Surgical Outreach, Page 21

ALSO THIS MONTH:

PAGE 11: HEALTH ADVOCACY
What are the issues what are your views? We would like to hear from you.

PAGES 22-24: CELEBRATING 80 YEARS
The story of how we began in 1920 to what we have become today.

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WELCOME TO 2007, which promises to be an exciting year. As we purposefully emerge from some of the shackles of the past, the College can be a more effective voice for surgery. In this process, we must reflect accurately the views of the Surgical Specialties.

**Australian Competition and Consumer Commission (ACCC)**

Our Authorisation is now over. Consisting of three parts, the first part of the Authorisation dealing with our training program formally ceased in January. The other two components dealing with the Accreditation of Hospital Posts and Assessment of Overseas Trained Doctors conclude in July this year.

The College has developed its policies, procedures and processes substantially over the past five years. These processes are robust and transparent. They are freely available for public scrutiny and we will continue to provide reports to our stakeholders including the Health Ministers and regulatory authorities on a regular basis.

Will this stop people complaining about our decisions or appealing our processes? Absolutely not – and it shouldn’t. The College’s role is to make decisions regarding standards, education, training, safety and quality. If people do not acquire the standards to enter or complete our training programs, we must tell them, even though this news may be confronting to the recipient. They cannot be surgeons unless they achieve these standards and should seek other career opportunities. Consequently it is important we have academically robust and procedurally correct actions that can stand scrutiny from all parties.

**The New Surgical Education and Training Program (SET)**

The consultative process late in 2006 was most useful. As a result, the College has amended the initial communication booklet and this is now available on the website. The Working Party is continuing to refine the detail so that the various boards and then Council can approve the documentation by the end of February. Obviously, change of any type is unsettling and creates uncertainty. However, the advantages of streamlining the surgical training program are well documented and the Working Party, which includes all the board chairs and is chaired by the Censor in Chief, has worked tirelessly to allow the Program to be introduced in January 2008. It is also an opportunity to update the approach of the College with regard to the Accreditation of Hospital Posts because SET 1 posts are to be accredited, initially on paper. In addition, selection and assessment tools will be updated. We are anticipating a substantial roll out of training for supervisors across Australia and New Zealand with the focus on assessment, particularly with respect to the marginal trainee. This process will continue throughout 2007 and 2008.

**Australian Medical Council (AMC) Accreditation**

The AMC wishes to review our current training program at the same time as acquiring a high level of understanding and certainty about SET and its transition. This will occur in July. As the College and the specialty organisations provide training in nine surgical disciplines, there is a substantial amount of material to prepare, align and present to the AMC accreditation team. Of importance, the AMC is interested in how it interacts and interfaces with maintenance of skills and ongoing professional development, the so-called “continuum of learning”.

**Emergency Surgery**

The provision of emergency surgery is becoming a substantial challenge internationally. Worldwide, the traditional models of being “on-call” and the expectation of working “day in, day out” are changing. At a medico-legal level the ability to do emergency surgery in the early hours of the morning and then line up for elective surgery in the same day is starting to be questioned. The changing profile of the medical and surgical workforce is also a strong driver. Emergency department physicians changed the role and the professionalism of the old “Casualty Doctor”. It may be that emergency (department) surgeons who are remunerated adequately will progress that revolution. Further, specialisation within the surgical disciplines is an additional and significant influence. Certainly the future surgical workforce needs to more appropriately juggle the competing demands and must address the work-life balance issues in a pragmatic way.

**Advocacy**

One of the most common criticisms of the College by our own Fellowship is that, from a surgical perspective, we do not provide strong enough advocacy in the community. The obvious areas are health service resourcing and surgical standards. However, it could be argued that as professionals we need to go much further. The College was at the leading edge of motor car and traffic reforms needed to reduce the road toll over the past 30 years. The work of Gordon Trinca and Sir Edward Hughes has had long-lasting and international impact. More recently, the Trauma Committee has influenced the debate on inexperienced drivers of powerful cars. The College needs to contribute to these important issues in a purposeful and planned way.

Elsewhere in this edition of Surgical News there is a brief article attempting to focus on this. What are the core issues that we should be addressing? Is it prevention (rather than treatment) of the obesity crisis? Is it global warming? Is it urban pollution of our water ways? Is it trauma related to workplace and farming accidents? Obviously such activities will require some financial and human resources but the College can be a powerful voice.
Council of Australian Governments proposals (COAG)

These proposals include a National Registration Authority and a National Authority for Accreditation of Education and Training of all health professionals. There is increasing concern regarding the proposals that the health working party, under the auspices of the Prime Minister’s Office, is circulating and “discussing” with stakeholders. The ambitions of these reforms are to reduce red tape, decrease bureaucracy, improve standards and improve mobility. Mobility will be improved by a National Registration system and there is general agreement that this will produce substantial benefits provided it is profession specific. However, the working party is proposing a number of additional committees and authorities which will increase the bureaucracy. Importantly they will potentially threaten standards by putting all health professionals together. This will be a retrograde step. Although common guidelines can be developed, each professional group has specific requirements in terms of training, registration and regulation. It was interesting to see that at the last stakeholders meeting, all the health professions were united in this view.

This is obviously not a turf issue but one of standards. It is imperative that all influential medical groups unite to ensure that reality and common sense prevail.

Sub-specialisation

As surgery becomes more complex, sub-specialisation will continue to evolve to maximise quality care. However, this process is placing increasing strains on acute services, particularly in general and orthopaedic surgery. Further, Australia and New Zealand are decentralised countries so surgeons with appropriate generic skills must be retained. In addition, generalists may have a special interest in a particular area of that discipline. Whatever the model, the College in consultation with government has an obligation to construct an environment that promotes and supports such surgeons. For example, it is my opinion that the conditions of service for surgeons who perform emergency services should be favourable enough to attract surgeons into this challenging area. I have already flagged the importance of this to some government officials and intend expanding the awareness of the issue over the coming months. Coinciding with this initiative, we are developing governance strategies within the College to promote the integration of pre- and post Fellowship training programs both to mitigate the above concerns and to reward Fellows who undertake validated post-Fellowship programs. With good will and objectivity, I believe we can achieve these aims.

General surgery and its subspecialties provide a specific opportunity to progress these initiatives but we are also examining multidisciplinary sub-specialisation where there is a desire to introduce a more formalised post-Fellowship education and training program.

Council elections

Nominations have been sought for the impending council elections. Eight new Counsellors will be elected and it is a great chance for able Fellows to help evolve and direct the College. Both the surgical specialties and the regions need to be part of this process if the College is to fulfill its overarching role and reflect adequately the views of the Fellowship and its associated organisations. I would like to urge Fellows to vote as it is a critical time for surgery and in particular the College.
THE MEETING RETURNS to New Zealand for the first time since 1999 and in particular to Christchurch, which we last visited in 1982. It is especially appropriate the Congress is being held across the Tasman in this, the 80th year since the seminal letter penned by Professor Louis Barnett from Dunedin, NZ suggesting the formation of our College. This is to be acknowledged in a special plenary session on Wednesday afternoon.

Our host city is beautifully situated astride the meandering Avon River and against the backdrop of the Southern Alps. Whilst the population is approaching 400,000, the central city is compact, visually attractive and invites walking, bike riding and dining. The venue will be the Christchurch Convention Centre and the adjacent Christchurch Civic Centre, the two being connected by a first-floor enclosed bridge. All the conference hotels are within minutes of the venue.

The Congress will start on Sunday, May 6 at 2.30pm with the Ecumenical Service in the beautiful Victorian gothic splendour of Christchurch Cathedral on Cathedral Square. The Convocation in the Christchurch Civic Centre will follow. One of New Zealand’s foremost scientists and an outstanding public speaker, Professor Paul Callaghan, will deliver the Syme oration. In addition to the presentation of new Fellows, we will acknowledge the enormous pro bono contributions of two new Honorary Fellows and eight Fellows of our College. The Honorary Fellows are Professors Patrick Bradley and O James Garden, both from the UK. The Australian and New Zealand Fellows to be honoured are: John Crozier, Patricia Davidson, Glyn Jamieson, John Hutson, Don Marshall, Andre van Rij, Don Sheldon and Robert Thomas.

By now, you should have received your copy of the Provisional Program for this, the 76th Congress. If not, or if you wish to check for updates or corrections to the program you can access a current copy on the College website, following the links from the home page. The Provisional Program presentation and layout has been substantially modified this year to better emphasise two of the major strengths of the Congress – content designed to appeal to all Fellows and content for specific surgical craft groups, with cross-fertilization remaining an important theme. The intent is that the Congress should appeal to the widest range of surgical specialties and to surgeons from trainee-surgeons to retired surgeons.

Rob Robertson, his executive team and the conveners of the section programs have designed an outstanding scientific program. The needs of all delegates have been considered and catered for. The strengths of the excellent Sydney Congress have been incorporated and enhanced and an outstanding faculty of invited speakers will participate in the meeting. The College’s ASC Visitor funding program and continued growth in unrestricted educational grants received by the College from industry make this possible.

The Congress program continues to evolve and innovation is vital to maintain relevance. New to the program for 2007 are a session specifically for senior surgeons and three natural science lectures (see Provisional Program, p27). The latter reflect a broader view of the world that will appeal to all delegates – Trainees, Fellows and Associates.

By general consent, the Sydney Congress Banquet was the best to date with registrants exceeding capacity. Christchurch we believe will surpass that with the venue being the Air Force museum with its 28 restored aircraft and music from the big band era. After the success of the Younger Fellows and Trainees’ dinner in 2006, this will again feature in Christchurch.

See you in Christchurch!
New vision for research scholarships

A plan to increase the number of scholarships and their stipend values should encourage innovative surgical research among our brightest scholars.

The Board of Surgical Research is in the process of designing and implementing a new vision to further promote surgical scientific research. With external funding increasingly difficult to obtain and the rapid development of medical science, the Board of Surgical Research believes the College’s scholarship program should take its place at the centre of Australasia’s surgical scholarship system.

Plans are now being developed to source more funding to allow all deserving surgical scholars to receive the funds they need for their research. In particular, the new aims of the scholarship program will be:

- To continue to steadily increase scholarship stipend values so that “Foundation for Surgery” scholarships stay at a level where it is viable for surgeons to take time out of their careers to study full-time;
- To expand the scholarship program by increasing the number of scholarships and fellowships offered, so that every talented potential academic surgeon wanting to conduct critical research, can source the necessary funding;
- To identify and fund important areas of surgical research that are unable to attract funding from traditional sources such as the National Health and Medical Research Council.

