons (NOTSS)

VIC

29 September, Melbourne
Academy Educator Studio Session
24 October, Melbourne
NHET Sim
24 October, Melbourne
Clinical Decision Making (CDM)
24 October, Melbourne
Training Standards: Interpretation and Application
15 November, Melbourne
Communication Skills for Cancer Clinicians
20 November Melbourne
Supervisors and Trainers for SET (SAT SET)
21 November, Melbourne
Non-Technical Skills for Surgeons (NOTSS)

WA

25 September, Perth
Foundation Skills for Surgical Educators
15 November, Perth
Building Towards Retirement (via weblink)

THE ONGOING DISCUSSION AROUND FEES

Being silent will only further erode our community standing

MICHAEL GRIGG
PRESIDENT

Following June Council, I initiated a discussion about the mounting concerns with excessive, extortionate fees. This has received positive media attention. Why have I done this? Well, I believe a major purpose of the College is to protect the professional status of surgeons. That professional status is very much dependent upon the simple equation of autonomy (the freedom to act in the best interests of patients) in return for self-regulation. The vast majority of surgeons act responsibly in terms of fees, but those who don't, encourage the perception of failure of self-regulation by the profession that in turn threatens the ongoing professional status of all.

The Council and I felt that it was important to provide some leadership on this issue. The challenge was to move the College into an open discussion so that the views of the Fellows of the College could be clearly heard.

Thus far the response has been overwhelming. In my nine years on Council, I have not seen another issue where the Fellows making comments have been so vocally positive and supportive of our stance. Certainly, we have received emails of concern that the College has ventured 'into this minefield'. There are surgeons who are very concerned that we might have any discussion at all with the ACCC. The AMA has raised specific objections, which the College will certainly need to evaluate carefully and learn from.

However, in the various Regional meetings that are currently underway, the voices have been echoing what has been sent in correspondence. Comments have included:

"It is the College responsibility to become involved in these issues."

"Excessive fees should be brought out into the open."

"Surgeons charging fees which can only be described as rapaciously greedy is abhorrent and certainly brings the whole profession into disrepute."

"As far as I can determine, this is a culture shift predominantly occurring in the younger surgeons."

"The latest one I heard about was an $8000 'booking fee'... who knows what the eventual cost for surgery would be!"

"Fraud is obviously a legal term, so I will simply indicate that in spinal surgery, it seems relatively common now to bill for services not rendered."

"The trashing of the reputation of RACS, the Australian Orthopaedic Association and other professional organisations is to be lamented and condemned."

"Pressure also needs to be exerted on government and insurers who have created a situation of fee anarchy by their undermining of fair value."

"I would have rather more concerns about the very blatant fraudulent manipulation of the MBS item numbers which is occurring all around us, than a fee agreed between patient and surgeon prior to surgery."

"I believe surgeons should be accountable for their fees and I also believe that a system needs to be put in place so GPs and patients are able to see the fees a particular surgeon will charge for a number of the main operative procedures."

"Patients also need to know that surgical fees have no direct correlation to the surgeon's skills."

And perhaps it is best summed up by one response:

"I am so proud that our College is showing leadership in this area".

And so, we shall continue.

College praises the stand of the Australian Orthopaedic Association (AOA) about inappropriate use of item numbers.

There have been suggestions of differences of opinion between the AOA and the College. I have not experienced these as President. Instead my experience has been that many Orthopaedic surgeons have contacted me supporting the College's stance. My interactions with the AOA have been through the President of the AOA, Peter Choong. I know him to be highly motivated and passionately ethical – what else could one request of a colleague? In the midst of all this discussion around fees, the College needs to praise the stand by the AOA about the inappropriate use of item numbers. The AOA First Vice-President, Mr John Tuffley, in the latest AOA Newsletter wrote extensively about this issue. He highlighted that:

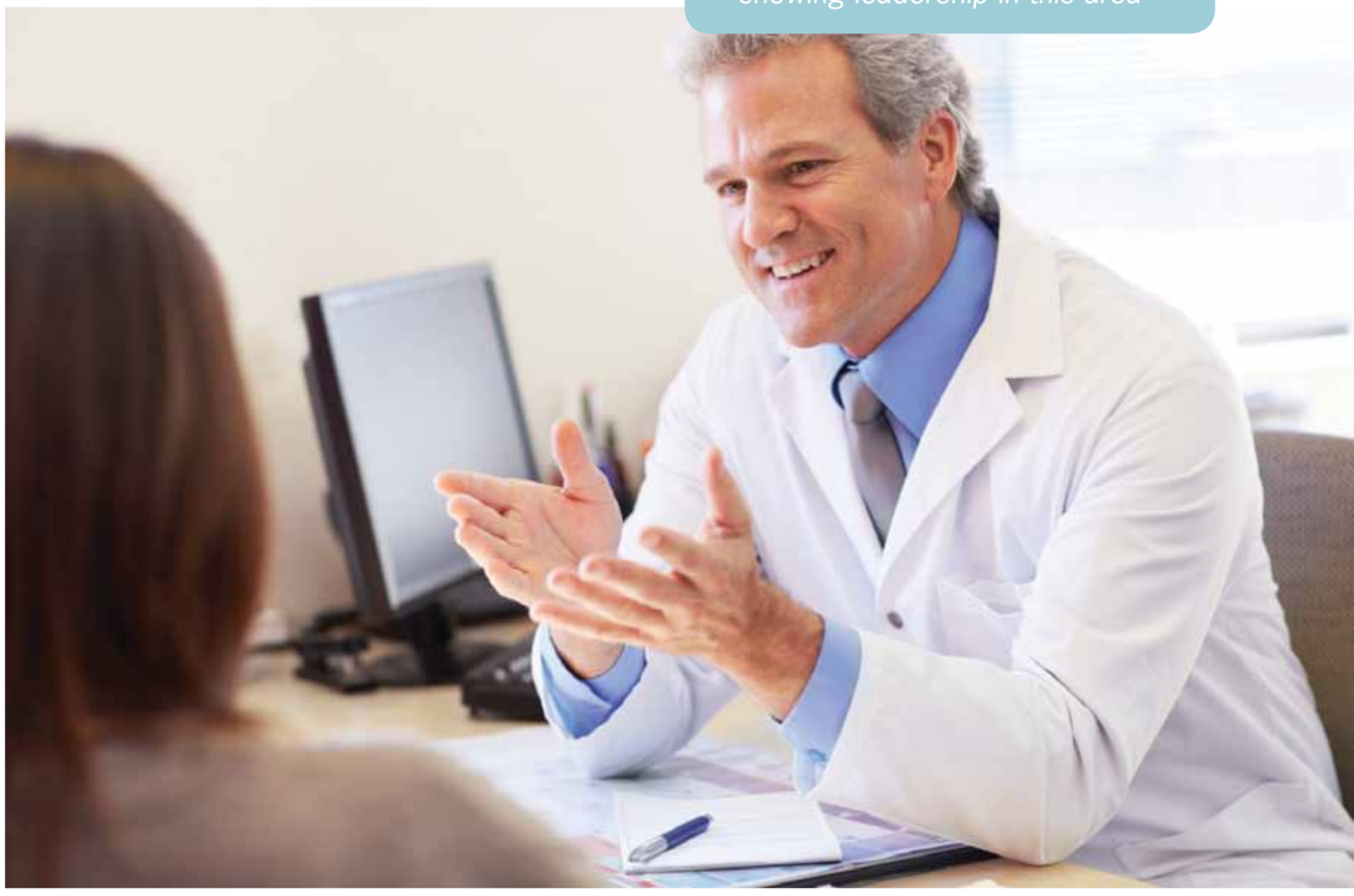
"It would be timely for orthopaedic surgeons to review the introductory and explanatory sections of the MBS Schedule, which lay out in detail how the schedule should be used. The intention and 'spirit' of the schedule is that for almost every procedure, only one item number is applicable... Those orthopaedic surgeons abusing the Medical Benefits Schedule are not contributing to the honour and noble tradition of the medical profession; quite the reverse. The AOA endorses any action or actions by the Department of Human Services to improve correct use of the MBS."

The College highlights this strong stand by the AOA on this important issue. It is sage advice for all surgeons.

So why are we in this discussion?

The AMA has been and is concerned about the statements and submissions the College has been making about fees, particularly to the current Senate Committee enquiry. Part of my response was:

"As you say, the College of Surgeons does not traditionally get involved in discussion around fees. ▶



This is an area where the AMA and many of the surgical specialty societies / associations are far more active and appropriately so. However, there have been increasing concerns expressed by Fellows of the College to the President and other Councillors about the negative impact of extortionate fees. This has moved from anecdotal comments to survey based responses where the surgical profession and the standing of surgeons in the community is now under threat. The College will always step into a discussion where the standing of the surgical profession is being eroded or negatively impacted."

It will be eroded if the professional organisation of surgeons, the College, does not make clear statements about the appropriateness (or not) of manifestly excessive fees. It will be eroded by lack of transparency on fees for the public. It will be eroded by not focusing on the primacy of the patient in our clinical relationships.

None of this is 'news'. However, the groundswell from the public, other professional groups and various government and regulatory authorities is something that no professional membership based organisation can ignore. The threat of accountability replacing autonomy of professionals is very real as evidenced by the current 'assault' on the autonomy of Plastic Surgeons by the private insurance industry.

So where to next?

We know from Government data that the vast majority of fees (more than 80 per cent) of patients in hospital do not involve an 'out of pocket' expense, so most surgeons will not be personally affected by the outcome of this debate.

But the issue of fees is complex. As the College pointed out in its submission to the Senate Committee enquiry, the failure of Medibank and private insurance agencies to keep pace with inflation is a recipe designed to increase 'out of pocket' costs. And again, there is the issue of individuals claiming to be surgeons when we would not recognise them as such i.e., they are not Fellows of the College, but can still use the non-protected descriptor of surgeons. These 'surgeons' often charge exorbitant fees utilising our reputation and prestige to justify their charges, but in doing so, unjustifiably harm us. They may be members of the AMA but they are not members of the College!

The Vice President (David Watters) and I will be meeting many Fellows at Regional meetings over the next two months. We need your opinions and your advice. Separately the issue is being discussed with the Presidents of all other Medical Colleges. I have been meeting with the ACCC to ensure that discussions about fees are not regarded as collusion and thus anti-competitive. The AMA is calling a Round table to have broader discussion. RACS fully expects there to be divergent and sometimes firmly held views.

We need to define the key principles that we will endorse. RACS will never establish a fee schedule. That is for other groups like the AMA. However RACS does need to be able to provide clear principles in the way that these issues should be approached. Our principles currently include:

- Surgeons, like all professionals, are entitled to establish and charge fees for their clinical work.
- Fee levels should be based on skills, experience, time and resources used for the clinical services.
- Surgeons should have established fee structures that are justifiable (discounting of fees may be appropriate in certain circumstances).
- Fees should not be regarded by their professional peer group as excessive or disproportionate to the service provided.
- Surgeons must not inhibit nor discourage a patient's request for a second opinion with respect to either the course of treatment recommended or the fee to be charged. They must co-operate fully with the practitioner providing the second opinion.

What else should be included?
Please let me know. This is a really important issue for our profession. We cannot be silent.

Letters to the Editor

Simple to save water

I note with interest Professor Catchpole's letter in the recent edition of 'Surgical News' (August 2014).

The amount of water used during the surgical scrub was the subject of a small project we conducted in 2009. I would direct Prof Catchpole to our article in the 'Australian Journal of Rural Health'.

Petterwood J, Shridhar V. Water conservation in surgery: A comparison of two surgical scrub techniques demonstrating the amount of water saved using a 'taps on/taps off' technique. 'Australian Journal of Rural Health' 2009; 17: 214–217.

We found that a standard surgical scrub used a mean of 15.5L per scrub. Utilising a 'taps-on, taps-off' technique led to a mean saving of 11L per scrub (p<0.001).

I agree that we need to emphasise the need for conservation of materials in surgery and the simple 'taps-on, taps-off' technique is one way in which we can do this.

Dr Joshua Petterwood
SET5 Orthopaedic Registrar
St Vincent's Hospital Melbourne

More on Penicillin

In my dissertation on Empiricism in 'Surgical News' (July, 2014), I touched upon the penicillin story.

Since that time I came across some facts that I was unaware of at the time. And I cannot recall it in the books by McFarlane and Williams about Florey and the Penicillin story.

The SBS news commentary mentioned the fact that it was the Pfizer company in New York that delayed production because they wished to install patents on this important discovery. This was unknown to me.

It was the British biochemist Ernst Chain who isolated penicillin in the 1930s and insisted that patents in the UK should apply, but Florey overruled him and said no, this is for the good of humanity and we will leave it untouched commercially.

Incidentally this patent factor meant that the National Health in the UK had to pay royalties across the Atlantic. Need I say also, it was the Pfizer company which has reaped the benefits from the use of Viagra which was used initially in the treatment of Parkinsonism. One of the incidental effects of this prescribed drug in the elderly male needs no elaboration.

The second thing of interest is that they needed a more robust penicillin mould than that sewn into the lining of Florey's garments when he flew across to America via Lisbon. One should appreciate this was done in case he was captured by the Germans during wartime.

Fortuitously, the third thing of interest: a person by the name of Hunt happened to call into one of the fruit market squares in New York city at midday and when all was finished came upon a cut cantaloupe that was totally covered with this blue

grey mould, obviously from some days in the sun beforehand. She must have been attuned to keep an eye out for various moulds in pieces of garbage.