For the past decade, the College, through its Foundation for Surgery, has been one of the most significant supporters of surgical research in Australia and New Zealand with more than $1 million in funding provided annually to the most academic and able surgical trainees and Fellows.

According to the Board of Surgical Research Chair, Professor Guy Maddern, the new focus of the scholarship program will allow it to better meet the needs of surgical scholars.

“What we are trying to achieve is a scholarship funding system that will enable surgeons to spend the time they need to concentrate on their research interests.”

“What we are trying to achieve is a scholarship funding system that will enable surgeons to spend the time they need to concentrate on their research interests,” he said. “It has become increasingly difficult for surgeons to travel overseas to conduct research because of family commitments and the scarcity of funding avenues, so we want to support the people who have the potential to generate novel surgical solutions within and for Australasia, rather than having to import them.

“We are also encouraging scholars to source a proportion of their necessary funding from other areas – as we have done for the past four years – to free up our funds and allow them to go further.

“Fortunately, the quality of scholar that we already attract means that they are certain to attract external financial support.”

Professor Maddern said the Foundation for Surgery planned to provide scholarship recipients with a reasonable annual stipend of about $50,000, with $38,000 coming from the College and $12,000 from the university or hospital department supporting the scholar.

“The NH&MRC provides some funding for research but it is difficult to obtain and not overly generous, which makes it difficult for people well into their careers to take the time out they need,” he said.

“We believe this needs to change and already the Foundation for Surgery has shown that with $10 million of funding invested in scholarships over the past decade, there has been a multiplier effect of up to $60 million, in terms of other funds attracted.”

Under the new focus, the Board of Surgical Research will need extra monies raised to allow it to support Centres of Excellence in Surgical Research.

Professor Maddern said if sufficient funds were sourced, the College could support a number of centres to promote world-class surgical science.

“There might be an opportunity to support a unit undertaking particular research such as tissue engineering, burns management or surgical education research that the College could sponsor,” he said. “We would need donations to increase over the next few years to allow this to happen and it may sound like a task, but it is not an impossible ask.

“It is crucial for the public and for our brightest scholars that we create an environment which encourages innovative surgical research within Australia and New Zealand.”
Breath tests could detect breast cancer

West Australian doctors have teamed up with Breastscreen WA to look at whether a patient’s breath could provide the key to early cancer detection.

PERTH BREAST CANCER Surgeon Professor Christobel Saunders is leading a team that is about to launch a two-year research program investigating the efficacy of a breath test, which could detect early indicators of the disease.

Professor Saunders and her team have sourced research funding of almost $100,000 from the National Breast Cancer Foundation for two years.

A West Australian doctor now based in the US, Dr Michael Phillips, designed the breath test and was granted Food and Drug Administration approval in 2004 to use the technology, along with mainstream diagnostic tools, to determine if donor hearts were being rejected.

Dr Phillips, the CEO of Menssana Research Inc. in New Jersey, has developed computer software to analyse data provided through gas chromatographs and mass spectrometers, which can show up “fingerprints” of various diseases including lung cancer and pre-eclampsia. He has been quoted in US media reports as likening the concept to that used by ancient physicians who smelt the breath of their patients as a regular diagnostic procedure.

Professor Saunders said research teams around the world were now initiating other investigative programs to determine if the breath test could be of use to detect early signs of certain cancers and diabetes.

“This technology allows us to look for, and at, the mix of volatile organic compounds (VOCs) exhaled in a patient’s breath,” she said.

“There are many thousands of these in every breath but this technology has a two-fold beauty in that it can test for tiny concentrations of particular VOCs as well as particular combinations that may predict the development of cancer. We believe that VOCs could be a predictor of disease in that they can indicate whether cells are under oxidative stress whereby they release a particular group of chemicals.”

Professor Saunders said a research assistant would be appointed this month to run the project, which will involve the recruitment of 300 women. It is hoped that the women will be recruited through Breastscreen WA as part of their normal screening check-ups.

“We are hoping to recruit 150 women who are coming in for a regular mammogram along with 150 women who have had an abnormality show up in the test, which is yet to be diagnosed,” she said.

“Then we will use this technology to determine if those women who have no abnormality show up clear via the breath test while we will then see if the technology will allow us to know whether those with an abnormality have a benign or malignant tumour. The point of the research will be to test for both sensitivity and specificity.”

Professor Saunders said that some data coming out of the US had showed that the test was effective for a small group of women with cancer but that little had been done to see if the test was effective for women with no abnormality.

While she said the technology would not replace mammography, it could indicate those women who were unlikely to have breast cancer while enhancing the accuracy of mainstream diagnostic tools.

“We know that mammography is only 85 per cent accurate so if this test proves effective it would be used in tandem. The aim of researchers around the world is to find a diagnostic tool to detect cancer at the earliest possible stage. We are not suggesting the breath test as a replacement of mainstream technology but as an adjunct and we don’t even know if it works yet,” she said. If successful, a randomised clinical trial would follow the initial research.

Professor Saunders is the Professor of Surgery at the University of Western Australia and a consultant at the Royal Perth and Sir Charles Gairdner Hospitals. She will be assisted in the research project by Dr Liz Wylie from Breastscreen WA.

Professor Saunders said the team was grateful for the funding provided through the National Breast Cancer Foundation. “The whole point of this type of funding is to provide support for research that may not have attracted other grants because the science is so new,” she said.

“The source of this funding then underscores the fact that it is very early research. We don’t know yet how accurate this technology will prove to be, how specific or how effective. But that is the point of research.”

Professor Saunders said she did not believe the technology would replace regular mammogram tests nor that it would be conducted by GPs but that if it proved effective it would be best used through specialised breast cancer screening services.
A culture of lifelong learning

The College encourages all Fellows to participate in professional development

Rob Atkinson, Chair
Professional Development

AN ONGOING COMMITMENT to professional development is becoming increasingly important in today’s dynamic world. The acquisition of new skills and methodologies is also crucial to long-term professional growth and success.

The core activity of the College is to maintain the highest standards of safe and comprehensive surgical care by selection, training, and performance throughout our surgical careers. This core activity can be value-added from a broader range of non-technical aspects of competencies, as identified in the definition of surgical roles and competence.

These generic roles include communication, collaboration, management and leadership, health advocacy, scholar/teacher and professionalism, which are in addition to the core roles of a surgeon in relation to medical and technical expertise and clinical decision-making.

The challenge for the College is not to add to the information overload of this day and age but to facilitate an easier, high standard of daily surgical life. Through the Department of Professional Development, the College offers a range of workshops aimed at equipping Fellows with the knowledge and skills they need to meet the increasing demands of their complex role. There are learning opportunities for all Fellows – for those interested in training or selection interviewing as well as those wanting to improve their communication or business, leadership and management skills.

While encouraging all Fellows to participate in professional development, the College recognises the expectations and competing demands for their time and energy from many sources, including workplaces and families. Consequently, there are a number of professional development activities on offer which can be selected by busy professionals, their practice staff and families to assist with their daily activities and enhance quality of life – essential to the sustainability of any profession. These include ‘Practice Management for Practice Managers’, ‘Beating Burnout’, ‘Winding Down from Surgical Practice’ and ‘Polishing Presentation Skills’.

The College is now embracing a range of delivery options such as video conferencing and online learning. Particularly for Fellows in rural and regional locations, these flexible delivery methods help to make professional development easier and quicker to access. The geography that encompasses our two countries, as well as the time differences, challenges us to use information and communication technology in the best ways possible to deliver activities equitably to all Fellows. As this is an evolving area of technology, I would be pleased to discuss new methods of overcoming these difficulties.

In addition to being personally rewarding, participation in professional development is also a very powerful tool enabling Fellows to demonstrate to the Australian and New Zealand communities and governments a culture within our professional body aimed at maintaining the highest standards through self-regulation. Through the College’s Continuing Professional Development Recertification Program, surgeons have a robust tool to demonstrate that surgical regulation is not required through an outside body.

Our College has shown leadership in many areas of professional development. In addition other colleges and organisations also offer activities that could benefit surgeons, which enables for a cross fertilisation of ideas and sharing of experiences. A list of courses accredited by the College is available on our website by clicking on the Fellowship and Standards menu. Professional Standards then ‘Approved CME activities’.

Fellows are the College and thus it is important to note that the Professional Development Committee, with input from the elected representatives and indeed from all Fellows, provides the process for the selection and review of activities to ensure that they are aligned with the surgical competence framework, meet Fellows’ expectations and reflect current practice.

It is my strong belief and observation that the Fellows of our College do have a culture of lifelong learning and understand that an inquiring attitude and daily education are fundamental to life itself. I strongly encourage you to participate in professional development activities, to enable their sustainability and evolution and particularly to share your experiences and learning with your colleagues.

Colorectal Surgical Society of Australia and New Zealand (CSSANZ) Media Prize

Some 14,000 new cases of colorectal cancer will be identified each year in Australia and New Zealand. It is the most common cancer other than skin, yet is almost completely preventable. Public education activities will help to raise the consciousness of the Australasian population. In addition, the treatment of colorectal cancer carries significant implications for outcomes based on the quality of specialist surgery and on decision regarding management programs. The Society’s most important initial target is bowel cancer, in the areas of prevention, detection and management.

The Council of CSSA has decided to offer an annual media prize to be awarded for the best published article, television documentary (or segment) or other similar media format, considered by the Media and Public Relations Committee for the CSSA to be of optimal benefit to patients in that year. The Committee’s recommendations will be presented to the President and the Council of the CSSA who will ratify the decision.

Presentation of the award will be in May each year, during the ASC of the College. The prize will consist of a commemorative plaque and a cash award (initially $1000) and will include attendance at the Convention to receive the award. Council reserves the right not to make an award in any given year.

Please contact CSSA Secretariat, Ms Jan Farmer (secretariat@cssa.org.au)
PROFESSIONAL DEVELOPMENT ACTIVITIES 2007

Designed to support Fellows in many aspects of their professional lives, the College offers a broad range of professional development (PD) activities in a variety of formats to suit your requirements.

PD activities will earn you CPD points and assist you to maintain your knowledge and skill base in training and interviewing as well as strengthening your communication, business, leadership and management abilities.

PD Activities Overview
In 2007 the College is offering new and exciting learning opportunities via face to face meetings, video-conferencing and online learning.

All College PD activities address one or more of the roles outlined in the Surgical Competence Framework:
• Professionalism
• Scholar/Teacher
• Health Advocacy
• Management and Leadership
• Collaboration
• Communication
• Medical Expertise
• Judgement - Clinical Decision Making
• Technical Expertise

Want to enhance your management and leadership skills?

Why not attend the Surgeons as Managers retreat, enrol in the Graduate Certificate in Business Administration or review your practice systems and equip your staff with new skills at our Practice Management for Practice Managers workshops. You can improve your communication skills and learn how to reduce your liability in our Master Classes in Risk Management or Mastering Difficult Clinical Interactions. Find out more about the process of obtaining informed consent in Mastering Consent. Alternatively Mastering Adverse Outcomes highlights strategies to manage clinical interactions if an adverse event has occurred.

Be one of the first to pilot the brand new From the Flight Deck: Improving Team Performance, a unique activity that uses the experiences of the aviation industry to build team management skills in crisis situations.

Still looking for ideas?
Refine your teaching skills with the Surgical Teachers Course or develop your interviewing technique with our video-conferenced Interviewer Skills Training. You may also be interested in the new Supervisors Training Workshop which focuses on using assessment tools providing effective feedback and managing Trainees.

Further information:
Visit our new and improved website at www.surgeons.org and click on Fellowship and Standards at the top of the page then select the PD link from the drop down menu.

Online registration is now available for all workshops. You can obtain a brochure and registration form on +61 9276 1106 or email PDactivities@surgeons.org

"I think the scenarios in the afternoon with the actors was also excellent and it gave us an opportunity for each of us to be put on the spot and to get an idea of how we are performing in a more public environment."

Mr Brett Courtenay, FRACS, Risk Management Master Class 2006

FIND A WORKSHOP IN A STATE NEAR YOU:

VIC
24 February
Mastering Difficult Clinical Interactions
24 March and 10 November
Communication Skills for Cancer Clinicians
30-31 March and 1-2 June
From the Flight Deck: Improving Team Performance
16 April
Interviewer Training (video conferenced)
Date TBA
Polishing Presentation Skills
19 May
Expert Witness
20 October
Winding Down from Surgical Practice
27 October
Beating Burnout (VIC ASM)
27 October
Practice Management for Practice Managers

NSW
21 March
Practice Management for Practice Managers
2 April
Beating Burnout
23 April
Interviewer Training (video conferenced)
16 June
Mastering Difficult Clinical Interactions
10-12 August
Surgeons as Managers

QLD
22-24 March
Surgical Teachers Course
28 April
Risk Management Master Class (Urology)
13-15 July
Surgeons as Managers (video conferenced)
1 September

SA
30 March
Risk Management Foundation: Mastering Consent
6-8 September
Surgical Teachers Course

WA
30 March
Winding Down from Surgical Practice
21 April
Mastering Difficult Clinical Interactions

NZ
28 March
Interviewer Training
11-13 May
Surgical Teachers Course (ASC)
3 August
Winding Down from Surgical Practice
4 August
Mastering Difficult Clinical Interactions

ALL
1 February
Australian Indigenous Health Program (online)
20 February
Cross Cultural Communication (video conferenced)
7 March
Cross Cultural Communication (video conferenced)
16 and 23 April
Interviewer Training (video conferenced)
Financial and Procedural Consent

Workshops will provide opportunity to consider implications of new policy

THE COLLEGE HAS reviewed its policies on Consent, and particularly its policy on Informed Financial Consent. Most would be aware of pressure from the Federal Minister of Health for all parties undergoing a procedure to have informed financial consent as well as the required informed procedural consent.

It is known that where informed financial consent fails, and a patient is disgruntled, that the failure is mostly related to lack of knowledge of the fees charged by anaesthetists, surgical assistants, radiologists and allied health professionals. It is not the surgeon’s duty to provide this, but merely to facilitate this information transfer. This has been incorporated into the published policy.

The development of these policies has involved the specialist surgical societies associated with the College and their input has been very welcome. The policies are available on the website: www.surgeons.org.

To aid in the process of providing consent the College regularly runs Professional Development Workshops. There are two such workshops offered in 2007 that will discuss the implications of these policies.

The first is a workshop entitled “Risk Management Foundation – Informed Consent” which will focus on helping Fellows to develop strategies to identify and minimise the risk of adverse outcomes in practice management. It explores the process of informed consent, informed financial consent, and focuses on improving communication with patients and managing patient expectation. Fellows and their Practice Managers are invited to attend this workshop, and it will be held on March 30, 2007 in Adelaide.

The second workshop, with a similar content but a greater focus on reducing the risk of adverse outcomes in relation to clinical interactions, will be held in Brisbane on 1 September 2007 and is called “Risk Management Foundation – Dealing with Adverse Outcomes”.

More details of these courses are available on the College website, or through Merrilyn Smith – Manager, Professional Development, contact merrilyn.smith@surgeons.org.

The Rotary Club of Wandin has been for many years a back support for the Children of Interplast who have had operations by the visiting Interplast teams. We know it feels really good to have a cuddly friend when you wake up from an operation and this club has for many years provided the comfort needed at that point in time.

A great big thanks to Wandin Club and especially AG Keith and Val Corbett who organise this special “cuddle” for all those children in our neighbour countries of South East Asia and South West Pacific.
Health advocacy – where to next?
Choosing the right topic and approach is crucial when considering future directions

ONE OF THE core competencies of a surgeon is to be a health advocate and this occurs at the level of the individual patient, the practice population and the broader community. As medical professionals this has been happening for centuries. One only needs to reflect on the activities of Dr John Snow and the “Broad Street Pump” in 1854 to understand the power of careful analysis, conviction and action. This has been demonstrated many times since and the activities of the College and our Fellows in the 1970s saw Australia lead the world in strategies to decrease motor car deaths.

The release of Australia’s Health 2006 by the Australian Institute of Health & Welfare (AIHW) makes powerful reading. The chart gives a clear understanding of where we stand amongst OECD countries.

Advocacy is an issue where careful choice of topic and possible approaches is most important:
- Do we focus on areas that don’t appear to improve in this chart? Action on the mortality from prostate cancer, suicide and in the infant age-group are crucial.
- Do we acknowledge that risk factors are vitally important and highlight the prevention as well as treatment of obesity?
- Do we continue strongly where our strengths are with road trauma recognising there is much still to be done particularly if we focus on issues like workplace and farm trauma.
- Do we take a more holistic view and contribute to the debate on river cleanliness in our major cities or global warming. Dr Matthew Nott FRACS recently received the Green Globe Award for his community awareness work in the area.

We need to know what should be done next. Professor Peter Danne recently corresponded stating:

“The epidemic of obesity in this country has received great press. It is also receiving a large amount of surgical attention from the group of surgeons who have adopted the term “Bariatric” surgeons…”

The point of writing to you is, however, to raise the issue of prevention of obesity. I believe it is critically important that the College should be positioning itself well in the forefront of the move to prevent obesity in this country, as well as to treat it. We have had great success in the preventative field with regard to road trauma and most other specialty surgical groups are actively involved in the prevention of disease.

It is quite probable that the bariatric surgical group is also positioning themselves this way, but I believe that the College as a whole should be visibly seen, at high levels, to be developing lines of prevention…

If the surgical fraternity is simply perceived as treating this disease only, and not being active in preventing it and reducing the incidence, then this will be a very poor image to a concerned public.”

The College is now developing a fuller agenda for this issue of health advocacy. We will work closely with other bodies to achieve outcomes remembering that our effective lobbying can be highly leveraged.

What are the issues? What are your views?
Please let us know at david.hillis@surgeons.org.
**Patient Information**

The use of self-expanding metallic stents for obstruction of the colon and rectum caused by cancer is explained.

**What happens when cancer obstructs the colon and rectum?**

The colon and rectum are the parts of the large bowel at the end of the digestive system (see figure 1). These can become blocked by cancer, most often primary cancer of the colon or rectum. Acute obstruction can lead to symptoms such as abdominal pain, nausea, vomiting and constipation. Left untreated, the patient’s condition may worsen, with increased pain, vomiting, rupture of the bowel and possible death.

**What are the conventional treatments?**

The section of the bowel containing the cancer may be cut away with open surgery (see figure 2). This is performed through large cuts in the abdomen and usually only for patients with less advanced cancer who are in good general condition. The bowel ends may be joined or alternatively a colostomy fashioned to allow the fitting of an external collection bag (see figure 3). A colostomy may be surgically reversible but in some cases, particularly in very advanced cancers, it may need to be permanent. A colostomy has implications physically and psychologically and may well affect quality of life and restrict independence of the patients.

Medical drugs may also be used to stabilise the patient for surgery or provide palliative relief.

**What are self-expanding metallic stents?**

Recently, minimally invasive treatments, such as placement of SEMS, have been developed.

This new technology is particularly important for some patients for whom major surgery and/or a colostomy is best avoided (for example, palliative care), and may also be used to stabilise patients for surgery. The metallic tubes are collapsed and passed, usually through the anus, into the rectum or colon. An endoscope or X-rays are used to help guide the stent to the site of the obstruction. The stent then slowly expands under its own force so that the tube can hold the intestine open (see figure 4).

This procedure is an alternative to open surgery, and is carried out either under conscious sedation or without any anaesthesis, avoiding the risks of a general anaesthetic. However, complications may occur, such as breaking or movement of the stent, reblockage of the rectum or colon, puncturing of the bowel, painful straining when going to the toilet, bleeding, and pain in the anus or abdomen.

**What is the evidence?**

There was not enough evidence to clearly determine the safety and effectiveness of SEMS for obstruction of the colon and rectum caused by cancer. However, the limited evidence suggested that:

- SEMS placement was safe and effective in overcoming obstruction of the descending colon and rectum caused by cancer.
- SEMS compared well with surgical treatments for obstruction of the colon and rectum caused by cancer, with fewer major complications for patients and shorter hospital stays. Mortality rates after the procedures were similar.
- SEMS placement before elective open surgery was safer and more effective than waiting until the patient needed emergency surgery. Following the SEMS procedure, the subsequent operation was more likely to be performed in one stage and less likely to result in colostomy and serious complications, and patients had shorter hospital stays. However, the limited quality and quantity of the evidence means that these findings are not conclusive.

**What is ASERNIP-S?**

The Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S) is a program of the College. ASERNIP-S conducts literature reviews on the safety and effectiveness of new surgical techniques before they are widely accepted into the health care system. One of the procedures reviewed was the use of SEMS for relieving obstruction of the colon and rectum caused by cancer. Each review collects all relevant information, or evidence, on new and standard techniques used to treat a medical condition. The quality of evidence is assessed. ASERNIP-S then makes recom-
mendations on the safety and effectiveness of the procedures, that are endorsed by the College. Reviews are regularly updated. ASERNIP-S recommendations are sent to hospitals and surgeons in Australia and overseas, and published on the website with summaries for consumers.