She took that to the lab where production was being organised in the old milk factory, using old milk cans, and it proved to be a bonus beyond belief.

The next point in this story is that penicillin mould proliferates under the influence of maple syrup as a sort of fertiliser to accelerate growth.

But to aerate the fluid medium in which this whole concoction sat in the milk cans, the production team found that bubbling in oxygen (the lining of the bubble increased the surface area to allow the reaction and accelerate the production of penicillin) – which came out in abundance.

Whereas Florey at Oxford had a teaspoonful for his first treatment of the rose thorn prick in the face of the gardener with periorbital cellulitis (who died), in New York they were producing it in such volumes it was beyond their comprehension.

I finished off that story in the Empiricism article about how it saved the lives of a quarter of a million injured US soldiers and many others after the D-day invasion.

Felix Behan
Victorian Fellow

ELECTION TO COLLEGE COUNCIL

DAVID WATTERS
VICE PRESIDENT

The College is a not-for-profit organisation that is owned by its members, now 7000 Fellows. It is governed by a Council of 25 Fellows who are elected by its membership. The Council consists of 16 Fellowship Elected Councillors, elected by all Fellows and nine Specialty Elected Councillors who are voted for only by those with a Fellowship in the relevant Specialty.

Fellows are entitled and encouraged to vote regardless of whether they are active or retired. There are more than 5800 active Fellows and just over 1000 who are retired.

On Friday September 19 you will receive an email with a link to the ballot to elect Fellows to vacancies on the College Council.

Why should you bother voting?

Firstly, the authority of Council is enhanced by a strong mandate from the Fellowship.

Secondly, the authority of the College as a professional body is enhanced by evidence of strong engagement by its membership.

Thirdly, Councillors who are elected by a good proportion of the Fellowship, feel a commensurate obligation to keep faith with their electors by doing the best job they can on Council and to be held accountable.

Not all Fellows may wish or be in a position to stand for election, but by voting, every Fellow demonstrates their engagement with the organisation which after appropriate training and assessment, bestowed their means of livelihood – the Diploma of Fellowship.

The College aspires to champion surgical standards and to this end actively promotes Continuing Professional Development (CPD), lifelong learning, mortality and morbidity audit and a Code of Conduct. On our patients' and our Fellows' behalf we advocate on lifestyle issues such as the harm that can arise from excessive alcohol intake, the effects of smoking or obesity on health and operative outcomes and the risks in medical tourism.

We ensure that surgeons have a voice and an influence on government agencies charged with monitoring performance in the health system. A motivated and wise Council is a prerequisite to being effective in these and many other areas of College activity.

Candidates provide photographs and information about themselves. The Fellows supporting their candidacy make brief statements about why they think they would make good Councillors. These statements are intended to assist you in voting, whether or not you know the candidates.

As the College embarks on ever more rigorous advocacy on behalf of our members, it needs the best talent making decisions at the Council table. We need your vote.

Please take the time to read about the candidates and submit your vote. Electronic voting makes the process even quicker and easier. The introduction of electronic voting in 2013 was a great success and increased the number of returns.

Responsibilities of being a Councillor

Becoming a Councillor is not a role Fellows take lightly. It means becoming a company director with significant duties prescribed in law.

Councillors hold a position of trust and have a fiduciary duty to act in the best interests of you, the members.

Duties include:

- to act in good faith in the interests of the College as a whole
- to exercise care and diligence
- not to improperly use their position or information
- to declare conflicts of interest and to not influence Council's decision on those matters
- to prevent insolvent trading
- to ensure appropriate records are kept.

Councillors commit to not only attend Council and committee meetings, but to read agenda papers carefully, contribute to deliberations and to be accountable for decisions.

Council's role is to set, monitor and review the College's strategic direction and budget, determine and review policies and monitor their implementation by management, and to ensure legal and reporting requirements are met.

Specialty Elected Councillors are an important conduit for information between Council and the Specialty Societies, enabling the College to be the unified voice for surgery. They are expected to have a close relationship with the Executive of their Societies. As a Councillor they have full voting rights and the same responsibilities as Fellowship Elected Councillors to act in the best interests of the College as a whole.

All Councillors are expected to attend and contribute to the meetings of their Regional Committee and to convey accurately the decisions of Council and the reasons behind them.

Councillors are expected to be independent, demonstrate leadership, promote and support the values of the College, work cooperatively and to willingly and energetically take on any task asked of them by Council or the President! As one takes on more senior positions on Council, the more time and commitment is involved.

No Councillors receive remuneration, though expenses are reimbursed and training is provided, including funding for the Australian Institute of Company Directors graduate course, which all Councillors are encouraged to do. The knowledge and skills acquired are applicable to all aspects of a surgeon's life.

The majority of Councillors regard the time they serve on the Council as rewarding, a privilege and a significant life experience, despite the pro bono time and effort involved.

Being a Councillor might not appeal to all, but we still hope that you will exercise your right to vote and give your mandate to those elected.

If you would like more information, please contact me College.VicePresident@surgeons.org

Vacancies and Current Councillors

The current elections whose results will be announced by the end of October will see the successful candidates commence their terms as Councillors after the Annual General Meeting in May 2015. Each Councillor is entitled to stand for three three year terms – nine years in total. Those who wish to remain on Council after each three year term must be re-elected.

For 2015, there are four vacancies in the category of Fellowship Elected Councillor with two current Councillors standing for re-election.

THERE ARE SIX VACANCIES AMONG THE SPECIALTY ELECTED COUNCILLORS.

These are –

Cardiothoracic Surgery	(264 Fellows)
General Surgery	(2,420 Fellows)
Otolaryngology Head & Neck Surgery	(621 Fellows)
Paediatric Surgery	(168 Fellows)
Plastic & Reconstructive Surgery	(537 Fellows)
Vascular Surgery	(226 Fellows)

FELLOWSHIP ELECTED COUNCILLORS

Current Fellowship Elected Councillors are:
Retiring Members:
Sean Guy Hamilton (Plastic & Reconstructive) WA
Simon Alan Williams (Orthopaedic) VIC

Members who are eligible for re-election:
Phillip James Carson (General) NT
Lawrence Pietro Malisano (Orthopaedic) QLD

Because Councillors only stand for re-election every three years, the members not due for re-election on this occasion are:
John Charles Batten (Orthopaedic) TAS
Spencer Wynyard Beasley (Paediatric) NZ
Ian Craig Bennett (General) QLD
Graeme John Campbell (General) VIC
Catherine Mary Ferguson (Otolaryngology) NZ
Sally Jane Langley (Plastic & Reconstructive) NZ
Barry Stephen O'Loughlin (General) QLD
Richard Edward Perry (General) NZ
Julian Anderson Smith (Cardiothoracic) VIC
Philip Gregory Truskett (General) NSW
Marianne Vonau (Neurosurgery) QLD
David Allan Watters (General) VIC

SPECIALTY ELECTED COUNCILLORS

There are nine Specialty Elected Councillors. Two current Specialty Elected Councillors are retiring and four are eligible for re-election.

Retiring Members:
Michael John Grigg (Vascular Surgery) VIC
Alan Charles Saunder (General Surgery) VIC

Members who are eligible for re-election:
Julie Ann Mundy (Cardiothoracic Surgery) QLD
Anthony Lloyd Sparnon (Paediatric Surgery) SA
David Robert Theile (Plastic & Reconstructive Surgery) QLD
Neil Anthony Vallance (Otolaryngology Head & Neck Surgery) VIC

The Specialty Elected Councillors who are not due for re-election on this occasion are:
Andrew James Brooks (Urology) NSW
Bruce Ian Hall (Neurosurgery) QLD
Roger Stewart Paterson (Orthopaedic Surgery) SA

Standing tall

Severely debilitated by a spine defect, East Timorese teenager Margarita can now stand tall. After two years and special weight treatment, she has finally had the surgery she needed with the help of surgeon Michael Johnson. Working hard to ensure that Margarita understood the risks of the surgery, Mr Johnson was happy to perform the operation "She could continue to live as she is, but I got the clear impression from her that this was something she wanted," Mr Johnson said.

***Daily Telegraph*, August 9**

Quit advice from surgeons

Controversy has been sparked with statements from Scotland that some doctors refuse to see patients who smoke.

"Evidence shows that they would not do well in treatment," Vascular surgeon Zahid Reza said.

Support for the right of surgeons to suggest patients attempt to quit before treatment is offered came locally.

"If you've got to ration treatment, there are better outcomes for those who are off cigarettes," Australian and New Zealand Society of Vascular Surgeons president Dr John Quinn said.

***news.com.au* August 14**

Insurers playing doctor

Many people are unaware that their health insurance may not cover reconstructive surgery after cancer, burns or accidents due to health insurers deeming the operations as 'cosmetic'.

A survey conducted by the Australian society of Plastic Surgeons found that eight out of ten people would not know that their policies excluded plastic surgery such as breast reconstruction following a mastectomy. "Insurers are playing with people's health with their own bottom line in mind," ASPS president Dr Tony Kane said.

***Sunday Telegraph*, August 10**

Learning from the audit

Deaths resulting from surgery have been reduced and are continually falling each year.

The sixth annual report from the Victorian Audit of Surgical Mortality (VASM) shows that surgery is far from the risk it once was.

However, VASM Clinical Director Barry Beiles also pointed out the importance of feedback as part of the audit.

"[Feedback] is essential to the audit's overarching purpose, which is the ongoing education of surgeons and the improvement of surgical care for all patients," he said.

***AusMed*, August 19**

HOW FAST ARE YOU AGING?

Conserving your telomeres

Do you ever wonder why some patients and colleagues age so much faster than others? Is aging preset at birth and unchangeable? Although an individual's DNA is programmed early, life events affect its decay. 'Age' is not just greyness of hair (which can, of course, be concealed with colour), but recognised by skin texture (cosmetically unaided), alertness, strength, energy and a whole lot more going on inside with neurotransmitters and hormones.

Last week Dr T L O'Meares consulted me. I hadn't seen O'Meares for some years, but I was shocked at the changes I saw. T L O'Meares had aged, aged significantly – at least in appearance. What had happened and how had it happened over a relatively short period?

T L O'Meares was sleeping poorly and had had a torrid time emotionally. Vivid recollections of a traumatic life event some years earlier were flashing back during the night and at other times. This manifestation of post traumatic stress disorder (PTSD) had been unmasked by a heavy workload, family worries (young adult children) and a growing sense of failure coupled with grumbling cynicism, citing the unreliability of family and frustration with everyone involved in the health system. It was not hard to diagnose depression and burn-out.

I find most surgeons are reluctant to admit to being depressed, but T L O'Meares had at least come seeking treatment. Australia's survey of mental health in doctors (Beyond Blue) suggested that although around 20 per cent of surgeons and up to 30 per cent of specialists reported having suffered mental illness, few feel it is safe to admit as much to their colleagues for fear of being perceived as dangerous or underperforming.

Of course, this just makes their plight all the worse. It reduces their likelihood of seeking help, appropriate treatment and/or support. Beyond Blue reported a third of 51-60-year-old doctors had suffered burn-out symptoms of emotional exhaustion and/or cynicism, though only 12 per cent believed it had affected their professional efficacy. Similar findings have been reported from a US-based Medscape survey.

Managing health

T L O'Meares already has some excess abdominal adiposity. Lipids were slightly raised, blood pressure similarly. I checked iron and haemoglobin, thyroid function, serum calcium (for hyperparathyroidism), Vitamin D, magnesium and B12.

There were no dramatic changes though the magnesium was on the lower limit of the lab normal (total red cell magnesium later proved low). There was no argument from TL about treating the depression, starting magnesium supplements and raising Vitamin D levels to at least 70nmol/L – nor with taking time off.

O'Meares asked initially whether it would be fine just to reduce the workload by a day a week. I counselled otherwise – so a four-week break was agreed starting the following Monday. Then on return I recommended a further consultation followed by a day off each week till the end of the year.

Poor T L O'Meares had a full house of factors that shorten telomeres. Telomeres are like protective caps on the end of your chromosomes (DNA), akin to the ends of a bootlace that prevents the lace fraying and becoming unthreadable. We want them to be as long as possible as once they are sufficiently shortened, the cell enters stable cell cycle arrest or senescence.

Cellular senescence is caused by various insults such as telomere erosion, oncogene activation, irradiation, DNA damage, oxidative stress and viral infection. Telomeres play an important part in all dividing tissues, including the hippocampus, the immune system and bone.

Oxidative stress among all its other ill effects is associated with shortening of telomeres. Depressive illness can also be associated with age-matched shortening – not overnight, but over many years. Inflammation and thus cytokines do sing the blues with their score of inflammatory and oxidative effects wailing through the body like a requiem.

Studies of telomere length have usually been performed on leukocytes, but oxidative stress and deficient telomerase (an enzyme that restores and repairs telomeres) have also been shown to contribute to telomere shortening in oligodendrocytes of the brain. Telomeres are shortened in war veterans with post traumatic stress disorder, victims of family violence and social disruption. There is an association with Type 2 diabetes, depression, poor sleep quality, high visceral adiposity and metabolic syndrome.

Albert Schweitzer once said: "The tragedy of life is what dies inside a man (woman) while he (she) lives." Although the length of telomeres is programmed in utero, stress during childhood and later life accelerates the erosion of telomeres. Life's events are responsible for 50 per cent of the speed of aging.