**Glossary**

**Colon:** the large intestine or bowel. It conserves water by absorption from the bowel contents. It also helps in the synthesis of vitamins.

**Colostomy:** an artificial anus on the front wall of the abdomen, formed when the cut upper-end of the colon is brought to the exterior. Bowel contents are caught in a waterproof bag.

**Endoscope:** a tube with a viewing mechanism at the end, used to see inside hollow organs in the body and to perform various surgical procedures.

**Evidence:** the studies included in the review.

**Minimally invasive treatment:** operation accessing the site using a telescope through an opening in the body or small cuts.

**Open surgery:** operation in which the surgeon approaches the site through a surgical cut.

**Primary cancer of an organ:** cancer consisting of that organ’s cells.

**Randomised controlled trial:** a study where researchers randomly place participants in groups; one group receives the new surgical procedure and another undergoes the conventional operation. Researchers compare the outcomes of the different groups.

**Rectum:** part of bowel between intestine and anus.

**Acknowledgments**

Figures 1, 2 and 3 were prepared by Kathrin Hohloch; Figure 4 (Cook Colonic Z-Stent®) provided courtesy of Cook Australia.

For further information on SEMS please see the full literature review on the ASERNIP-S website: [http://www.surgeons.org/asernip-s](http://www.surgeons.org/asernip-s). For more information on ASERNIP-S, please contact: Professor Guy Maddern, ASERNIP-S Surgical Director, PO Box 553 Stepney, South Australia 5069, tel: +61 8 8363 7513, fax: +61 8 8362 2077, email: consumer.avernip@surgeons.org.

The winners of the First Class Around the World Qantas ticket for the RACS Virtual Congress May-October competition is Dr Roger Jansen, Wakefield Hospital (SA).

Ansell HealthCare would like to congratulate the winners and thank everyone who participated.
Provincial Surgeons of Australia
Outstanding presentations provided provincial surgeons with the latest approaches to managing rural trauma.

THE PROVINCIAL SURGEONS of Australia Annual Scientific Conference was held in Kalgoorlie, Western Australia, November 22-25, 2006, with the theme of “Rural Trauma”. This annual conference has now been declared the official educational component of the Divisional Group of Rural Surgery (DGRS), giving rural and regional surgeons the opportunity to participate in educational sessions and interact with peers and mentors who are affected by similar rural issues.

Guest speakers included Russell Gruen from Melbourne, who recently undertook a trauma fellowship in Seattle, USA; neurotrauma surgeon Marianne Vonau, from Brisbane; and vascular surgeon Campbell Miles, from the Alfred Hospital in Melbourne. All of them gave well-researched, outstanding presentations on issues facing rural surgeons.

College Vice President, Professor Stephen Deane, and Chair of Professional Standards and Development, Ian Dickinson, also addressed delegates providing them with the opportunity to raise questions, express their concerns and offer recommendations in an informal environment.

Local Kalgoorlie surgeon, Mike McGushin, convened the conference and is congratulated for organising a highly successful meeting that showcased Kalgoorlie’s attractions in an array of unique venues from a five-star bush dance to dinners at the Mining Hall of Fame and the imposing Town Hall reflecting the town’s immense wealth during the gold boom.

Support from the local medical community was invaluable with local anaesthetist Charlie Nadin providing an educational – as well as highly entertaining – pictorial history of the Kalgoorlie-Boulder twin cities while local radiologist Binky Freyne engaged the audience in an interactive x-ray quiz where delegates could exchange ideas and ask questions.

For more information about the next PSA Annual Scientific Conference in Whyalla, South Australia, November 14-17, 2007, contact Kymberley Walta from the College Conferences & Events Management Team on +61 3 9276 7406 or email kymberley.walta@surgeons.org.
Sydney Upper Gastrointestinal Surgical Society

Presents a symposium on

LAPAROSCOPIC SURGERY - THE STATE OF THE ART

SATURDAY 10th MARCH 2007
8.30am - 4.00pm
NOVOTEL, OLYMPIC BOULEVARD, HOMEBUSH BAY, NSW

Topics

• Pathophysiology of pneumoperitoneum
• Laparoscopic inguinal hernia repair
• Laparoscopic ventral hernia repair
• Laparoscopic anti-reflux and hiatus hernia surgery
• Laparoscopic simulators
• Robotic surgery
• Laparoscopic colonic surgery
• Laparoscopic adrenal surgery
• Laparoscopic bile duct exploration
• Laparoscopic surgery for Upper GI Malignancy
• Laparoscopic Bariatric Surgery

REGISTRATION FORM

Name.................................................................................. Address..................................................................................

Email Address........................................................................ Suburb..............................................................................

Name on Badge....................................................................... Post Code.........................................................................

Member: $ 150 $ ..............................................................

Non Members: $ 200 $ .........................................................

Surgeon-in-training $ 100 $ .................................................

Membership Dues $ 50 $ .......................................................

Total $ .................................................................

PLEASE MAKE CHEQUES PAYABLE TO:
SYDNEY UPPER GASTRO INTESTINAL SURGICAL SOCIETY

Please return registration forms to:
Cherie Berry, Level 2, Vindin House Royal North Shore Hospital, ST LEONARDS NSW 2065
Ph: 02 9926 7692, Fax: 02 9926 8930
PART-TIME TRAINING

South Australia – leading the way

A new model for part-time training positions has proven successful, with the first two Trainees recently obtaining their Fellowships in general surgery.

SOUTH AUSTRALIA HAS led the way in part-time training. Two Trainees have now completed part of their training in South Australian part-time positions and successfully obtained their Fellowships in general surgery. This year South Australia will have a further three Advanced Trainees in part-time training positions.

Part-time training is being sought by an increasing number of Advanced Trainees in general surgery. There are many reasons for this, including feminisation of the surgical workforce, postgraduate medical training, and changing societal norms such that Trainees with small children wish to be involved as principal or part-time carers while still progressing their training. While the Royal Australasian College of Surgeons policy endorses part-time training, a significant number of Trainees remain frustrated by an inability to obtain a suitable part-time training position.

Popular myths of part-time training include: part-time training is only for women, it demonstrates a lack of commitment, it increases the workload for other registrars and is disruptive to unit functioning. The reality is that part-time training is increasingly being sought by both male and female Trainees, and not just for family reasons. Far from demonstrating a lack of commitment, the ability to manage the demands of part-time training and care for a young family requires a high level of organisational skill. By addressing the demands that combining work and family places on Trainees, both Trainees and surgical units can benefit by avoiding negative impacts on Trainees’ ability to work and study effectively.

Traditional models of part-time training have focused on shared full-time positions. The first two Trainees to undertake part-time training were Dr Tim Bright and Dr Cea-Cea Moller. They were in the unusual situation of being married to each other and successfully managed to job-share both a teaching hospital and rural position over two years. Both have now obtained their Fellowships in General Surgery. This was clearly a unique situation. For others, job-sharing has a number of disadvantages including the need to find an equivalent Trainee seeking a part-time position in the same area of training. Hospitals have to carry employment liability for two part-time registrars and there have been perceived difficulties with providing continuity of care, with communication, and with role allocation. Part-time training over a six-month rotation provides only three months of accredited training necessitating a second part-time training position or an additional three months of full-time training.

In South Australia a new model has been proposed to establish part-time training positions in General Surgery. The key features of this model are that each position is a stand-alone part-time position over 12 months, designed to meet College requirements and surgical unit needs. There are a number of benefits of such a model. The stand-alone position does not require job-sharing, is designed to comply with all college training requirements, and avoids diluting the experience and training of other registrars on the unit. The provision of a 12-month position provides the hospital and surgical unit with continuity and stability and provides Trainees with an appropriate level of experience equivalent to a six-month full-time position. Where units have the capacity to meet the training requirements for an additional part-time trainee but not an additional full-time trainee, the creation of these positions helps address the national shortfall in advanced training positions.

This year the first of these part-time positions will be offered on the Royal Adelaide Hospital Breast Endocrine Unit. A specifically designed program will provide a two and a half day week providing experience in endocrine, surgical oncology and breast surgery. The position incorporates inpatient and outpatient care, operating and general surgical on-call as well as participation in hospital and unit educational and audit activities. A similar designed part-time position in Upper GI Surgery at the Queen Elizabeth Hospital has also been approved, while a third position in Vascular Surgery at the Queen Elizabeth Hospital is being developed and may be offered from 2008.

It is hoped that the success of the part-time training positions in South Australia will significantly enhance the College’s ability to attract and retain Trainees who are currently seeking ways to combine training with parenting young families.

Part-time Trainees in South Australia

Completed training:
Dr Tim Bright
Dr Cea-Cea Moller

Part-time advanced training positions 2007:
Flinders Medical Centre - Hepatobiliary Unit
Royal Adelaide Hospital – Breast Endocrine and Surgical Oncology Unit
Queen Elizabeth Hospital – Upper Gastrointestinal Surgery Unit
SYDNEY OBESITY SURGERY CENTRE – VICTORIAN OBESITY SURGERY CENTRE

2007 – WORKSHOPS IN LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING

Course Director
Dr. Paul Dumbrell
M.B.,B.S., F.R.C.S. (Ed.), F.R.A.C.S.

COURSE OBJECTIVES

• Demonstrate the surgical technique of laparoscopic adjustable gastric banding (LAGB).
• Advise and discuss patient selection for the procedure.
• Discuss the post operative management of LAGB patients.
• Discuss identification and management of common complications specific to LAGB surgery. How to prevent them, and how to manage them.
• Advise how to set up a multi-disciplinary obesity surgery practice.
• Post course mentoring

The workshops are designed for surgeons with advanced laparoscopic skills or experienced advanced surgical trainees

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<th>SYDNEY</th>
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<td>The Hills Private Hospital, Baulkham Hills, Sydney</td>
<td>Warringal Private Hospital, Heidelberg, Melbourne</td>
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CPD points applicable

CONTACT INFORMATION
Programme Co-ordinator - Robyn Drinkwater

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5 Burgundy Street
Heidelberg Victoria 3084
Telephone: 03 9450 6800 / Facsimile: 03 9457 3295
Email: robyn.drinkwater@laparoscopicenterprises.com

Workshops sponsored by:
Helioscopie, Matrix Surgical Company, Tyco Healthcare,
The Hills Private Hospital, Warringal Private Hospital.
PROFESSIONAL STANDARDS CPD
Ian Dickinson, Chair,
PROFESSIONAL DEVELOPMENT & STANDARDS BOARD

CONTINUING PROFESSIONAL DEVELOPMENT PROGRAM
All active fellows of the College (engaged in medicine, surgery and medico legal services) are required to participate in the Continuing Professional Development (CPD) Program. The program aims to advance the individual surgeon’s surgical knowledge and skills for the benefit of patients and provide surgeons with tangible evidence of participation in and compliance with the program by the award of a certificate.

2006 CPD RECERTIFICATION DATA FORMS
Fellows should by now have received a Recertification Data Form for 2006. This data form is to record details of your continuing professional development activities during 2006, and should be returned to the College by 31 March, 2007. Please contact Kylie Mahoney, Department of Professional Standards, on +61 3 9249 1274 or email cpd.college@surgeons.org if you require assistance completing your data form.

VERIFICATION
Each year 2.5 percent of Fellows are randomly selected to verify the information contained in their annual recertification data form/online diary. If you have been selected for 2006, you will have been notified accordingly.

CPD ONLINE
Data collection for the 2007 CPD Program is available online via the College website (www.surgeons.org). Fellows are able to access a personal CPD Online Diary using usernames and passwords to maintain CPD records in a real time format. Fellows using the CPD Online Diary for 2007 are not required to complete the hard copy recertification data form issued at the conclusion of 2007, however Fellows are encouraged to continue keeping evidence of CPD activities for verification purposes.

CPD Online training and telephone assistance is available through the Department of Professional Standards on +61 3 9249 1282.

New for surgical supervisors in 2007!
The Supervisor Training Workshop

Are you a supervisor interested in honing your assessment and feedback skills in relation to trainees?

The College is very pleased to announce the introduction of a new workshop aimed at supporting supervisors to effectively fulfill the responsibilities of their important role.

This free, half day workshop is designed to assist supervisors to understand and effectively use some of the competency-based assessment tools that have been developed as part of the restructuring of the Surgical Education and Training (SET) course. Participants will have an opportunity to practise using a range of assessment tools while viewing pre-recorded Trainees in action and then compare scores with their colleagues through a peer discussion.

It will also be an opportunity to find out about some simple but effective feedback techniques, especially in relation to the not-yet-competent trainee. This workshop will allow supervisors to share their experiences, explore barriers to feedback and gain insights into better supporting trainees in the development of new skills.

If you would like to find out more about the Supervisor Training workshops or are interested in facilitating any of the workshops, please contact Merrilyn Smith in the Department of Professional Development on +61 3 9276 7441 or email merrilyn.smith@surgeons.org.
Hair to help the Pacific
Orthopaedic registrars grow moustaches to raise funds for Orthopaedic Outreach.

IN MOVEMBER 2006, nine brave Victorian orthopaedic registrars banded together to don hairy upper lips for 30 days.

The results were varied, some had fine examples of testosterone-driven manhood, while others could only manage three of the finest hairs their bodies could muster.

Nevertheless, fun and admiration was accomplished by all, including raising more than $5500 for Orthopaedic Outreach. During the campaign, we even managed to make it into Launceston’s Examiner in aid of our cause.

Orthopaedic Outreach’s principal goal is to provide surgical training and services to the under-developed countries to our north and north east. Training programs for orthopaedic surgeons have been established in Fiji, the Solomons and Papua New Guinea. Orthopaedic Outreach also provides services in areas such as East Timor and Banda Aceh.

The gallant participants were Jeremy Kolt, Richard Kjar, Derek Carr, Camden Fary, Ash Chehata, Justin Wong, Austin Vo, Chris Jones and Phong Tran. We would like to thank all those who supported us, our partners, patients, staff, consultants and the following companies for their generous support: Zimmer, Synthes, Orthotech.

In 2007, a series of fundraising dinners will be organised to continue Victorian orthopaedic registrars support of Orthopaedic Outreach.

Phong Tran [contactphong@gmail.com]

Royal College of Surgeons of Thailand annual meeting 2007
27-30 July 2007 / Pattaya, Thailand

The Presidents and the Executives of the Royal College of Surgeons of Thailand (RCST) and the Royal Australasian College of Surgeons have agreed to collaborate their activities more closely.

An important aspect is to increase co-operation and communication between the Fellows of our two Colleges by increasing the reciprocal attendance of Fellows at each College’s Annual Scientific Congress. To facilitate this, the RCST is offering complimentary registration for up to five Australasian Younger Fellows to attend their annual meeting held in July each year. This year the meeting is in Pattaya, a beautiful coastal resort 80 kilometres from Bangkok. Our College is providing similar sponsored attendance at our Congress. The RCST annual meeting in 2007 has been designated a combined meeting with the Royal Australasian College of Surgeons. Australasian Fellows are invited to register and attend the annual scientific meeting of the Royal Thai College. The Thai College has expressed the desire to include Australian and New Zealand delegates on their program for the meeting as co-chairs or as speakers.

The website address is www.surgeons.or.th
Registration is possible by way of the website or via a link from our website www.surgeons.org
“WHAT IS THE FUTURE OF ACADEMIC SURGERY?"

A forum organised by
Associate Professor Bruce Waxman,
Chair, Section of Academic Surgery.

When: Saturday February 24 2007
Where: College Headquarters
Spring Street, Melbourne
Who: All Fellows & Trainees

For information on academic surgery contact Nicola Robinson,
Division of Research & Audit
+ 61 8 8363 7513  nicola.robinson@surgeons.org
or for registration details contact Kymberley Walta,
Conferences & Events Department
+61 3 9276 7406  kymberley.walta@surgeons.org

Meeting Announcement

International Conference on the Education and Training of Surgeons
Tuesday 4 March 2008
Royal Australasian College of Surgeons, Melbourne,
Victoria, Australia

***Don’t forget to add this to your diary***
Surgeon Scientist Scholarship

Two years in Arnhem Land and a decade of research have given Russell Gruen insight into improving surgical outreach for remote communities.

SPECIALIST SURGICAL OUTREACH services to remote disadvantaged communities are pivotal if Australia is seriously committed to improving indigenous health, according to Associate Professor Russell Gruen.

Associate Professor Gruen is now a trauma and general surgeon at the University of Melbourne and Royal Melbourne Hospital and chair of the College’s Indigenous Health Program Subcommittee. He received support from the College’s Surgeon Scientist Scholarship from 1999 to 2002 for his PhD research into outreach services to remote Aboriginal communities.

His findings, published in The Lancet last year, were that outreach visits improve access to specialist consultations and procedures, are cost effective, are popular with patients and support remote community health workers, improve communication and trust and do not increase elective referrals or demands for hospital inpatient services. Gruen pays tribute to the contribution of surgeons and other specialists who have been involved in outreach to remote Aboriginal communities.

The specialist outreach service in the Top End of the Northern Territory was initiated by Darwin surgeons and an obstetrician/gynaecologist, with crucial support from the College and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Launched in 1997, it was the first government-funded multi-disciplinary outreach service to remote areas. “It has become a model for Australia and the rest of the world,” Gruen said.

Gruen conducted a population-based observational study of regular surgical, ophthalmological, gynaecological and ear, nose and throat outreach visits over an 11-year period from 1990 to 2001. During his research, he and his wife, Theresa Yee, a general practitioner, spent more than two years living in the small Aboriginal community of Oenpelli in Western Arnhem Land.

He described the lives of many Aboriginal people in remote communities as being characterised by “hardship, suffering and invisibility”. He said the barriers to hospital-based care in Darwin, hundreds of kilometres away, were often insurmountable, with monsoonal floods cutting roads for months and non-existent public transport. “A simple 15-minute outpatient appointment could require a three-day journey,” Gruen said. He said poverty, cultural differences and unfamiliar health services also created barriers with most remote Aboriginal people speaking several languages, of which English may be only their third or fourth.

“The experience of living in such a remote community was invaluable in that I was able to witness first hand not only the barriers to specialist care but the affects of those barriers. “Many patients referred for specialist care at the hospital never got to see a specialist and too often patients didn’t arrive for booked operations. People were suffering unnecessarily because they could not access needed specialist care. We found that specialist investigations and procedures in community clinics removed the need for many patients to travel to hospital and, furthermore, that outreach consultations were associated with a reduced rate of planned procedures in hospital.

“Concerns that outreach visits could increase elective referrals and overwhelm hospital-based services were unfounded. Instead specialists saw many patients earlier and in better circumstances.”

Gruen became interested in issues of public health and disadvantage during medical school electives at a leprosy hospital in Nepal and in Vietnam. He came back with major interests in continued on page 25

continued on page 25
IN FEBRUARY WE celebrate the 80th birthday of this College. Our story began in 1920, and our forefathers took seven long years of hard work to reach their goal. Another four years elapsed before we received our present name. We are today indeed proud inheritors of a rich legacy.

“Throughout the period to 1920, and for some years afterward, most doctors were ‘occasional operators’… Major surgery was commonly undertaken by general practitioners with no special surgical expertise… This situation was compounded by the widespread practice of fee splitting… There was no official body to control the situation…”

This was the condition of the practice of surgery in Australia and in New Zealand about 100 years ago, as recorded by Andrew Newton in his thesis *The History of the Royal Australasian College of Surgeons from Foundation to 1935*. It is against this background that the surgeons of both countries were moving for change 87 years ago.

In February 1920, Louis Barnett, the Professor of Surgery at the University of Otago in Dunedin, gave the first indication that a number of surgeons wished to form a body distinct from other medical practitioners. His initial move was to propose the formation of a New Zealand Association of Surgeons. He also had a concurrent proposal for an Australasian surgical association.

In autumn of that year, members of the surgical staff of the Melbourne, the Alfred and St. Vincent’s Hospitals, formed the Surgical Association of Melbourne. Membership was only open to the senior surgical staff of these hospitals, and limited to 50. It was independent of the BMA. It was also a “closed shop” and its proceedings were not reported to any one. The first president was F.D. Bird and the vice-presidents were Hamilton Russell, Alfred Hospital, and George Syme, Melbourne Hospital. Across the Tasman, New Zealand surgeons who were disillusioned with the BMA supported the formation of this surgical body. When a few Victorian country surgeons were admitted as members, it became known as the *Victorian Association of Surgeons*. The VAS met with strong opposition from the monolithic BMA which demanded that all members of the VAS had to be members of the BMA. The threat of the BMA was ignored, and the VAS quietly went about its business.