There is therefore great value in addressing your (oxidative) stressors and minimising or controlling them. First you have to recognise they exist. The earlier you do this, the longer will be your telomeres. Most of my readers are unlikely to live to 100, but your longevity is partly bestowed in those bootlaces. Look after them!

Dr BB G-loved

Does every problem have to come down to ageing?

BY **PROFESSOR GRUMPY**

OLD TIMERS

There is one thing that really annoys me and that is ageing. I know that the few readers I have under the age of 50 will stop reading now as they are not aged nor will they age in their view. But the others might read on.

It is not ageing that gets at me, not the increase of numbers from one decade to the next (as happened to me recently), but the increasing minor symptoms that are damned annoying. A single ache or symptom is fine – tolerable, even enjoyable for a dinner table conversation – but three or four are more than one should really have to put up with.

What is even worse is the attitude of some medical professionals. A painful big toe joint when one walks, a bowel that does not absorb Mrs Curmudgeon's culinary delights properly, a heartbeat that is irregular are dismissed as "just arthritis", an "aging gut" and "age related dodgy ticker". Well, let me say that they are all diseases that are clearly defined – why trivialise them by saying they are "just age related"?

Recently I had a minor procedure and the nurses decided that I should be on the aged pain relief protocol because I was nearly 70. It is true I was nearly 70, but I was not quite there so why should I be labelled as aged? I protested but was pacified with: "At your age we can't be too careful." I was tempted to say that I could outwalk all of them, but walking is a little hard with a catheter in place.

We curmudgeons are proud of our prowess, be it physical or mental. We don't need to have seats offered to us on buses; we don't need special driving tests and we don't always need to wear glasses to read menus. The latter problem is the fonts that are used in menus – too small and the wrong colours – try reading 12 point size in a French Script MS that is red on a yellow background.

So ageing can be a pain, an unnecessary accompaniment to maturing and gaining wisdom, but as Orson Welles said, "Old age is the only disease you don't want to be cured of".

CASE NOTE REVIEW

Benign jaw tumour surgery in elderly patient

GUY MADDERN
CHAIR, ANZASM

This elderly patient was seen at an Oral and Maxillofacial clinic. The assessment was by an Oral and Maxillofacial Registrar who diagnosed a left anterior mandible lesion. It was noted that the patient had gastro-oesophageal reflux, for which the patient was taking Somac, and had been a heavy smoker for some 50 years. There was no history of alcohol intake and past history included a tracheostomy for a cyst.

The examination notes of the outpatient attendance describe an expansile left anterior lesion with normal inferior dental nerve sensation and left sublingual fullness. The recommendation was 'review by the consultant in a week for possible biopsy or en bloc resection with workup including chest x-ray, basic bloods'.

The review took place approximately one week later, confirming that there was a left mandibular cyst and an open biopsy was to be undertaken under local anaesthetic. The review was to be two weeks post-open biopsy and the patient was to have a CT scan and an Orthopantomogram (OPG) performed.

The next outpatient entry was 14 days later and had only the letters 'R/V' recorded. The clinical notes are then somewhat deficient in that they do not include the objective report of the surgical procedure. Several descriptions suggesting that the surgical procedure of partial mandibulectomy and iliac crest bone graft proceeded uneventfully have been documented.

However, the Coroner's report does indicate that the induction of anaesthesia was difficult and that nasal intubation – even via fibre-optic visualisation – was not possible and that an oral tube was used. Extubation was accompanied by respiratory distress almost immediately and required reintubation.

The patient was then admitted to intensive care in an unplanned manner. Soon after the patient required formal tracheostomy and a revision tracheostomy some days later. The patient continued to have issues with postoperative bleeding, including a leak around the tracheostomy tube; hence the need for revision.

The patient's general condition continued to worsen and there was a sudden further deterioration some 13 days postoperatively, which led to death.

The overall findings were those of a significant pulmonary embolism. However, there was a background of deteriorating general health in the lead-up, mainly due to respiratory failure, acute pulmonary oedema and pneumonia. There are findings of acute respiratory distress syndrome. There was also a background of severe coronary atherosclerosis.

Clinical lessons

The major areas of consideration in this case are at the preoperative level and also relate to the immediate intraoperative management. The scanty nature of the outpatient notes suggests that there was little in the way of multidisciplinary workup in the decision-making process. Certainly the multidisciplinary Head and Neck clinic at this major hospital was not involved in the decision-making.

The full assessment of comorbidities has not been well documented and, with a background of the removal of a benign tumour in an elderly patient, is certainly another area of consideration. There also seems to have been no definite preoperative anaesthetic assessment: the anaesthetic at the time of surgery was quite complicated and difficult, and the perceived need for intraoperative tracheostomy was obviously not anticipated. This effectively led to the patient requiring reintubation, perhaps suffering aspiration of blood and then going through a period of urgent tracheostomies and tracheostomy revision. Another area of consideration was the level of thromboembolic prophylaxis; there were only scant records regarding this.

This case highlights the problems with single department decision-making in major surgical resection for non-life threatening diseases in major hospitals where multidisciplinary teams exist for this purpose. This patient may well have been managed differently if the input of other specialties had been sought and certainly the assessment of all potential comorbidities prior to major non-urgent surgery would have been better.

Some of these investigations may have been undertaken externally, but there is little in the way of records to support this. Likewise, the assessment by an experienced Head and Neck anaesthetist preoperatively may have raised the need for a tracheostomy intraoperatively, rather than encountering the airway issues postoperatively that necessitated reintubation and ultimate tracheostomy with a subsequent revision.

All these factors contributed to a prolonged stay in intensive care which ultimately would have been the cause for the patient developing a deep vein thrombosis and then a pulmonary embolus. The lack of documentation of deep vein thrombosis prophylaxis is also an area of concern, given the fact that none of this was well documented.

Join the conversation: http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2014/anzasmcnrsep2014/

WORKING ON

Alcohol related harm

College progresses on key advocacy issue

DAVID WATTERS
VICE PRESIDENT

As this topic is a key item of advocacy for the College, I would like to keep you informed as to the College's involvement in the issue of reducing alcohol related harm. Over the last 90 days, the College has:-

- Had representation at the National Alliance for Action on Alcohol summit in Canberra relating to the marketing of alcoholic products to children.

The conclusions of that summit were that relying on the alcohol industry to self-regulate and cease marketing through sports events including televised games before 8.30pm was ineffective.

- Responded to a submission requested by the NSW Legislative Enquiry as to the impact of legislative changes made affecting the Sydney CBD Entertainment Precinct.

It is encouraging to hear information from surgeons working in the area that indicates a reduction in the number of presentations to the emergency department as a result of alcohol related harm and a reduction in the severity of injuries.

- Attended the launch of the Alcohol's Burden of Disease in Australia study funded by FARE and VicHealth in collaboration with Turning Point.

The study looked at hospitalisations and deaths due to alcohol and its contribution to cancers, cardiovascular diseases, digestive diseases, infections and parasitic diseases and neuropsychiatric diseases. The data shows that in 2010 there were just over 157,000 hospitalisations related to alcohol (does not count harm to third party) and over 5,500 deaths.

- Agreed to support the "Call for Action" in New Zealand. The NZ Medical Association recently endorsed a Call for Action on Alcohol to the incoming government of 2014.

The Call is for legislation to enact four priorities related to marketing and pricing, the two main drivers of alcohol demand.

HYBRID THEATRE FOR TASSIE

New theatre in Launceston will make a difference in improving outcomes for patients

The Launceston General Hospital (LGH) is the first regional hospital in Australia to house a purpose-built hybrid operating theatre featuring a $1.5 million 3D X-ray imaging machine.

Part of a multi-million dollar redevelopment and refurbishment of the hospital, the new hybrid theatre opened in July. The new facility – designed via input from senior surgeons across a range of specialties and the hospital's chief angiographer – is also the first theatre of its kind providing staff with real-time measurements of X-ray exposure.

The Director of Surgery at the LGH, Mr Brian Kirkby said the new theatre would reduce operating times, patient recovery rates and decrease morbidity and post-operative complications.

He said it had been designed and equipped for a range of procedures.

"The hybrid theatre took four months to plan and involved input from me as a vascular surgeon, urology surgeon Steve Brough, orthopaedic surgeon David Edis and the hospital's chief angiographer and radiographer Robbie Miller," Mr Kirkby said.

"This co-ordination was vital because we wanted to be able to use the hybrid theatre to perform trauma surgery, vascular and urology procedures, such as stone surgery and for orthopaedic cases, particularly spine surgery.

"We were also assisted by the design team from Phillips and Maquet."

The 3D X-ray and imaging machine is set on rails that can rotate around the patient and requires a room almost seven metres wide to allow it to be used effectively.

It is the single most expensive piece of equipment to be installed as part of the redevelopment of the hospital's intensive care unit, central sterilisation department and operating theatres.

Mr Kirkby said it would allow surgeons and specialists to work within a space that combined components of a traditional operating theatre and a traditional X-ray and imaging facility.

"Most surgeons will understand that having a hybrid theatre necessarily requires compromise, which is why we spent so much time and attention on the design details," he said.

"While we might lose some space, the benefits of having the imaging equipment where we need it are unquestionable, both in terms of patient safety and surgical efficiency.

"For instance, in the past if a surgeon suspected that a patient may have internal bleeding or compromised blood flow they would have to pack up the patient and move them, with all the equipment attached, to a separate unit for angiograms and then take them back to theatre if necessary.

"Now, we can take those scans at the time they are needed without disturbing the patient, right there in theatre.

"It also allows surgeons to conduct procedures that require X-ray imaging, which will be of great benefit to the orthopaedic surgeons."

Mr Kirkby said another benefit of the state-of-the-art X-ray equipment was that it reduced exposure to radiation by up 80 percent.

Monitoring equipment also allowed for the real time measurement of exposure for all theatre staff.

"Most of this equipment in the hybrid theatre is a first for a regional hospital," he said.

Mr Kirkby said LGH staff were proud of the new hybrid theatre, one of only 20 in use across the country, with all others found in metropolitan hospitals.

He said that while it had been mooted for future installation, extra funding had been sourced to allow for its development ahead of time.

"It is pleasing to be part of a first for a regional hospital in Australia and there is certain kudos in having access to facilities that are not available in some major metropolitan hospitals."

The new hybrid theatre is in use all day every day and for emergency procedures at night. It is one of five new theatres at the LGH; another four are in the process of being redesigned and refitted.

With Karen Murphy

e-news

Pay online at the College

The College now has an online secure payment capability, which allows certain College financial transactions to be completed via the website. These transactions currently include donations to the Foundation for Surgery as well as the purchase of College merchandise via the online store. This secure payment allows all purchasers to immediately receive email confirmation of payment and an emailed tax invoice/receipt as well as shipping confirmation for any merchandise purchased.

It is intended that the capability will be expanded in the future to include other payments to the College.

Please visit the online store at Royal Australasian College of Surgeons Webstore where there are several items of College merchandise, including wearable items for Fellows only, and other College specific goods.

Donating to the Foundation for Surgery via the online store allows designation as to which particular area of the Foundation will receive the benefit of your donation.

Your donation will make a real difference, so please visit the website today to make your safe, secure donation to support:

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Foundation for Surgery
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PNG NEUROSURGEON achieves outstanding results

Dr William Kaptigau's extraordinary effort to improve patient outcomes for the people of Papua New Guinea

Former Rowan Nicks Scholar Dr William Kaptigau has become the first surgeon in the country to graduate as Doctor of Medicine for his research based on his audit over the first decade of the introduction of a neurosurgical service at Port Moresby General Hospital, Papua New Guinea.

Dr Kaptigau, PNG's first national neurosurgeon, established the country's first neurosurgery service in 2004 and from the outset began compiling rigorous reports of activity and outcome across the full range of procedures conducted.

Until he established the service, with the assistance of neurosurgeon Professor Jeffrey Rosenfeld and the former Professor of Surgery at the University of Papua New Guinea (UPNG) Professor David Watters, most neurosurgery cases were treated by general surgeons across the country.

Marianne Vonau, the College Treasurer is another ongoing supporter of William and neurosurgery in PNG, having led a neurosurgery team with neurosurgeon, Teresa Withers, to assist William over the past six to seven years.

Dr Kaptigau's audit showed a dramatic decrease both in the mortality rate from severe head injuries and complication rates in patients treated in the Port Moresby unit over the decade of its establishment, indicating the value of the specialist surgical service.

Conducting all the research alone while heading the unit, training another neurosurgeon and also providing general surgery, Dr Kaptigau's graduation in April as Doctor Of Medicine from UPNG represents a remarkable achievement, according to Professor Watters.

Professor Watters trained Dr Kaptigau as a general surgeon during his time as Professor of Surgery at UPNG, and lent support to his application for a Rowan Nicks Scholarship when Chair of the RACS International Committee.

Now the Vice President of the College, the Divisional Director of Surgery at Geelong Hospital and Professor of Surgery at Deakin University, Professor Watters has maintained his support and mentorship to Dr Kaptigau since his departure from PNG in 2000.

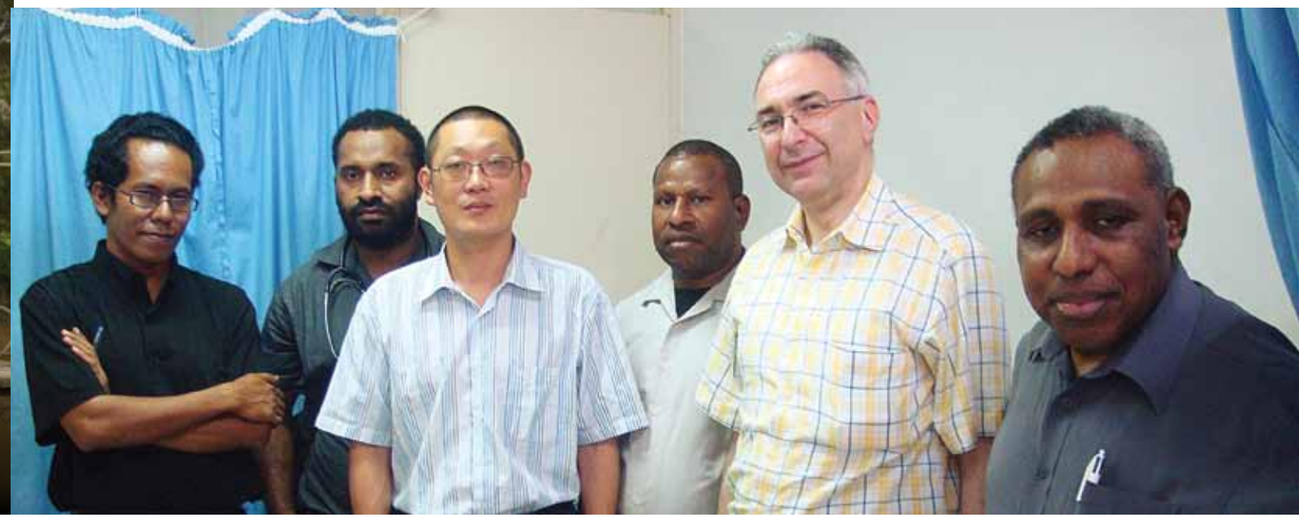
"Very few surgeons in PNG go onto a higher degree and the fact that Dr Kaptigau completed his research and thesis when he was dealing with his own health issues shows tremendous strength and resolve," Professor Watters said.

"He is the first surgeon to get his Doctor of Medicine, which is a remarkable achievement in itself. The fact that he took on that work while running the neurosurgery unit, training and doing general surgery makes it even more outstanding.

"The audit of his unit, which predominately treats head trauma, spinal disease, hydrocephalus and space-occupying lesions, demonstrates continuous improvement during the decade of his leadership, particularly in head injury outcomes. Willie had already published a number of a papers in a focus edition of the 'PNG Medical Journal' dedicated to neurology and neurosurgery [2007; Vol 50 March-June pp 1-101].

"For example, in 1996, an article comparing head injury outcomes in Goroka and Port Moresby demonstrated a mortality rate for severe head injury (GCS < 9) of 60 per cent in Port Moresby and 55 per cent in Goroka," Professor Watters said.

Joao Pedro (Timor Leste Surgeon), Lino Tom (Trainee), Professor Ren Hong Bing, Sammy Thomas, Professor Jeffrey Rosenfeld and William Kaptigau.



"A decade later in 2007, the mortality from severe head injury in Port Moresby had reduced to 26 per cent which is a great credit to the work undertaken by Dr Kaptigau not only through his own skills as a neurosurgeon, but also because of the training he has provided others in pre-hospital trauma care and post-operative care.

"Neurosurgery under his leadership is one of the few specialties in PNG to produce annual written reports and make submissions for vital equipment all as part of Dr Kaptigau's dedication to advancing the specialty and improving patient care in PNG.

"His dedication and commitment to his work and his patients has shown PNG what a specialist neurosurgery service can achieve and what it can become, even in an environment of limited resources given that Dr Kaptigau didn't even have access to a CT scanner until 2008.

"He has saved many lives, particularly the lives of children suffering from hydrocephalus, has given 10 years of excellent service to the people of PNG and his audit data describes extremely impressive results across a range of procedures."

Dr Kaptigau completed medical school in 1987 and was later posted to Kimbe where he spent three of five years working as a medical superintendent.

Accepted for surgical training in 1995, he completed his MMed in 1999 with a thesis on the changing patterns of abdominal surgery in Port Moresby over 40 years.

Having chosen to pursue training in neurosurgery, Dr Kaptigau came to Australia in 2002 under the Rowan Nicks Scholarship and the International Scholarship and carried out his attachment at Townsville Tertiary Hospital under Mr Eric Guazzo and Mr Reno Rossato before moving to Melbourne to work under the supervision of Professor Rosenfeld. ▶

By the end of 2004, he had successfully completed his Higher Postgraduate Diploma in Neurosurgery at UPNG, becoming not only the first qualified neurosurgeon trained in PNG, but also the first in the South Pacific.

Mr Guazzo, who continues to work and teach at Townsville Tertiary Hospital, said he first met Dr Kaptigau during a College-managed Pacific Island visit to PNG in the late 1990s.

He said he was so impressed with his skills and dedication to his patients, he encouraged Dr Kaptigau to apply for a Rowan Nicks Scholarship and organised visiting rights to allow him to train and operate under supervision at Townsville Hospital.

During the year of his visit, Dr Kaptigau conducted outpatient consultations, operated under supervision and participated in ward work both at Townsville Hospital and the Mater Private hospital alongside Mr Guazzo.

While there, he participated in the treatment of 117 cases including spinal surgeries, tumour, skull fracture and VP shunt surgeries.

Mr Guazzo said Dr Kaptigau brought his wife Eimi, a senior nurse, and his children with him to Australia for the duration of his visit.

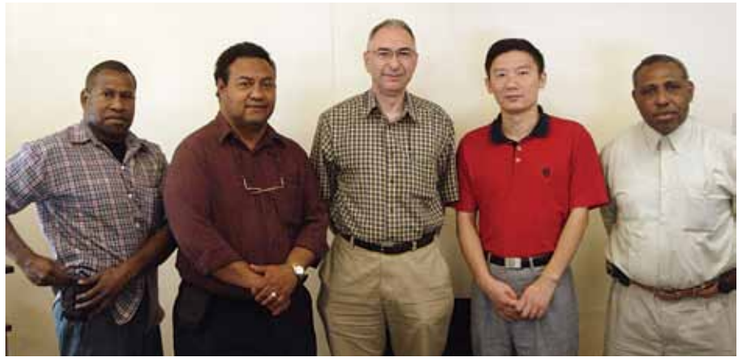
"When I met William I was very impressed by his devotion to the people of his country while it was clear he had remarkable capabilities," Mr Guazzo said.

"At the time he came to Townsville he was a very capable General Surgeon, but was determined to develop his skills in neurosurgery so we selected cases for him to work on that would advance that ambition.

"We included the management of trauma of both the head and the spine, infections of the central nervous system, tumour surgery and a variety of spinal procedures.

"It seemed a huge task to set up a neurosurgery service in PNG with all the economic and social challenges involved, but if anyone could do it, it was Dr Kaptigau not only because of his surgical skills, but because he is a champion for his country and a strong advocate for his people."

Mr Guazzo said he remained in contact with Dr Kaptigau following his return to PNG and often consulted on complex cases via email and telephone.



L-R: Mr Sammy Thomas (PNG's second trained neurosurgeon, now working in Madang Base Hospital), A/Prof Ikau Kevau (Head of Surgical Department, University of Papua New Guinea, and orthopaedic surgeon, Port Moresby General Hospital), Prof Jeff Rosenfeld OBE FRACS, Professor Xie Yan Feng (Visiting Chinese Neurosurgeon, now is based at Chong Qing Medical University Affiliated Hospital-China), Mr William Kaptigau MD, PNG's first neurosurgeon.

Dr Kaptigau was so highly regarded, Mr Guazzo said, that he was invited to attend the 2006 Annual Scientific Meeting of the Neurosurgical Society of Australasia.

He was the right person

In recent years, Dr Kaptigau has also selected patients with benign pathology for pro-bono neurosurgery by Mr Guazzo and others at the Mater Hospital.

Mr Guazzo congratulated him on achieving his Doctor of Medicine and said Dr Kaptigau was a wonderful example of the worth of the Rowan Nicks and International Scholarships.

"I've long been a great supporter of the RACS' commitment to promoting expertise in our geographical neighbourhood," he said.

"Dr Kaptigau is a perfect example of how we can help many people by selecting the right person and giving them the skills and support they need to do the work that needs to be done."

Professor Jeffrey Rosenfeld, Head of the Department of Surgery at Monash University and Director of the Department of Neurosurgery at the Alfred Hospital, helped Dr Kaptigau establish the neurosurgery service in 2004.

Having completed a six-month rotation in PNG when a Trainee at the Royal Melbourne Hospital, Professor Rosenfeld has been travelling back to PNG to teach and operate for more than 30 years and supervised Dr Kaptigau during his attachment to the Alfred in 2003.

Since then, he has helped develop a neurosurgery curriculum for the UPNG, acted as an examiner and worked closely with Dr Kaptigau to set up the audit which he used as the basis of the thesis.

"William set out to see whether neurosurgery patients treated in one dedicated unit led to improved results and to do this he collected and analysed the outcomes of 3626 patients over 10 years," Professor Rosenfeld said.

"His findings showed a dramatic improvement in head injury cases, better management of more complex patients and a reduction in complication rates.

"Both the results and the research represent an enormous achievement and the culmination of years of extraordinary effort to improve the health system and patient outcomes for the people of his country.

"David Watters and I wrote a book a few years ago called 'Neurosurgery in the Tropics' because we believed such a resource was needed for General Surgeons treating such cases in developing countries.

"Then William took up the challenge of becoming a neurosurgeon and without him there would be no neurosurgery service in PNG."

With Karen Murphy

> *It's good to know that the College thinks we are on the right track and also that this work is of interest to the wider clinical community*

HELPING OTHERS STAND TALL

Support from the College is crucial to continuing work of young research group

Research supported by the College is now underway at the Sydney Orthopaedic Research Institute (SORI) aimed at providing clinicians with a better understanding of knee function and structural integrity following surgery to repair multiple ligament knee injury (MLKI).

The Director of Research at the Institute, Dr Corey Scholes, was last year awarded the Brendan Dooley and Gordon Trinca Trauma Research Scholarship – one of the few scholarships offered by the College which is open to medical researchers working outside the field of surgery.

Dr Scholes said that while a great deal was known about the results of anterior cruciate ligament (ACL) reconstructive surgery, considerably less was known about whether surgical reconstruction could restore knee function to resemble that of uninjured knees and prevent cartilage degeneration following MLKI.

He said the majority of such injuries were caused by trauma such as motor vehicle accidents, sporting injuries or falls.

"Traumatic injuries to the knee involving multiple ligaments are less frequent than isolated injuries, but are often more serious and in some cases devastating to joint function with associated local vascular and neural disruption," Dr Scholes said.

"These types of injuries are complicated to repair and involve lengthy and costly rehabilitation and can involve long-term negative consequences for the patient with regards to loss of joint function and decreased quality of life.

"A recent survey revealed that despite the lower frequency of multiple ligament injuries, the mean financial cost per occurrence is highest for the knee when compared to all orthopaedic joint dislocations.

"We also know there is an increased incidence of knee osteoarthritis in these patients compared to the general population; however, there remains little data to help identify patients that may be at risk of rapid onset and development of degeneration as a result of MLKI," Dr Scholes said.

"We are therefore working to advance efforts to provide clinicians with an objective method to identify patients at risk of poor outcomes or accelerated knee degradation so that treatment plans can be individualised as required."

Working with patients recruited from the Institute's database, Dr Scholes is in the process of conducting a 'gait' study using facilities and equipment at the Biomechanics Laboratory, University of Sydney, comparing the knee kinematics of post-operative MLKI patients with matched controls while also using custom-designed software to map cartilage from MRI data.

He said the 'motion capture' study now underway, was only the second to be conducted on MLKI patients, according to a review of published English scientific papers, and that the team had discovered functional differences in knee kinematics never before reported.

"Knowledge about the long-term effects of MLKI is quite poor for a number of reasons," he said.

"This is due to the difficulty in obtaining pre-operative data because of the traumatic nature of the injury and also because most patients who suffer a MLKI are usually young, active and part of a mobile demographic that makes long-term follow up analysis difficult and because there are fewer patients overall to study.

"This means that while surgeons and scientists have long had a suspicion that these patients face an increased risk of developing osteoarthritis we don't know the percentage increase and we don't know which patients are most at risk."

Dr Scholes said the small gait study now underway – which examines knee angles during walking in three dimensions – had already revealed that MLKI patients demonstrated significant deficits in overground locomotion compared to healthy controls.

In particular, he said that patients with a combined bicruciate and medial injury stepped shorter and wider and also spent more time in double support, alterations which were associated with reduced confidence and altered joint loading.

"In addition, we also found significant differences in knee motion during gait," he said.

"We now believe that these inter-limb differences in knee angle during weight acceptance and the resulting abnormal knee kinematics will likely have implications for the long term health of the joint, including the possible development of osteoarthritis."

Dr Scholes also said new software had been designed at the Institute to measure the quality of the cartilage across the entire knee joint with researchers now analysing both the patient and control's cartilage for comparisons.

He said he expected to complete the mapping within the new few months, with his findings to be presented at the next meeting of the Australian Orthopaedic Association meeting in October.