At the 11th Australasian Medical Congress which met in Brisbane the same year, Hamilton Russell moved a resolution to give effect to Barnett’s proposal of an Australasian surgical association because Barnett could not get to the meeting. Hamilton Russell’s words were: “…The time has arrived for considering the desirability of forming an Australasian surgical association with the object of raising the standard of surgery in Australia.” Gordon Craig of Sydney made an amendment. He wanted a section of surgery in every branch of the BMA in Australia and in New Zealand instead of a separate body of surgeons. Barnett’s proposal was defeated because it sounded too much like the VAS “closed shop”. Craig’s amendment was well received because every BMA member could then also go to meetings of the surgical section. Neither proposal passed.

Within the Congress at that time, the loyalty of members of the Surgical Section to the BMA was not unexpected because nearly all of them were at the same time members of the BMA, and a good number were either members of the federal committee or office bearers of the state committees. George Syme, like Craig, was also opposed to Barnett’s idea at first. So strong was the pro-BMA lobby that Henry Newland of Adelaide, who was to become the second president of the College, said “the formation of a new association would be a dagger in the heart of the BMA”.

Celebrating 80 years
As the College prepares to celebrate 80 years, here is a look at how the Foundation Fellows came to our name
“Of more significance was the principal that the new Australasian body of surgeons would not be an appendage of the BMA, the Royal College of Surgeons of England or the American College of Surgeons”

In 1924, William Mayo and Franklin Martin visited Melbourne. They were major players in the founding of the American College of Surgeons in 1913. During the visit, Martin lauded the success of the American College, and the seeds of a possible Australasian College of Surgeons with some semblance to the American College were sown. Afterwards, they invited eight Australian and New Zealand surgeons to attend the Annual Meeting of the American College of 1925. While in America, Hugh Devine went on a cruise in Mayo’s houseboat down the Mississippi. During this cruise, Mayo said to Devine: “My boy, go home and found your own College and make it fit into your own Australasian conditions and circumstances.” Devine returned to Melbourne fired with the enthusiasm to found a “college of surgeons” worthy of the high ideals he embraced. He was an eloquent man, and many colleagues, including Syme fell to his persuasion. The importance of Syme could not be underestimated. He had just retired, and he was the doyen of surgery at that time. He commanded enormous respect from all, including the surgeons of NSW and New Zealand. Above all, the BMA trusted Syme.

Because of the intense pressure from the BMA, the VSA capitulated to become the Surgical Section of the Victorian BMA in 1925. However, Syme, Russell and Devine had other ideas, and they drafted and signed the now famous “Foundation Letter” of November 19, which was sent to the surgeons of all public hospitals in Australia and in New Zealand. The opening sentences were: “Senior surgeons and surgical specialists in all the states of Australia have noticed with much concern, a growing disregard by younger practitioners of recognized ethics in Surgical Practice, combined with a spirit of commercialism tending to degrade the high tradition of the surgical profession. Difficult and dangerous surgical operations are undertaken by practitioners who have not been properly trained in surgical principles and practice, and who divide fees with colleagues who refer the patients to them.”

Eighty-one surgeons responded. They were to become the Foundation Fellows of the College.

The following year, 1926, was a very busy one for these Fellows. New Zealand had decided officially to join Australia in this venture. Among the tasks was the writing of the constitution and the problem regarding finance. There was the threat of litigation by those members of the BMA who had no higher surgical qualification but wished to join this renegade body. This was of major concern because there was no examination for admission to membership at that time. The lack of an entry examination might also have been the reason that some of the senior surgeons favoured the model of the American College, and others were impressed by the emphasis of the American College on the practical issues of surgery and the raising of the standard of surgical care in (American) hospitals. In addition, they had to decide where the headquarters would be situated and what the name of this new body of surgeons would be.

The deliberations of these Foundation Fellows in April and August that year spanned the issues of trying to found a surgical body with minimal disruption to the general medical fraternity and appease the hostility of the BMA. The terms “Guild” and “Society” were considered but rejected. A proposal for “voluntary incorporation” of individuals was not considered because it would lack the authority of an organization. It was also suggested that a senior surgical degree might be accomplished through the proposed University of Canberra. The degree would be given ad eundum gradum. This was deemed unsatisfactory. Of more significance was the principal that the new Australasian body of surgeons would not be an appendage of the BMA, the Royal College of Surgeons of England or the American College of Surgeons. In Melbourne, the surgeons had used the term “Association,” while their Sydney counterparts favoured the term “College;” hence, the proposal “Australasian College of Surgeons.” The name “The College of Surgeons of Australasia” was introduced and was written into the minutes of a meeting on June 1, 1926. In addition, the minutes of a meeting in August, that year, stated: “That members of the College be designated as Fellows and be entitled to place after their names the letters F.C.S.A. (Fellow of the College of Surgeons of Australasia, which includes New Zealand).
Another important meeting of the nucleus of this fledgling surgical body took place in Sydney in August, 1926. Devine and others from Melbourne joined this meeting. The “federal” nature of the representation of New Zealand and the various States was formalized. The number of representatives from each State and from New Zealand was stipulated. There were to be 40 “Founders of the College.” These “Founders” are not to be confused with the “Foundation Fellows.” An “Exordium” drafted by Professor F.P. Sandes of Sydney was signed by the “Founders.” This Exordium was printed on parchment.

On August 8, 1925, Sandes wrote to Devine informing him that the general feeling of the Sydney surgeons was that a change in the surgical establishment in New Zealand and in Australia was imminent, and that they would give full support to the establishment of this new College by the Melbourne group.

A BMA meeting of the Australasian Medical Congress was held in Dunedin in 1927. Barnett was the president of the Congress. At the same meeting seven years earlier in Brisbane, Barnett’s proposal to form a surgical body was rejected. He now had the satisfaction to proclaim, together with 19 surgical colleagues, the formation of the “College of Surgeons of Australasia.” Ten surgeons were elected into office: Syme, Barnett, Worrall, Newland, Gordon Craig, Hamilton Russell, Robertson, Sandes, Kenny and Devine. On February 5, 1927, the first Council Meeting was held – this was the birthday of our College.

The next matter was the Letters Patent and the Coat of Arms. The Letters Patent recording the College Coat of Arms was granted to the “College of Surgeons of Australasia” on January 30, 1931, following a petition by Devine to the College of Arms in London. Although the prefix “Royal” was granted on December 23, 1930 by King George V, it was too late for the craftsmen who were making the mace, presented to us by the English College, to alter the inscription already engraved. It now has the words “The Royal College of Surgeons of Australasia” carved upon it.

In his presidential address at the Fourth Annual Meeting of the College in March, 1931, Sir Henry Newland announced the new name “Royal Australasian College of Surgeons.” The announcement had to have royal assent. This was recorded in the minutes of a meeting of our Council which took place on March 30, 1931. Our name was then officially changed from the “College of Surgeons of Australasia” to the “Royal Australasian College of Surgeons,” which was ratified in September, 1931.

This is the story of how we got our name. If one were to examine the correspondence and the minutes of early meetings of the College, the single passion that pervaded those early Fellows was “to raise the standard of surgery.” Today, we not only continue to uphold these ideals, but we spread the same message in all our outreach programs.
surgery and public health focused on disadvantaged populations. He combined these interests during his research in the Northern Territory.

Following his PhD studies, Gruen was awarded the Harkness Fellowship in Health Care Policy for 2002 – 2003, which supported studies at the Harvard School of Public Health and Harvard Medical School. There, he studied professionalism in surgery and participated in the development of both the American College of Surgeons’ Code of Professional Conduct and the RACS Code of Conduct.

He said important and often-undervalued aspects of professionalism are commitments to improving systems of care and contributing expertise to public health and access issues. However, research he conducted in the US indicated that 90 per cent of surgeons believed that such broad community engagement was important. “Surgeons in the past have led the way in many public health campaigns, such as road safety, that have saved thousands of lives,” he said.

Now, Gruen combines his interest in trauma surgery with his commitment to public health advocacy. “I saw quite a lot of trauma in the Northern Territory and it appealed because of its multi-disciplinary systems-orientated and collaborative aspects,” he said.

He recently spent a year as a Trauma Fellow at Seattle’s Harborview Medical Centre, one of the world’s leading trauma centres. “And even though I am back in an urban environment I still work with disadvantaged people who are victims of trauma and interpersonal violence.

“We often witness and treat the consequences of social disadvantage.” That’s why, according to Gruen, our society also needs surgeons to contribute their expertise in advocating for a safer society, improving the health of the most disadvantaged, and getting care to those who need it most. “It’s a role that may seem quite unfamiliar to many of us.”

“Evidence of what works is essential in this process.” As an editor in the Cochrane Collaboration, a global organisation devoted to aiding healthcare decision-making by promoting and disseminating systematic reviews of literature, Gruen encourages evidence-based clinical practice and health policy. He also maintains his interests in Indigenous health, and in development of trauma services in low and middle income countries.”

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**Letters to the Editor**

**Dear Editor,**


I consider the comments of Ms Cathy Ferguson, Chair, NZ National Board, need to be considered further.

She is in favour of ending the affiliation of New Zealand Fellows with the Australasian College.

In the same way that both countries have gained from common economic pathways, I consider that affiliation with New Zealand and Australian Fellows should be continued. Both countries are small but New Zealand is simply too small to be recognised as a centre of excellence in the training of general surgeons and the various sub-specialties.

I urge all Fellows to support the status quo and remain and Australasian College with international recognition and acceptance.

Yours sincerely,

Henry Glennie

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**Dear Henry**

Surgical News forwarded a copy of your letter on my comments regarding the College name to me. I would like to clarify this issue with you.

You suggest in your letter that I am in favour of ending the affiliation of New Zealand Fellows with the Australasian College. This is definitely not my or the NZ National Board’s intention.

What we are seeking is to have New Zealand’s status as one of the two national partners since the inception of this institution recognised by having the words “New Zealand” included in the College title.

There is considerable confusion amongst Fellows, many overseas surgeons and a number of government agencies regarding the meaning of Australasian. Quite a number of Australian surgeons have identified themselves in their own websites as being Fellows of the “Austral” College; and the word Australasian is taken by many to be simply a variant of, and therefore interchangeable with, Australian. Alternatively, Australasian is described as referring to Australia and Asia. Even within College committees and offices it is not unusual to see or hear the word Australian used in place of Australasian.

The College’s Articles of Association are very clear that it was established to cover Australia and New Zealand. In fact, early documents show that there must have been confusion over the name even at that time, as for the first five years or so of its existence, the College title was always written as the “College of Surgeons of Australasia – which includes New Zealand”.

The proposal that the College name be changed, so that “Australasian” is replaced by “Australian and New Zealand”, is being made simply to reiterate the intentions of the founders and to provide clarity for both Fellows and others as to the two countries this College functions for.

I hope this has clarified our intentions and I’d be very happy to discuss this further if you wish.