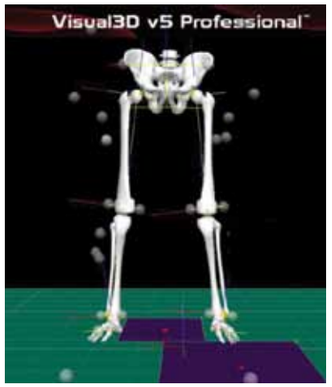
"Our future work will be the continuing exploration of the relationship between cartilage quality, injury patterns and functional tasks," he said.

The Sydney Orthopaedic Research Institute is a stand-alone not-for-profit organisation established by Dr David Parker and Dr Myles Coolican in 2003 with a mission to empower patients and clinicians with improved methods of diagnosis and treatment to restore knee function.

Dr Scholes has contributed to the multi-disciplinary team at SORI with a background in biomechanics. With surgical and engineering contributions, the team has presented papers on MLKI to the International Society of Arthroscopy and Knee Orthopaedic Surgery as well as to the Australian New Zealand Orthopaedic Research Society, the Australian Orthopaedic Association, the Australian Knee Society, the Surgical Research Society and the Mater Orthopaedic Research Meeting.

He said that while initial findings were encouraging, the small patient cohort and enormous variability in individual movement, patient confidence and quality of treatment following the initial trauma meant there was still much to be understood.

"There are a number of factors that come into play when you are ▶



AWARDS AND SCHOLARSHIPS achieved by Dr Corey Scholes

2013
Friends of the Mater Hospital Foundation: (2 projects)

2013
Brendan Dooley – Gordon Trinca Trauma Scholarship: Royal Australasian College of Surgeons.

2005 - 2008
Queensland University of Technology Vice-Chancellor's Blueprint Postgraduate Award.

2004
Queensland University of Technology Faculty of Health Honours Research Scholarship.

IN MEMORIAM

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

David Rogers,
New Zealand Fellow
Denis Campbell,
Queensland Fellow
Ian MacIsaac,
Victorian Fellow
Alfred Lewis,
NSW Fellow
John Maloney,
NSW Fellow
Richard Fletcher,
Victorian Fellow
Arthur R. Waterhouse,
Victorian Fellow
Raymond Carroll,
NSW Fellow
Thomas A. Parsons,
Queensland Fellow
Thomas Stack,
WA Fellow
John Collibee,
WA Fellow

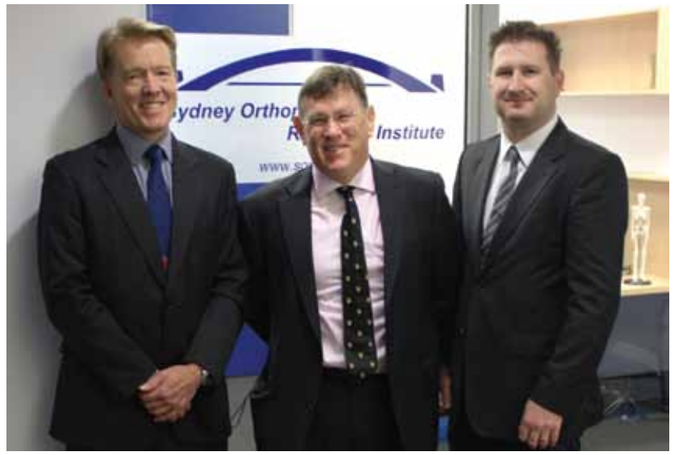
We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org** go to the Fellows page and click on In Memoriam.

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: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Meryl.Altree@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

SUCCESSFUL SCHOLAR



SORI Directors: Dr David Parker, Dr Myles Coolican and Dr Brett Fritsch

looking at longer-term functional outcomes following treatment for MLKIs such as the injury itself, the nature of the surgery, the character of the patient and the rehabilitation," he said.

"Then when you add to these factors the enormous variability in how people move and individual anatomy, the variables can seem infinite.

"There is still some uncertainty even in regard to the long-term results and optimal approaches to ACL surgery and we're far behind in our understanding of MLKI so the definitive links between outcome, treatment and long-term function will probably only be solved through multi-centre research.

"Still we are working toward giving clinicians a better understanding of the response to treatment through understanding both what is driving abnormal post-operative knee function and movement, and also trying to determine the risk factors specific to MLKI associated with knee degeneration.

"If we understand those, surgeons could be in a better position to adjust or refine surgical techniques or identify patients with a poor prognosis after surgery so they are more swiftly provided with longer term treatment plans such as physiotherapy or pain management therapy."

With up to eight researchers working alongside him, depending on funding available, Dr Scholes said he was delighted to have won the support of the College for the work being conducted at the Institute.

"As a relatively young organisation, receiving this scholarship felt like a big pat on the back for us in terms of the research we are conducting and how we are going about it," he said.

"It's good to know that the College thinks we are on the right track and also that this work is of interest to the wider clinical community."

Dr Scholes said he would like to acknowledge funding from the Sydney Orthopaedic Research Institute as well as the input and effort of colleagues and collaborators that have assisted with the project and grant-seeking particularly Amy Brierley, Joe Lynch, Dr Joe Costa, Laurant Kang, Jack Batchen, Milad Ebrahimi, Dr Brett Fritsch, Dr Myles Coolican, Dr David Parker and Prof Qing Li (University of Sydney).

He also thanked Professor Richard Smith and Mr Ray Patton (Biomechanics Laboratory, University of Sydney) for their assistance with access to the laboratory and its equipment.

With Karen Murphy

EXTENDED OPPORTUNITIES

Research & Scholarships

Due to availability of funding the College is pleased to be able to readvertise the following:

Hugh Johnston ANZ ACS Travelling Fellowship

The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship has been established to support an Australian or New Zealand Fellow of the College to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2015, which is to be held in Washington DC, USA. It forms part of a bi-lateral exchange with the ACS and is open to Fellows who have gained their College Fellowship in the past 10 years (2004 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America. While there, they must:

- Attend and participate in the American College of Surgeons Annual Clinical Congress in 2015
- Participate in the formal convocation ceremony of that congress
- Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

For further information, email: scholarships@surgeons.org

Applicants must not have commenced their travels prior to the closing date for applications.

This Fellowship is valued at AU$8,000.

Brendan Dooley & Gordon Trinca Trauma Research Scholarship

Open to Fellows, SET Trainees and Medical Scientists who are conducting a research topic relating to the prevention and treatment of trauma injuries in Australia and New Zealand.

For any other queries, please contact the Scholarship Program Coordinator,
Royal Australasian College of Surgeons,
199 Ward Street, North Adelaide SA 5006.
Tel: +61 8 8219 0999,
Email: scholarships@surgeons.org.

Applications close midnight CST midnight Monday 13 October 2014

This scholarship offers a stipend of AU$10,000 with a 12 month tenure.

FEAST OF ACADEMIC EVENTS

Academic surgery involves and has something to offer every Fellow and Trainee – and there's lots happening

RICHARD HANNEY

This year, the November academic meetings of the Academic Section and the Surgical Research Society of Australasia take place in Adelaide on Thursday, November 13 and Friday, November 14. The Academy of Surgical Educators is hosting a dinner forum on the Thursday evening, further enriching an intellect-packed two day cornucopia.

For the Thursday morning, Andrew Hill has once more put together an impact-rich program for those committed to a fulltime academic career. The course is planned to assist with career direction by guidance from those with proven success and track records. Academic promotion, raising one's international prominence, the value of higher degrees and involvement with the College will all be addressed. Associate Professor Taylor Riall, a proven outcomes researcher from the University of Texas in Galveston and visiting from the Society of University Surgeons, will speak on 'Emerging Trends in Surgical Research'.

James Lee has arranged three workshops to be conducted concurrently on the Thursday afternoon. The goal of these is to provide guidance for ongoing direction of your Section and academic surgery as currently practised.

All heads of Surgical Departments have been invited, and all interested Fellows and Trainees are welcome. John Windsor and Jonty Karpelowsky will chair 'Research requirements during training'; Alan Saunder and Stan Sidhu will chair 'Research funding and the College', while Guy Maddern and Julian Smith will chair 'Academic Career Pathways'.

This last session may have some very interesting light to shed on a challenging area, with a full day meeting of key international stakeholders to address this issue being scheduled the day before.

Julian Smith and Stephen Tobin will host the Academy dinner forum in Glenelg on Thursday evening, addressing the theme of 'Professionalism in training and practice: opportunities and obligations'. Last year's forum was engaging and interactive, with dynamic discussion during a terrific meal.

Leigh Delbridge will convene the 51st annual Surgical Research Society meeting on Friday, with national and international travel grants and awards on offer to the most successful presenters. This prestigious meeting showcases research work from some of Australasia's finest young surgeon scientists, and the attending senior academic surgeons have been increasingly delighted by the ability and enthusiasm on show.

Marc Gladman's Department of Surgery at Concord last year presented six papers and poster presentations, including the Young Investigator Award winner,who will attend the Academic Surgical Congress in Las Vegas next February.

In recent years, the SRS meetings have been highlighted by an increasing involvement from junior doctors and medical students, further broadening the academic church. Details regarding abstract submission are available from academic.surgery@surgeons.org with the closing date for submissions this year being September 22.

Professor Riall will again speak, this time on 'Pancreatic Cancer: Translation of Outcomes Research into Practice'. Associate Professor George Chang, from the MD Anderson Cancer Centre, will present his paper (of which the abstract was the highest scored of nearly 2000): 'Risk-adjusted Pathologic Margin Positivity Rate as a Quality Indicator in Rectal Cancer Surgery'.

COVIDIEN

Thanks to generous support from Foundation Academic Sponsors Covidien, these two full days of quality science and interaction will cost you a grand total of $160 for ASE members, $180 total cost for non-members. Join us, bring your families and enjoy the beautiful wine regions of Adelaide on the weekend.

Royal Australasian College of Surgeons
Annual Academic Meetings
November 13 and 14 Adelaide 2014

Academic Surgery Mid-career Course

Thursday 13 November - morning
Basil Hetzel Institute Woodville SA
Professor Andrew Hill - Convener

Visiting Speaker
Associate Professor Taylor Riall, University of Texas
"Emerging Trends in Surgical Research"

Professor John Windsor 'Success in Academic Surgery'
Professor Guy Maddern 'Academics and the College'
Professor Marc Gladman 'The Triple/Quadruple Threat'
Professor Andrew Hill 'Higher Degree vs No Higher Degree'
Professor Leigh Delbridge 'Making an International Impact'
Mr Richard Hanney 'The Section of Academic Surgery'

Section of Academic Surgery Heads of Departments meeting
(with interested others)

Thursday 13 November - afternoon
Basil Hetzel Institute Woodville SA

'Research, the College & the Section of Academic Surgery'
Mr Richard Hanney - Chair Section of Academic Surgery

Workshop Topics
Research Requirements During Surgical Training
Research Funding from the RACS
Academic Career Pathways

COVIDIEN

Academy of Surgical Educators' Forum Dinner

Thursday 13 November, 7-10 pm
Stamford Grand Hotel, Glenelg
'Professionalism in Training and Practice: Opportunities and Obligations'

Presenters
Associate Professor Alison Jones
Associate Professor David Hillis
Convenors
Associate Professor Stephen Tobin
Professor Julian Smith

Surgical Research Society of Australasia Annual Scientific Meeting

Friday 14 November
Basil Hetzel Institute Woodville SA
Professor Leigh Delbridge

Jepson Lecturer
Professor Julian Smith

International Visitors
Associate Professor George Chang, MD Anderson Cancer Center
Associate Professor Taylor Riall, University of Texas

Enquiries to academic.surgery@surgeons.org or by calling: 08 82190900

SERVING THE NEEDY

Left: Wisam Ihsheish works on internal fixation on a 40-year-old man. after a trauma accident in Kundunz Trauma Centre. February 2013. Copyright: Camille Gillardeau/MSF. Above: Afghani patients waiting at medical centre. Copyright: Mikhail Galustov.

It was a sense of giving back to populations in need, while also taking on the challenge of surgical care in resource poor settings, that drove Canberra-based surgeon, Dr Wisam Ihsheish, to work for the medical humanitarian aid organisation Médecins Sans Frontières (Doctors Without Borders)

Since joining Médecins Sans Frontières in 2012, Dr Ihsheish has been on two assignments. The first was to Southern Nigeria where he worked as an orthopaedic surgeon at the organisation's trauma program in a private hospital in Port Harcourt. Political tensions in the oil-rich Niger Delta region had led to an increasing need for emergency surgery, with the team carrying out 9,000 emergency consultations and treating 500 victims of sexual violence in the year of 2012.

In 2013, Dr Ihsheish went on his second field assignment, this time to Kunduz in northern Afghanistan. Here Dr Ihsheish worked in the trauma centre developed by Médecins Sans Frontières, which provides free, specialised surgical care to victims of general trauma and people with conflict-related injuries, such as injuries sustained from bomb blasts, shrapnel, and gunshot wounds. Before the hospital opened, most people with life-threatening injuries had to travel to the capital, Kabul, or to Pakistan for treatment. Over 2013, surgeons carried out 4,500 surgical procedures.

Why did you decide to work with an international medical aid organisation?

Surgery is a very rewarding and varied career, and adding a regular stint with aid organisations adds to the interesting nature of the work. Working in areas, hit hard by man-made or natural disasters, with needy populations allows us to contribute our skills and resources to these populations that are often unfortunate merely by virtue of their place of birth or ethnic background.

My personal interest in contributing to this type of work has stemmed from personal and professional reasons. Having grown up for the first years of my life in a region where I experienced first-hand the benefits these organisations give to needy populations brought about the impetus to give back in appreciation for what I once received. From a professional viewpoint, this type of work exposes one to rare and challenging scenarios, such as classic surgical presentations, high level trauma, and managing health care in settings with language and cultural variations, all with limited resources.

You spent six weeks working in Port Harcourt, Nigeria, in 2012. What did your role involve?

I worked in a trauma hospital in Southern Nigeria as one of two orthopaedic surgeons. The role entailed managing trauma cases from start to finish. This including initial assessments/triage, assignment of theatre time and resources, surgery, care on the wards and a post-operative clinic.

Although we had a general surgeon working with our team, there were no other specialist surgical or medical services available. The hospital had been established at a time when civil unrest existed, and although this has now changed, the population had no ready access to government trauma facilities.

More recently you were in Afghanistan. Could you describe the project you were working on?

The situation in Afghanistan is tragic for the general population; the context of course is that the country has been at war for several decades now. The most obvious effect is that the local population has had its progress severely retarded, with health care provision being hit particularly hard. Although there are some medical services available in the bigger cities, the vast size of the country and the extreme poverty puts these services out of reach of most.

The hospital was established in a historic building that had been built by the Soviets decades ago. Médecins Sans Frontières, as with other groups, utilises services of a great number of professionals, including architects, labourers and logisticians, to bring these projects to life. It was a pleasure to be involved in the ongoing process of getting this project up and running.

Our cases were mostly acute trauma, and although our policy was not to delve into how people acquired their injuries, it was quite evident that most were innocent civilians with no connection to any group.

As well as trauma, we saw a good number of neglected orthopaedic conditions. Some had been neglected because of the vast distance patients had to walk to get to a clinic, or the war situation, or the local preference to seek treatment from 'traditional' healers before seeking out the western doctors. It was fascinating to encounter and manage many classic orthopaedic conditions one often only reads about during our training.

What did your role involve?

The hospital is set up and managed by a Belgian arm of Médecins Sans Frontières; it is in the northern city of Kunduz. Our intake was limited mainly to trauma cases, approximately two thirds of these were orthopaedic trauma. I worked alongside two general surgeons and an anaesthetist, from Italy, Mexico, and Russia respectively.

The hospital had been set up only in recent years, and our role was in primary and ongoing management of trauma and neglected orthopaedic conditions, as ▶

well as input into managing the limited resources of the hospital. We had a keen number of locally trained Afghan doctors, nurses, and physiotherapists. A very important role in the hospital included setting up a program to pass on surgical skills and theoretical knowledge to allow them to take over once we had left.

What does it take to go into the field in an area such as this?

The skills, knowledge and motivation needed to help and endure in areas of suffering – whether they are man-made or natural disasters – I believe are possessed by most doctors. The biggest hurdle is the apprehension about personal safety in such regions.

It is fair to say that there is risk involved; however, it must be said that the populations are hugely appreciative of the care we provide them and the fact that it imposes no further financial burden on them. We built a great rapport with the local professionals and populations, and I felt safe and well regarded throughout our time there. The challenge in working long hours with often very tragic cases was well rewarded by the positive results that were borne out.

Did any patients make a particular impact on you?

The cases come thick and fast, so to speak, and most are very tragic innocent stories. One has no time to dwell on any one case. My overwhelming thoughts throughout my work were of how terrible war and its weapons are, and how fortunate we are to live in a stable society here in Australia.

How does being a surgeon in a war torn country differ from working in Australia?

The work in the field is varied in that it allows you to view 'text book' orthopaedic conditions and manage them, while also being confronted with a high number of severe and high energy war trauma, all with very limited resources. You often have to call on the basic general medical and surgical principles that you have learnt back in medical school or junior training years.

L-R: Dr Wisam Ihsheish (second from left) with fellow aid workers from Afghanistan, Belgium, and Brazil. Taken during the morning ward round at Médecins Sans Frontières Trauma Hospital, Kunduz, Afghanistan.

Our resources were limited in man-power, equipment, medicines and space available to care for these patients. There was also the lack of availability of other specialists to help deal with complex medical and surgical presentations.

The other major difference is you always have to take into account the cultural, religious, or language differences that inevitably exist in all these settings.

Did it make you a better surgeon working in conflict ridden and resource poor settings?

Undoubtedly so. The surgical, interpersonal and management skills are constantly called upon and tailored. The physical and emotional endurance you develop is also a big advantage.

All of these are a big asset when working in any demanding situation back home.

Do you have any advice for other surgeons considering work with an international medical aid organisation?

I was proud to see a number of Australians working for aid organisations in my travels, especially given our relatively small population. This work is not financially rewarding, and entails spending time away from comfortable settings at home, but is very rewarding professionally and certainly highly needed and appreciated in less fortunate areas. I would encourage my colleagues to look into it if their circumstances permit.

Where next?

I have a young family and a new practice in Canberra and Goulburn, both very exciting. I hope to continue to contribute to third world health in my capacity as a surgeon also on a regular basis.

Every year, Médecins Sans Frontières' surgeons perform more than 75,000 major surgical procedures. Surgeons working with Médecins Sans Frontières support independent surgical and medical care to people affected by conflicts, natural disasters or healthcare exclusion. Your skills and experience can support this important work. Learn more about the rewarding experience of working as a surgeon with Médecins Sans Frontières at **www.msf.org.au/join-our-team**

IT IS ALL ABOUT THE FALLS…!

'A wound, a hurt, a defeat' define the Greek origins of the word trauma.

JOHN NORTH
QASM CLINICAL DIRECTOR

Often a patient's trauma leads to death, and this is confirmed in a large proportion of surgical mortality audit data.

Since 2011, the Queensland Audit of Surgical Mortality (QASM) has been collecting trauma data and investigating its relationship to surgically-related death. In doing so, QASM asks the following questions: Was trauma involved in this surgical death? Was the trauma the result of a fall? Was the trauma the result of a road traffic accident? Was the trauma the result of violence?

Since 2011, QASM has audited 2,275 cases and 30 per cent (n=683) are trauma cases. Therefore, trauma occurs in significant numbers in surgical patients who die.

Of the 683 trauma cases:

- 80 per cent are related to falls
- 15 per cent are related to road traffic accidents
- 5 per cent are related to violence

When investigating the 683 trauma cases, the following was revealed:

- median age was 82 years (*IQR 65-88).
- 491 patients had surgical procedures
- 56 per cent were related to orthopaedic injuries and needed surgical intervention

Of all the trauma cases that led to death, 70 per cent had an operation.

Of all the non-trauma cases that led to death, 80 per cent had an operation.

When reviewing trauma data and age groups, the following was revealed:

- For patients under 66 years (n=152), who had an operation, neurosurgery was required in 50 per cent of cases.
- For patients between 65 and 80 years (n=122), who had an operation, orthopaedic surgery was required in 50 per cent of cases and neurosurgery in 30 per cent of cases.
- For patients over 80 years (n=331), who had an operation, the numbers substantially increase and 75 per cent required an orthopaedic procedure.

Therefore, as a trauma patient's age increases, the need for orthopaedic surgical intervention increases and the need for neurosurgical intervention decreases.

When reviewing trauma data and falls, specifically, the following was revealed:

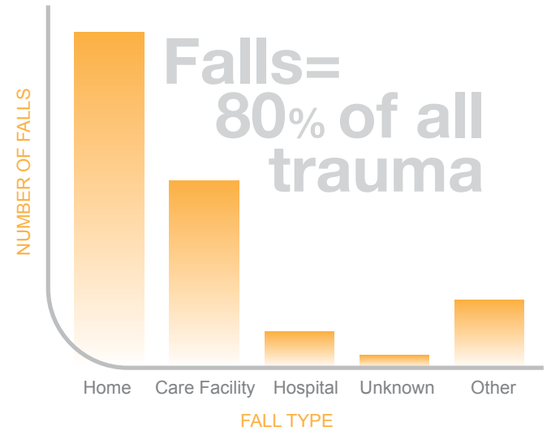
- the majority (81 per cent) of falls occur at home or in a care facility
- a minority (7 per cent) of falls occur in hospital

If we consider then that 88 per cent of fall-related trauma occurred in homes, care facilities, and hospitals, then we, as surgeons, need to be more proactive in promoting falls-prevention programs (particularly in the older age groups).

The surgical care is costly for patients who suffer trauma as a consequence of a fall at home or in a care facility or in a hospital. Preventing the falls may be the best option for both the patient and the care provider.

With this QASM data in mind, surgeons can consider all opportunities to reduce the fall-related surgical load.

We must reduce the burden on health care and surgical care by reducing fall-related injuries (particularly in the older age groups).



*IQR (interquartile range) shows the middle 50 per cent of data – it does not include extremes.
"Other" includes falls at workplace, in streets, on stairs, on farms, in shopping centres, in parks etc.

DOCTOR's HANDWRITING:

Age-old typecasting or cause for concern?

MR GLENN MCCULLOCH
CLINICAL DIRECTOR, SAAPM

We've all heard the old adage about doctors having terrible handwriting, but is it true? A quick online search has revealed a wealth of publications on the issue. Some argue that doctors' handwriting is no better or worse than that of any other profession,[1,2] while others suggest that not only does this stereotype have basis in fact, but that it is a serious quality and safety issue which can lead to delays or errors in treatment, and leave doctors potentially vulnerable to litigation.[3,4,5]

THE SAAPM EXPERIENCE
Surgical case forms

The South Australian Audit of Perioperative Mortality (SAAPM) is one of the state-based audits within the Australian and New Zealand Audit of Surgical Mortality (ANZASM).

The audit process begins when the SAAPM office is notified of the death of a patient who was under the care of a surgeon in a participating hospital.

When the consultant surgeon provides a completed surgical case form regarding the death to the SAAPM office, it is de-identified and then assessed by a first-line assessor. The first-line assessor will either close the case or advise that the case undergo further analysis, i.e. a 'second-line assessment' (case note review).

Surgical case forms and first-line assessments can either be handwritten, or completed online using the Fellows Interface. In 2013, 54 per cent of surgeons elected to complete the forms by hand. While SAAPM is very grateful for the time and effort of surgeons in completing and returning the forms, a significant amount of time is spent deciphering the handwriting in these cases. Of course, not all cases present a challenge in cryptography; some surgeons write with beautiful script that is a pleasure to read. In our experience, however, this is unfortunately a minority. Some less favourable examples are provided below.

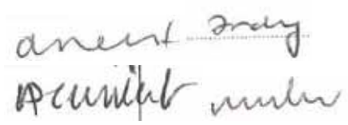


Figure 1: Handwriting excerpts from SAAPM Surgical Case Forms

Case notes

Once data from a Surgical Case Form is entered into the database, a typed form can then be printed, eliminating the issue of legibility for first-line assessors. However, cases that are progressed to second-line assessment require a review of the entire medical record. Feedback suggests that assessors also experience frustration with their colleagues' handwriting. A recent SAAPM survey returned the following comments from our assessors:

- "Legibility of doctors notes in hospital case notes still very poor and signatures not accompanied by printed names."
- "Audit of doctors handwriting and comments in audit would be wise and photocopies of examples where handwriting poor."
- "Reading other reports as an assessor, I am often disappointed that a junior person writes the report rather than the treating surgeon. Particularly if done in 'longhand', the reports can be un-readable or even misleading. Much room for improvement here!"

Poor handwriting in medical records is a serious concern. In addition to being time-consuming to decipher, misinterpretation of notes and instructions can lead to delays or errors in patient management. At the level of the audit it may lead to a less comprehensive or unfavourable assessment of the case. As most notes are handwritten, the only solution at present is increased mindfulness when writing in the case notes. Looking forward, technology may provide a solution. A study published in the International Journal of Surgery describing the implementation of electronic operation notes demonstrated a marked improvement in the quality of the documentation.[6]

Conclusion

Factors contributing to doctors' poor handwriting include significant time pressures and a substantial amount of paperwork. However, our feedback together with other research suggests that the issue requires greater attention to avoid the potential pitfalls of poor documentation. Regarding audit forms, the simplest solution is the use of the Fellows Interface allowing surgeons to complete and submit surgical case forms and first-line assessments online. The Fellows Interface requires only an internet connection and a username and password (supplied by the SAAPM office). The system is convenient, decreases turnaround time and reduces paperwork. Alternatively, typing reports or dictating them to a secretary removes the issue of legibility. Where typing is not possible, taking care to write clearly and legibly using only widely known abbreviations is important. Writing in print rather than cursive and using block letters can increase readability.

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TWENTY YEARS OF SERVICE FOR HANGZHOU HOSPITAL

The Sir Run Run Shaw Hospital, in the picturesque East China city of Hangzhou, celebrated its twentieth anniversary in April, this year. The College was represented by members from Project China

The Sir Run Run Shaw Hospital is a remarkable 2000 bed hospital in the east side of Hangzhou, a city of seven million people. It is affiliated to the Medical School of the Zhejiang University (Zhejiang is the Province south of Shanghai). It is remarkable because a substantial portion of its capital cost was donated by a philanthropist from Hong Kong, Sir Run Run Shaw, hence its name. From its opening in 1994, it was nurtured by the Loma Linda University of California, a well-known institution of the Seven Day Adventist Church.