Kind regards and all the best for Christmas and the New Year.

Yours sincerely

Cathy Ferguson, Chair New Zealand National Board
Arrival
I ARRIVED ON 17 December 2006 and was met by Phil Truskett the departing visiting College general surgeon and his wife Moira Truskett. I had the opportunity to do a ward round with Phil and to get a feel for the operating theatre. In the morning we did two gunshot pellet removals (minor cases) and I saw a fatal gunshot chest trolley’d to theatre followed by an arrow wound to the chest. I assisted the Cuban surgeon, Ernesto who was on-call but not particularly confident about thoracotomies. Another patient in the ward with an acute abdomen had also deteriorated and I operated on him later in the afternoon with Phil – he had multiple intra-abdominal abscesses – and did very well after his surgery. This was my introduction to Dili where I had not visited for four years. I arrived about 8.30am and by 17.00 had had a full surgical day despite it being a Sunday in which the Australian surgeon was not on call.

Living arrangements
Moira introduced me to the vagaries of the accommodation. I was happy to camp, squat at appropriate times, and stayed home many nights to cook for myself despite the limited facilities. There are also many restaurants in Dili. Eric Vreede, the team leader and anaesthetist in East Timor, introduced me to lots of people and made sure I wasn’t lonely, often inviting me out to join him and his friends. This was much appreciated. He also ensured I received security alerts and updates. We were on Security alert level two which meant we had to be careful to check where and when disturbances/fighting were occurring, avoid those areas and drive with the car doors locked at night.

The Working Day
I had an on-call roster and was on-call one in three, alternating with the two Cuban surgeons, Ernesto and Omar. We did ward rounds in the ICU every day (7.45am) and a weekly grand round (Fridays) where we saw all the patients together.
On-call they dealt with the immediate trauma emergencies and did whatever was necessary though they were not so comfortable with neurotrauma, thoracotomies and paediatric emergencies. Once my credibility as a surgeon was established Ernesto asked me to help or take over some of the challenging cases and sometimes came and watched me operate. In the four weeks I did over 50 procedures including craniectomies, a shunt for hydrocephalus, a duodenal atresia, laparotomies, and many cases with trauma or soft tissue infection. Abdominal and other forms of extrapulmonary tuberculosis were quite common but these do not usually require surgery. There were some Western General procedures too – an AP resection, a cholecystectomy, toilet mastectomy and three thyroidectomies. All the cases went well with only two laparotomy wound infections. However, I sent two patients home to die, both with advanced malignancy and saw two patients die of haemorrhagic shock due to a lack of blood. There were two slow lingering deaths in children with major burns who had multiple debridements.

Support Services
When I first visited in 2001 & 2002 there were virtually no support services. Now there is a functioning laboratory, which will shortly begin to provide a histopathology service under a Cuban histopathologist. Dr Reuben David and St John of God Healthcare are to be congratulated on what they have achieved and how they have integrated and involved the Cubans.

The radiology service is very good. Ultrasound, contrast radiographs (barium meal and enemas) are available. The radiologists are very willing to investigate patients after a clinical dis-
cussion and go out of their way to give as much information as quickly as possible. I started to drop in and talk to them almost twice daily. Their reports are written in English or Spanish depending on which language the report is requested. They will often do things right now and if not now, then tomorrow morning. There is no CT scan but I doubt that one would be appropriate in the near future.

The greatest limitation is the lack of blood for transfusion. I saw one patient die of haemorrhagic shock following a road accident and also was frustrated on many occasions by lack of blood, delay in finding a donor for the burns patients.

**Cuban and Chinese Specialists**

The presence of the Cuban and Chinese doctors is a real plus. They are providing a lot of services and take much of the emergency workload which enables more training to be provided by people like myself. I was only on call every third night and this gave me a chance to be fresh every day. The extra diagnostic services provided by the Cuban and Chinese doctors as well as sterilising work in the surgical subspecialties (urology, orthopaedics, ophthalmology) meant one could focus on general, paediatric and neurosurgery.

The Cuban and Chinese specialists have contributed in important ways so Australian Specialists should endeavour to be collegiate and show appreciation of what these specialists do for East Timor. With such a large contingent there are inevitably some weak links but there are always outliers in large delegations and it appears the Cubans have some mechanisms of dealing with problems.

**Comparing 2002 with 2006**

Things have progressed well over four years. There are now about 55 East Timorese Doctors as opposed to the 18-20 of 2001. Until 18 months ago surgical registrars had to do some days of public general outpatients and often missed out on clinical decision making and involvement in operative procedures for their patients. Now that there are more doctors there are three surgical trainees who work full time in surgery and are supervised by the RACS surgeon through the working day. There are also three others overseas in training (Malaysia and Indonesia). At present each Trainee does about three nights a month covering the whole hospital as a general medical officer (a pool of about 16) and so surgical on-call is done by the consultant who sees all the emergency department cases and does any procedures at night.

The wards are reasonably organised, and although there is a high dependency unit mechanical ventilation was unavailable for a variety of reasons. The theatre is busy and does over 4000 cases per year The staff work hard and show plenty of dedication despite the fact that many are displaced from their homes and are living in tents in the hospital. Patients have returned for elective surgery since the height of the unrest in mid 2006.

Dr Katherine Edyvane is the current College resident general surgeon and will be working in East Timor for the whole year. A surgeon willing to stay a whole year will make a much more consistent contribution than a series of short-term relievers such as myself. It will also provide a very exciting opportunity.

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Women’s Clinic on Richmond Hill seeks expression of interest for rental of Day Surgical Unit space, Saturdays and Mondays for minor surgical procure. An interest in reproductive health e.g. Vasectomies would be ideal.

Enquiries phone Robyn 0409 3888 20
New Editor in Chief

Professor John C Hall will focus on strengthening the content of the Journal.

IN LINE WITH a career dedicated to surgical science and education, Professor Hall, has been appointed the new Editor-in-Chief of the ANZ Journal of Surgery. He said he planned to alter the content of the journal to broaden its appeal and provide more relevant articles given the proliferation of medical information in the digital age.

Professor Hall graduated from the University of Melbourne in 1969 and worked as a junior doctor at the Austin Hospital before gaining a fellowship in surgery – a period interrupted by 18 months in national service and six months as a locum general practitioner in the Liebig Street Clinic in Warrnambool. Then traveling to England, Professor Hall became a surgical registrar at the Essex County Hospital in Colchester before winning a National Institute of Health (USA) contract as a fellow in oncology at the University of Leeds (St James’s Hospital).

Upon his return to Australia, Professor Hall took up the post of lecturer at Flinders Medical Centre in Adelaide before becoming a senior lecturer at Royal Perth Hospital in 1985. He was promoted to Associate Professor in 1992 and received a personal chair in 1996. As the author of more than 250 publications including book chapters, editorials, commentaries, abstracts and letters, Professor Hall said that his generic skills in scholarship developed during his career would shape his attitudes as the Editor-in-Chief.

He has been the chief investigator on clinical trials that have been published in the Lancet, British Medical Journal, Intensive Care Medicine, Urology, Annals of Thoracic Surgery, British Journal of Surgery, Annals of Surgery, and Archives of Surgery. Such as been his contribution, that in 1996 Professor Hall was awarded the Royal Australasian College of Surgeons Foundation John Mitchell Crouch Fellowship.

He said that Chief Editors needed to have anything of interest then they will not

More likely, most surgeons probably use the Journal in the same way that I do, or rather, used to. I would sort through the mail when arriving home at the end of the day and, with a drink in one hand, flick through the Journal pieces of interest, occasionally tearing out an article for later reference – before passing on to someone else or putting it in the bin.” Professor Hall said.

“Many readers outside the College access original articles on the web through medical search engines such as Medline; and, from this perspective, it is very inefficient to publish large numbers of original articles on glossy paper,” Professor Hall said.

Professor Hall also indicated that there was a need to increase the content of ‘generic’ information about critical evaluation and risk management; and that this could be achieved by introducing more updates, recent advances, and reviews. A reduction in the number of original articles would also result in an increase in the quality of the articles that are published in the Journal. He believes that it is also essential that the Editorial Board understood the reality of how others use and view the Journal. “Many readers outside the College access original articles on the web through medical search engines such as Medline; and, from this perspective, it is very inefficient to publish large numbers of original articles on glossy paper,” Professor Hall said.

Professor Hall accepts that if surgeons are not interested in scholarly record and listed his service on research committees including the: Gastroenterological Society; Cancer Foundation of WA; Australian Society for Parenteral & Enteral Nutrition; Raine Foundation; and the Patrick Burselum & Mary Healy Foundation. In addition, he has been a Board Member for the Surgical Research Society of Australasia, Immunogenetics Research Foundation and the Urological Research Centre (Western Australia). He has also contributed to the National Health and Medical Research Council (Australia) by serving on Regional Grant Interview Committees, the Discipline Panel for Surgery, and the Fellowships Advisory Panel.

But as important, he said, are the management and budgeting skills developed whilst being Chair of the Division of Surgery at Royal Perth Hospital (1992-6) and Head of Surgery in the University of Western Australia (1998-2001). These skills were employed in the College when he was the Interim Dean of Education (2001-2). The latter is important because Professor Hall has a great interest in surgical education at both an undergraduate and postgraduate level. Surgical Trainees have been the first author in 32 of his publications and he said it was inevitable that there would be an extra emphasis on surgical education in the Journal.

Professor Hall said journals have an important role to play given the vast amount of information available to surgeons. “The information overflow generated by the publication of large numbers of original articles should be counteracted by content that simplified the flow of information. In addition, the Journal has to serve the interests of all the specialty groups that make up the College; and, in order to achieve this, there must be less ‘prime source’ material, in other words less original articles, and more ‘pre-digested’ information of wider appeal.”

Professor Hall also said that there was a need to increase the content of ‘generic’ information about critical evaluation and risk management; and that this could be achieved by introducing more updates, recent advances, and reviews. A reduction in the number of original articles would also result in an increase in the quality of the articles that are published in the Journal. He believes that it is also essential that the Editorial Board understood the reality of how others use and view the Journal. “Many readers outside the College access original articles on the web through medical search engines such as Medline; and, from this perspective, it is very inefficient to publish large numbers of original articles on glossy paper,” Professor Hall said.

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Professor Hall accepts that if surgeons never find anything of interest then they will not
“As well as improving the quality and citation rate of the Journal, he aims to alter the content so that there will be longer and more interesting periods of browsing, more pages being ripped out for later reference, and less unwrapped journals being thrown straight into a rubbish bin.