In recent years the hospital was led by the immediate past-president Dr He Chao. He is a charismatic and dynamic figure who has galvanised the staff into an enthusiastic and diligent work force. Furthermore, most of the doctors, the nurses and the administration possess a very good standard of English, probably because of the American influence. Energetic and devoted, they are proud of their institution and run the hospital to a high degree of efficiency. From 2006, the Sir Run Run Shaw Hospital has earned three awards of the Joint Commission International (JCI) certificate for quality healthcare (the JCI is an American system of grading the performance in healthcare of hospitals).

Since 2004, Project China has brought a number of colleagues from the Sir Run Run Shaw Hospital to Australia to attend trauma courses, hospital administration and plastic surgery refresher programs together with other activities. Australian colleagues of various specialties have also participated in conferences there and others have spent time in the hospital sharing their experience with the Chinese surgeons.

These exchange programs have been made possible by the frequent visits of Gordon Low and his wife Rosie to Hangzhou, and have stimulated other colleagues to emulate their efforts. Alex Konstantatos, an anaesthetist at the Alfred Hospital, Melbourne, has made yearly visits to Hangzhou for the past eight years to conduct Pain Management and Peri-operative Courses. John Reeves, the Director of Intensive Care at the Cabrini Hospital, Melbourne, has conducted programs to enhance the efficiency of their Intensive Care Department.

At the anniversary celebrations, a statue of the late Sir Run Run Shaw was unveiled in the presence of Lady Mona Shaw. All the guests were invited to tour the Xiasha Hospital, a 1200 bed sister hospital opened a year ago and managed by the same administration. As well, some of the guests were presented with exquisite glass vases for 'Distinguished Service' to the hospital. We wish to thank President Cai Xiujun and the hospital for their kindness and generosity and, above all, for their trust and friendship.

With Alex Konstantatos, John Reeves and Gordon and Rosie Low

Opus XXXIV

FELIX BEHAN
VICTORIAN FELLOW

BUTTONS & SURGICAL BOWS

A protean perspective

In this, another letter from Spring Street, I note the feature of Curmudgeon's Corner in Surgical News is always stimulating. Originally I had to use the OECD to find this meaning (churlish or miserly), but it is really a collection of cantankerous idiosyncrasies – of a bad tempered old man.

This is a 16th century word. Incidentally the composer Wolf Ferrari wrote a comic opera in the 1900s called the 'Four Curmudgeons', but he was more famous for his piece 'The Jewels of the Madonna'.

In his diatribe in the June 2014 issue, I find Professor Grumpy is bugged by buttons, on tailored shirts, spare parts hidden under contour shapes and missing from the cuffs. He did not mention French cuffs (the Francos call them folded cuffs) nor cufflinks, which mirror our dress style.

This brings me to a little pearly vignette about Don Hossack, a man of artistic background who loved to drive a yellow Silver Dawn (Benny Rank drove the same model in black).

Don was a surgeon at Prince Henry's in the 1980s who sometimes wore a bowtie (now almost an edict from Infection Control Departments). He was also the Victorian State Police Surgeon. One evening going to an emergency at Prince Henry's and while driving along the St Kilda stretch, he was surprisingly intercepted at the red light intersection by a street courtesan.

The appeal of the car must have been irresistible to her. She was en grande tenue, yet a little deshabillé if not risqué – she opened the front door of the Rolla and positioned herself next to him, obviously with professional intent. Don's immediate response – while still stationed at the red light – was that he just showed her his Police Association cufflinks and made one remark, "You understand I am the Victorian State Police Surgeon." Without hesitation she retreated back into the shadows of the night.

In London, one of the buttons of my reefer jacket became detached and here is the genesis of another story. I needed a 3.0 silk on a Keith needle which was only available from the thoracic department stores and the sister-in-charge had the key to the stock cupboard.

Incidentally not many would know the thoracic surgeon in charge at the Westminster then was Sir Clement Price Thomas, who had performed the pneumonectomy on George VI on 23 September, 1951. The whole theatre contingent had moved en masse to Buckingham Palace for the procedure. Even the theatre table was given an honorary brass plaque. Incidentally the King had an attitude of knighting his surgeons during their post-operative visits.

I heard this knightly experience from Sir James Patterson Ross when entertaining me at dinner (incidentally he loved Aussies). He did a sympathectomy with James Learmonth on the King in 1949. He recounted during the post-op visit, the King asked him to kneel on the cushion and with a ceremonial sword (presumably a Wilkinson), knighted him on the spot, as must have happened to Sir Clement Price Thomas.

Royal talk

Here's another story of knightage: when Benny Rank came to London to receive his knighthood in October 1973, I was his aide-de-camp and I had organised his accommodation at the College for that weekly stay with Lady Rank. The ceremony occurred at Buckingham Palace that afternoon and that evening Benny, in a contemplative phase, reminiscing about his surgical career, told me his conversation with the Queen: which I repeat.

He recalled the Queen's comments that afternoon, "So Sir Benjamin, I see you are a doctor?" His response quite self-assuredly was, "No Ma'am, I am a surgeon." He even asked me about my future plans in surgery in London and subsequently invited me back to work in Melbourne. My hesitation initially was crystallised into a positive response when he said to me quite openly, "If you don't come back now son, forget Melbourne!"

Don Marshall told me about Price Thomas when he edited these recollections. He recounted the story of John (Sister, give me what I want not, what I asked for) Hayward. He was a cardiothoracic surgeon from RMH who worked with Sir Clement Price Thomas in London. On his return to Melbourne one of his registrars in training was late for one of the theatre sessions and John reprimandingly said to this young Trainee, "When I was working with the great Sir Clement Thomas Price in London, I would never have dreamed of being late." The young Trainee – sotto voce – is reported to have responded by saying, "And when you get your knighthood, Sir, I will give you the same courtesy." Don knows his name.

Silk thread

Now back to my 3.0 silk and my loose button on my Saville Row jacket.

I managed to get the special needle from the theatre sister who could only be described as exclusivity personified, and did the repairs. Initially my attempt was successful, but needless to say it fell off again. After another try, I went and sought the help of a specialist, taking it to a tailor in Pimlico who diagnosed that the cutting edge needle was the culprit. This is how we learn. It is a good surgical principle that if you fail twice, get another opinion – and I learnt this trick early in my surgical career which has stood me in good stead since.

Surgically I keep modifying what I am taught and in the creative phase of my career – doing mattress sutures on almost every theatre list for over 50 years. I learned to lock a mattress by inserting the needle through the loose loop of the mattress which locked the tissue into perfect eversion – simplicity personified. I use this trick to repair my own socks (being basically parsimonious). I do note that Professor Grumpy's wife rejected his requests for haberdashery help, like my French wife told me to caisse toi.

Zips and Velcro (Velours velvet, and crochet hook en Francaise) are mentioned in the Grumpy article. The Velcro principle was established by George de Mestral from the Swiss Alps, having found micro hooks on the native seeds after walking his dog. Human hairs have the same micro hooks, which are important in the pathogenesis of pilonidal sinus.

Now the curmudgeon's story gets even better. The reference to the zip intrigued me. The word has its origin from the onomatopoeic element of the sound echoing the sense for the ascending and descending phase, fastening or unfastening. The idea was patented by a Californian engineer called Whitcombe Judson. When I phoned Rodney Judson, Director of Surgery at RMH about this nominal association, he was ▶

unaware of the link and a little taken back. But his response was quite amusing when he said, "Felix, if you suddenly find the Judsons have bought a flat in Paris, you will know we have collected some untapped royalties, but I am not holding my breath."

Buttons and Hand Surgery warrant a place in this story – Benny Rank – the Australian facile princeps was the first president of the Australian Hand Surgery Society involving plastic and orthopaedic surgeons. John Hanrahan, later PRACS, initiated my membership to the Society in the 1980s. Benny showed us the technique at the VPSU, of reattaching the long flexor over a subungual button for a zone 1 division of the FDP. I also did something similar in my long flexor tendon repairs in zones 2 and 3, no man's land – using the Kessler and paratenon appositional repairs, thread the loose ends of the 3.0 nylon up the lumen of a 20 gauge lumbar puncture needle and tie it over a subungual button at the pulp cord down the tendon. Thus one can test patency of movement with confidence.

I presented this technique (level 4/5 evidence) at the Australian Hand Surgery Society meeting in Cairns in the late '90s.

Incidentally that was the last time I went marlin fishing with the late Bill Wilson. Over four (with four XXXX) hours we enjoyed the buoyancy of each other's company, the buoyancy of the boat in those placid reef conditions and Bill's repetitive stories of the world figure associates (Rex Harrison and Jean Renoir, to name a few). And yes, the magnificent marlin eluded these city slickers.

In conclusion I congratulate Professor Grumpy for his efforts, but like retiring academics a cliché is often quoted – how they regret losing their faculties. So keep publishing sir, and the weeds won't grow under the gate – an Irish metaphor my grandmother taught me.

DOCTORS AFFECTED BY BLOOD BORNE VIRUSES

New guidelines for special case doctor management

MICHAEL GORTON
COLLEGE SOLICITOR

The Medical Board of Australia, through AHPRA, is currently consulting on new guidelines to regulate the management of doctors who are infected with blood-borne viruses.

For members of the public, this will be a sensitive and controversial area, where a great deal of understanding and education may be necessary.

It raises significant issues of patient safety, balanced by issues of discrimination.

The guidelines are timely, given the recent case settled in Victoria involving an anaesthetist who infected female patients with Hepatitis C. The doctor was convicted of a criminal offence and a large class action arising, was settled in favour of the patients. As a matter of principle, there is nothing wrong with doctors with some impairment or condition continuing to practice, so long as patient safety is protected. The same principle applies in relation to doctors infected with blood-borne viruses, who are clearly able to practice and treat patients without risk of infection, so long as appropriate safety measures are taken.

The draft guidelines recognise the many views of stakeholders and the public in relation to these issues. The draft guidelines include the following general principles:-

- Doctors have a responsibility to prevent transmission to patients.
- Doctors should comply with the general safety guidelines issued by the Communicable Diseases Network of Australia (CDNA), as the current benchmark for science and clinical practice in this area.
- Doctors have a responsibility to know their blood-borne virus status, and particularly be tested following any sharps injury or potential exposure.
- Doctors can continue to practice, when infected with a blood-borne virus, so long as they practice safely and comply with CDNA guidelines. However, their blood-borne virus status may require a limitation of scope of practice, where issues of patient safety are involved.
- A doctor who is infected should be under regular care of an appropriate specialist doctor, relevant to their blood-borne virus status (If the doctor does not comply with the treating doctor's advice, mandatory reporting may be initiated).

- If an infected doctor is fully compliant with CDNA guidelines, there is no requirement to notify the Medical Board of Australia, and a treating physician of the infected doctor is under no obligation to report.

Employers and contractors dealing with infected doctors must do so in a non-discriminatory way, under general anti-discrimination legislation. Accordingly, treating an infected doctor differently could give rise to a claim under anti-discrimination law, unless patient safety or other health risks arise.

The guidelines do not deal with circumstances in which an infected doctor may be required to advise or warn patients, but if doctors are practising safely, in accordance with CDNA guidelines, and there is no risk to the patient, then obviously there may be no legal obligation to inform a patient of the doctor's health status.

Information regarding the draft guidelines, and the consultation process, which all members of the public can comment on are available on the AHPRA website.

Awarded at the 2014 Singapore Annual Scientific Congress

CONGRATULATIONS on your achievements

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

PROFESSOR ANDREW HILL FRACS 2014 John Mitchell Crouch Fellow

Professor Andrew Hill completed an MD in Surgery from the University of Auckland in 1996 and a Doctorate in Education in 2011. Following a research fellowship at Harvard University in 1993 and 1994, Andrew completed surgical training in 1997 and worked in Kenya as a medical missionary. Andrew returned to the South Auckland Clinical School at Middlemore Hospital in 2002 where he now practices as a Colorectal Surgeon and is the Head of the South Auckland Clinical School. He has received extensive research funding from the University and from External Sources and has used this to develop a significant research portfolio.

His research interests are improving outcomes from major abdominal surgery and medical education and he has published over 150 peer-reviewed papers in these areas. Andrew leads the New Zealand and Australia Enhanced Recovery after Surgery (NZERAS) group, an interdisciplinary research group aiming to improve patient outcomes after major surgery. This group runs a once yearly international symposium on enhancing recovery.

The John Mitchell Crouch Research Scholarship will be used to further research into improving outcomes from colorectal surgery.

Established in 2000, the RACS Excellence in Surgical Research Award is an honour created to recognise the contribution of a pre-eminent surgeon scientist who has made significant contributions to surgical research.

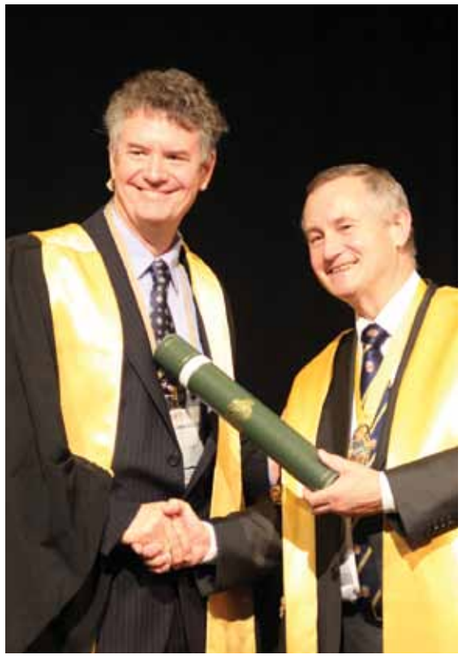
PROFESSOR DAMIEN BOLTON FRACS Excellence in Surgical Research Award

Damien Bolton completed training in Urology through the Royal Australasian College of Surgeons in 1993, after having additionally undertaken a period of RACS-scholarship funded research leading to the degree of Doctor of Medicine through the University of Melbourne. Thereafter he commenced a clinical fellowship at the University of California San Francisco, and extending his tenure there for a further period as an Assistant Professor of Surgery.

Shortly after returning to Melbourne he was appointed Director of Urology at the Austin Hospital where he initiated a urologic research Fellowship program with twin arms of clinical and basic laboratory research. These have focused primarily on clinical outcomes in urologic oncology treatment, and on small protein function in urologic malignancies.

To date, this research Fellowship program has been a stepping stone for more than 25 Trainees who have gone on to gain selection to advanced training in urology and general surgery after a period of full-time research.

The research output from this Fellowship program has subsequently gone on to attain more than 50 postgraduate scholarships for the Trainees concerned, to produce multiple postgraduate degrees, and to



form the basis of in excess of 100 peer-reviewed publications. Surgical Trainees from this program have been presented with more than 20 separate awards and prizes on the basis of their research.

Based on research undertaken in this program Professor Bolton was awarded the John Mitchell Crouch fellowship of the RACS, being the first urologist to receive this award, as well as the British Association of Urologic Surgeons Silver Medal for surgical research. He has served on multiple international collaborative projects for clinical research in urology, as well as the editorial boards of three urologic journals.

In developing the Austin Hospital's urology research Fellowship, Professor Bolton has been an investigator on grants receiving over seven million dollars in competitive funding. Several of the Trainees to have completed research through this urology department have also gone on to undertake academic-based post-Fellowship training in North America and the United Kingdom, with collaborative surgical research projects consequently being established between Australia and major centres abroad. Presently there are six surgical Trainees participating in this surgical research program at different levels of progress towards postgraduate degrees including PhD, Doctor of Medical Science and Master of Surgery.

Citation kindly provided by Mr David Winkle FRACS

IN HIS NAME

A scholarship in honour of Sir Benjamin Rank has been established

SAM GRAY

It is a special thing, the bond between grandparent and grandchild. So it was with my grandfather, Sir Benjamin Rank.

My most treasured memory of him is, whenever we used to visit his home in Mt Eliza, his huge smile and beams of delight radiating from his face as he opened the front door to welcome us.

But on pondering my grandfather's life, the characteristic most revered was his ever-present desire to give back to the community. Through the example he gave us through his actions, he passed this on to his children and to me (amongst others) as one of his grandchildren.

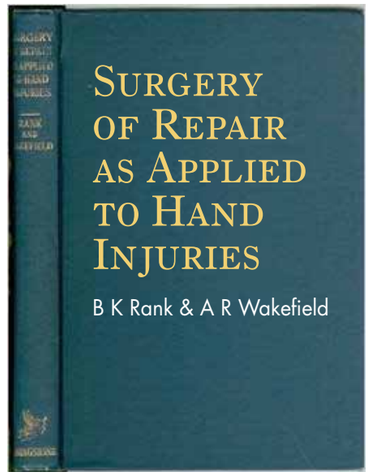
It has therefore been a great pleasure to have been able to initiate, with the wonderful people at Interplast, a scholarship in his honour, the Sir Benjamin Rank Scholarship. This is essentially an extension of the many wonderful activities of Interplast. The scholarship will enable a surgeon or surgeons to visit Australia for short-term observational training, in order to ultimately develop and enhance their skills further. The first of these scholarships will be provided during 2014.

Interplast operates throughout the Asia-Pacific region particularly in the poorer countries. It sends specialist surgical teams to perform free operations on those who would otherwise not be able to afford them. It also trains surgeons from these countries, so as to improve their skill set – thus providing lasting changes to the quality of medical services they offer.

The training of others was an activity in which my grandfather was very active for a long period during his professional working life, including under what was known as the Colombo Plan. His knighthood recognised his contribution to the field of plastic surgery in Australia and worldwide. It is fitting that this scholarship enables the spirit of his contribution to continue by enabling further training of overseas surgeons.

The bestowing of this scholarship is a significant honour to recipients as my grandfather's legacy of professional achievements lives on to this very day. By way of a summary of some of those key achievements, Sir Benjamin Rank:

- Served in the Second World War performing plastic surgery operations in the Australian general hospital in 1941
- Is regarded as one of the pioneers of plastic and reconstructive surgery in Australia
- Was pivotal in the establishment of the charity Interplast in Australia, approximately 30 years ago
- Through the Colombo Plan made a significant contribution to India and Pakistan in establishing plastic surgery there and training various surgeons, for which he was awarded Companion of the Order of St Michael and St George in 1955
- Was knighted for his services to plastic surgery by the Queen in 1972
- Was on the council of the Royal Australasian College of Surgeons from 1955, and served as its President from 1966-1968.
- Became in 1965 the first and only overseas President of the British Association of Plastic Surgeons (BAPS)
- Was appointed in 1958 as Sims Commonwealth Professor of Surgery and visited Canada in this role.
- From 1946-1966 was in charge of the Plastic and Facio-maxillary unit at Royal Melbourne Hospital
- Authored a number of books, including 'Surgery of Repair as Applied to Hand Injuries' (1953) by B K Rank and A R Wakefield, which was translated into multiple languages.



It is a great honour to be able to help his legacy thrive, to recognise my grandfather and, most importantly, to contribute to our neighbours in the region who are less fortunate than us.

ADVANCE CARE PLANNING AND ADVANCE CARE DIRECTIVES

DR SARA BIRD
MANAGER, MEDICO-LEGAL
AND ADVISORY SERVICES
MDA NATIONAL

This article is provided by MDA National. It was first published in MDA National's 'Defence Update' Autumn 2014. MDA National recommends that you contact your indemnity provider if you have specific questions about your indemnity cover

What is Advance Care Planning?

This is a process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known so they can guide decision-making at a future time when that person cannot make or communicate his or her decisions.[2] Advance Care Planning is based on principles of self-determination, dignity and avoidance of suffering.[3]

What is an Advance Care Directive?

Advance Care Planning will often lead to the completion of an Advance Care Directive (ACD). An ACD is a means by which a competent adult can determine the medical treatment that he or she wants to accept or refuse in the future if decision-making competence is lost.[4] An ACD is generally a written document intended to apply to future periods of impaired decision-making capacity, which provides a legal means for a competent adult to record preferences for future health and personal care and/or to appoint and instruct a substitute decision-maker (SDM).[5] ACDs are not clinical care or treatment plans; but clinical care and treatment plans can and should be informed by ACDs.[2]

When is an ACD valid?

In general terms, an ACD is valid when it meets the following criteria:

- It is made by a competent adult.
- It is made free of undue influence.
- It applies to the situation at hand.

Use of ACDs

In recent years there has been a greater focus on the role of advance care planning and ACDs. This policy has been driven by a number of factors including Australia's ageing population, medical and technological advances which prolong life, increased emphasis on autonomy and patient-centred care, and the provision of quality care at the end of life.

However, to date, ACDs have not proved to be a popular planning tool. This is despite the fact that individuals are encouraged to discuss with their families how they would like their health care to be managed if they are no longer able to make their own decisions, and for doctors to incorporate Advance Care Planning as part of routine health care, including raising the topic with all older patients.[2]

Some of the concerns that have been raised in relation to the use of ACDs are:

- **Validity and reliability –** the person making the ACD may lack the information required to make an informed choice, especially where the ACD is made prior to the onset of an illness for which a treatment decision must be made, and the way in which the ACD is written may be influenced by the manner in which questions are posed.
- **Durability –** an individual's treatment choices can change over time such that an ACD made at a particular time may not accurately reflect the person's wishes at a later date, and may not reflect advances in medical practice.
- **Efficacy –** the person's true wishes may not be accurately ascertained from an ACD with sufficient clarity to guide clinical management.
- **Accessibility –** it may not be possible to locate an ACD when needed.
- **Portability –** each state and territory has a different legislative framework for ACDs.

As a result of these factors, medical practitioners may be concerned about following an ACD, especially where they do not believe it represents "good" medical decision-making, or that the ACD may not represent the true wishes of the patient. Practitioners may also be concerned about potential liability, especially where there is conflict with the wishes of the patient's family. ▶

Tips for successful Advance Care Planning conversations[6]

- The individual needs to be ready for the conversation and mentally capable of participating – conversation cannot be forced; at the same time clinicians, in most instances, need to take the lead in initiating such conversations.
- Capacity to engage in conversation must be maximised by treating any transient condition affecting communication and optimising sensory function (e.g. by ensuring the patient's hearing aid is being worn).
- Conversations need to take place on more than one occasion (over days, weeks and even months) and should not generally be completed on a single visit.
- Conversations take time and effort and cannot be completed as a simple checklist exercise.
- Conversations should take place in comfortable, unhurried surroundings; time is a key factor.
- Conversations should be devoid of medical jargon, language should be positive, and trust must be built using empathic listening skills.
- A step-by-step approach to identifying and resolving issues should be used, coupled with "time out" periods where doctors withdraw from the encounter to allow the patient and family to discuss among themselves the care options being presented.
- Individuals should be given realistic information on prognosis and treatment options with emphasis on how their illness is expected to impact on their daily function.
- Conversations should avoid focusing initially on medical interventions (e.g. cardiopulmonary resuscitation, intubation) but rather determine values, goals and preferences (e.g. prolonging life and preserving mentation versus minimising suffering and avoiding undignified states or an unacceptable functional status).
- Look out for cues suggesting individuals are becoming uncomfortable talking about certain issues or may wish to end the conversation.
- Encourage patients to identify a surrogate decision-maker and to discuss their wishes with that individual; if desired, offer to facilitate a conversation between the patient and their surrogate or other family members; identify whether patients have specific desires for how information is shared among family members.
- Summarise and check the patient's and, if present, their surrogate's understanding of what has been discussed at the end of sessions.
- Encourage patients and surrogates to have conversations documented, but reassure them that these documents are not necessarily final or binding.
- Plan for a review as clinical circumstances change.

Code of ethical practice for ACDs[2]

1. ACDs are founded on respect for a person's autonomy and are focused on the person.
2. Competent adults are autonomous individuals and are entitled to make their own decisions about personal and health matters.
3. Autonomy can be exercised in different ways according to the person's culture, background, history or spiritual and religious beliefs.
4. Adults are presumed competent.
5. Directions in ACDs may reflect a broad concept of health.
6. Directions in ACDs can relate to any future time.
7. The person decides what constitutes quality of life.
8. The substitute decision-maker (SDM) has the same authority as the person when competent.
9. The SDM must honour residual decision-making capacity.
10. The primary decision-making standard for SDMs is substituted judgment.
11. A SDM should only base his or her decision on "best interests" when there is no evidence of the person's preferences on which to base substituted judgment.
12. An ACD can be relied upon if it appears valid.
13. A refusal of health-related intervention in a valid ACD must be followed, if intended by the person to apply to the situation.
14. A person, or their legally recognised SDM, can consent to the treatment offered, refuse the treatment offered, but cannot demand treatment.
15. A valid ACD that expresses preferences or refusals relevant and specific to the situation at hand must be followed.

Legal framework for ACDs

The common law recognises, as part of the right to self-determination, that an individual can complete an ACD that will bind a health practitioner who is treating that person, even if the directive refuses life-sustaining treatment. A 2009 NSW Supreme Court judgment confirmed that if an ACD is made by a capable adult, is clear and unambiguous, and extends to the situation at hand, it must be respected.[7]

In addition to the common law, legislation governing ACDs has been enacted in every state and territory, except NSW and Tasmania where the common law would apply with regard to ACDs.

However, the legislation is complex and there is considerable variation in the scope of the legislation. Between jurisdictions, the legislative name of ACDs varies and there are differing restrictions that affect their operation (see Table 1).

A more detailed summary of the legislation in each state and territory can be accessed at:

- A National Framework for Advance Care Directives, Appendix 1: ahmac.gov.au/cms_documents/AdvanceCareDirectives2011.pdf.
- Advance Care Planning Australia's website: advancecareplanning.org.au/advance-care-planning/for-professionals/the-law-of-advance-care-planning

References can be found at http://www.defenceupdate.mdanational.com.au/advance-care-planning/

Table 1

State/ Territory	Name	Restrictions
ACT	Health Direction	
NT	Direction	Effective only when person suffers from a terminal illness.
QLD	Advance Health Directive	For directions to withhold/withdraw life-sustaining measures: 1. direction cannot operate unless there is no chance of the patient regaining capacity and any of the following: • terminal illness/incurable condition and expected to die in one year • permanent coma/post-coma unresponsiveness • illness/injury so severe that no reasonable prospect of recovery without life-sustaining measures 2. for directions regarding artificial nutrition/hydration (ANH), commencing or continuing ANH would be inconsistent with good medical practice.
SA	Advance Care Directive Anticipatory Direction	Effective from 1 July 2014. Effective only when person is in terminal phase of a terminal illness, or in a persistent vegetative state. *(Still legally effective after 1 July 2014.)*
VIC	Refusal of Treatment Certificate	Does not cover procedures that would be considered palliative. Applies only to a current condition.
WA	Advance Health Directive	A treatment decision will not operate if circumstances exist that the person would not have reasonably anticipated at the time of making the directive and would have caused a reasonable person to change their mind about the treatment decision.

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