Professor Hall said a wide audience had different expectations of the Journal from the perspectives of surgical Trainees, medical students, surgeons in other countries, the Editors, the College Executive, librarians, advertisers, and the Publishers. He said it has become clear that the Journal would no longer be just an opportunistic publisher of original articles.

He said there would be no cosmetic make-over of the Journal nor any merger with other publications. “We will concentrate on the main game – the development of appropriate content,” he said. Making cosmetic changes and doing deals is no substitute for improving the content in the Journal.

Professor Hall has been married for more than 30 years and has three boys. His wife, Jane, is an “old fashioned triple-certificate nurse” who has worked with him as a clinical trials co-ordinator at Royal Perth Hospital for almost 20 years. Professor Hall has a wide range of personal interests. He likes working around the house and in the garden, and still has many of his father’s carpentry tools which were used recently to build wall-to-wall shelves in his study. His interests include French art glass from the 1930’s and antiquarian books, particularly those relating to Western Australia. A treasured possession is a copy of “Australia Twice Traversed” by the explorer Earnest Giles containing an inscribed dedication to Sir John Forrest, the first premier of Western Australia.

His current magazine subscriptions are to the New Yorker and Architectural Digest. “The last book I read was about Paul Keating,” he said. “I liked the phrase ‘the dogs are barking, but the caravan has moved on’, because that’s what I want to do. The direction is clear and the Journal is going to change.”

Advocacy

I think the most important thing that any of us can do is to make sure that the fragmentation ends...where there is common ground we should be speaking with one voice.

Professor Sir Graeme Catto President, General Medical Council (18 March 2005)
IN RECENT YEARS concern has been expressed regarding the existence of multiple guidelines on correct patient, correct side and correct site surgery and the variation in the “time out” processes promoted in the various protocols and guidelines. In December 2005, the Professional Development and Standards Board Executive agreed to reactivate the Correct Patient, Correct Side and Correct Site Working Party to review these issues.

Following several meetings of the working party, the College Council has approved the following revision (see next page). We believe the guidelines will enable flexibility between surgeons, specialties and hospitals. The guidelines are an important contribution to the maintenance of standards, and ensuring quality and safety in healthcare. The working party views the guidelines as an empowering tool which can guide all healthcare workers to ensure optimum patient safety.

The College Council has agreed to declare the revision to our Fellows, and will encourage a collaborative approach to implementing the guidelines. The working party will publish evidence in regard to errors, which will allow us to adapt our guidelines and practices in the light of new evidence.

The working party appreciates all feedback on the guidelines. Feedback will be discussed when the guidelines are next revised in September next year.

Rob Atkinson
Chair Correct Patient, Correct Side, Correct Site Surgery Working Party

New Zealand Health Careers

CONSULTANT GENERAL SURGEON
TARANAKI BASE HOSPITAL, NEW PLYMOUTH, NEW ZEALAND
Vacancy No. 4430
Applications are invited for the post of Consultant General Surgeon to join a department of four other Consultants, two of whom have a sub-speciality interest in vascular surgery. This is a new position where you will take part in a 1:5 rota with registrar and house surgeon support.

Taranaki Base Hospital is an active secondary hospital with a wide range of medical specialties including an ICU/HDU/CCU and a Radiology Department with both CT and MRI scanners. All have good administrative and IT Services. There is potential for developing an area of special interest while its size and location lead to easy collegial contact between departments.

Taranaki is an area of New Zealand with outstanding recreational facilities that is currently undergoing strong economic growth and is an excellent place to live and raise a family. There are first class educational facilities.

The successful applicant must have a FRACS with vocational registration or the equivalent qualifications. They will be expected to contribute to advanced trainee registrar teaching and the department’s audit activities.

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The College recognises the paramount importance of patient safety and expects hospitals and surgeons to adopt protocols utilising multiple, complementary strategies. To the extent possible, the patient or their designated representative should be involved in the process.

Adopting a “team approach” in the theatre will reduce risk but the operating surgeon is ultimately responsible. Every member of the operating theatre team has a duty to be aware that the correct patient, side and site are operated on. If any member of the team believes the incorrect patient, side or site is being prepared for surgery, they should immediately voice their concerns.

There should be no criticism of persons raising concerns even if their concerns prove to be unfounded. Surgeons should be aware of the level of risk for wrong site or side surgery for a particular procedure.

Consent and Documentation

Verification of the patient must be made with the patient or the patient’s designated representative (if the patient is legally a child or unable to answer for him or herself). Appropriate legal requirements in this matter must be attended to.

Patient consent must be obtained.

The consent form must include and the patient or representative must verify:-

- Patient’s full name
- Name of procedure
- Site of procedure
- Side of procedure

The site and side of the operation must be recorded in full (i.e. RIGHT or LEFT) and not abbreviated to R or L, whenever the side is recorded. All documentation must include the side and site. This includes patient notes, hospital forms and operating theatre lists.

Marking the Site of the Procedure

- The surgeon should be satisfied on which side and site the procedure is to be performed. This should occur in consultation with the patient.
- An indelible pen is used to unambiguously mark the side/site of the procedure. This is done or checked by the surgeon in consultation with the patient (where possible) and medical record. The patient (who should not have been sedated) is informed that the pen mark indicates the site of the operation. The mark should be within the operative field and should be initialed by the person making the mark. Multiple operation sites must be individually marked.
- The pen mark is checked by the nurse as the patient leaves the ward or holding area for the operating theatre.
- The pen mark is checked by the scout nurse prior to the patient entering the operating theatre. This mark must then be verified by the scrub nurse.
- The surgeon visibly checks the pen mark prior to commencing surgery and ensures this is in accord with his or her intended operation before induction of anaesthesia.

Implants

The surgeon and the operating nurse must check the presence of the appropriate implants in the operating theatre before the anaesthetic commences.

Imaging

The surgeon and his/her team must confer that the appropriate images are available, and confirm the site and side of the proposed surgery.

Final Verification

The surgeon, anaesthetist and nursing team must confer and concur to ensure the correct patient, procedure, site and side. Marking of the operative site must be confirmed. A “time out” or “final check” should be part of this procedure. This should preferably occur before induction of anaesthesia.

Emergencies

In emergency (life or limb threatening situations) some of these steps may be omitted.

At all stages of this process, there should be consistency of documentation of side/site. If any inconsistency arises, progress towards operation should be suspended, the incorrect documentation should be changed and signed, and an explanation of the inconsistency recorded in the patient’s medical history and signed by the surgeon. The surgeon should satisfy him/herself of the appropriate side/site of surgery and record this in the patient’s medical notes before proceeding with surgery. An incident form should be completed.

If the surgeon remains uncertain of the side/site of surgery or the side/site differs from that previously discussed with the patient, the procedure should be postponed or cancelled.

Review Date September 2008
IT IS CLEAR that Day Surgery is now an important part of our health care system. On some estimates, there are now over 200 free standing day surgeries throughout Australia, conducting in excess of 500,000 procedures per annum. There are over 1,000 public and private hospital day surgery facilities.

Day surgeries have an increasing level of sophistication of technology involved, and follow dramatic improvements in diagnostic services and procedures. The growth in the range of procedures offered through Day Surgery has been extraordinary in recent years.

Day Surgery should continue, given government pressure to reduce the costs of our health systems, to develop as an important part of our health care system. On some estimates, there are now over 200 free standing day surgeries throughout Australia, conducting in excess of 500,000 procedures per annum. There are over 1,000 public and private hospital day surgery facilities.

Pressures
Nonetheless, Day Surgery is conducted in an environment where there are a range of pressures and demands:

- The pressure for time is not limited to Day Surgery, but particularly affects Day Surgery.
- The demand for scarce resources also particularly affects procedures in Day Surgery.
- Staffing levels becomes an issue for the management.
- Competitive behaviour, particularly in the private sector, and with increasing corporatisation, means pressure for greater productivity and efficiencies.
- The increasing need for greater record keeping and bureaucracy.

Higher Level of Risk
It can be argued that Day Surgery therefore involves a higher level of risk, and therefore entails a higher duty of care.

Whilst not necessarily prevalent in all cases or all procedures, the following factors might suggest that Day Surgery involves a higher level of risk:

- In many cases, there will be a shorter lead time, and therefore shorter contact time with patients before a procedure, and for informed consent processes.
- Procedures in Day Surgery may have reduced access to the full range of hospital equipment and services which might be available for in-patient procedures.
- There may be greater risk involved in earlier discharge and greater reliance on external post-operative services.

Recognition of these greater risks will help in the development of appropriate risk management strategies.

Legal Risks
A Day Surgery centre will have a non-delegable duty of care, for having responsibility for the overall control and supervision of the facility. Like a hospital, it is not able to remove this duty. Some of the legal risks identified with Day Surgery facilities will include:

- Informed consent, particularly given the more limited time involvement with patients.
- Particular risk associated with limited time for pre-admission assessment.
- Sterilisation.
- Adequacy of equipment and facilities, and whether facilities are sufficiently comprehensive.
- Dealing with emergencies, and whether facilities and policies are adequate to deal with them.
- Adequacy of expertise, skills and training of staff.
- Adequacy of protocols and procedures.
- Premature discharge.
- “Informed Consent” on discharge – Providing patients with sufficient information to deal with post-operative issues.
- Adequacy of follow up and post-operative home care.

Many of these legal risks also apply to hospitals, but are more particularly relevant in the context of a Day Surgery facility.

Duty of Care
Given the general duty of care of Day Surgery facilities, a number of areas should be given particular attention:

- Equipment and facilities.
- Product liability.
- Patient pre-admission assessment and preparation (both whether the procedures are appropriate, and whether the information given is sufficient).
- Liability for contractors (since increasingly, facilities are relying on independent contractors, medical and otherwise).
- Patient assessment immediately upon admission, and upon discharge.
- Training and education of staff.
- Protocols and procedures.
- Accreditation and quality assurance issues.

Informed Consent
Because of the nature of Day Surgery procedures, as previously noted, there may be time constraints, or lack of time, in which important issues for the informed consent process can be dealt with.

It should be noted that, for Day Surgery, there is the same duty to fully inform patients and warn of material risks as for any other procedure in any other facility.

If a procedure in a Day Surgery context involves any additional significant risk than for a formal admission as an inpatient, this may potentially be an additional risk which should be advised to the patient. In such circumstances, the patient should have the opportunity to either have the procedure carried out in a Day Surgery context, or in a full inpatient admission.

continued on page 36
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OLYMPUS
Your Vision, Our Future
TOWARDS THE END of 2006 an unusual piece of furniture came into the College Collections. It is a chair designed specifically for the examination of patients with ear, nose and throat conditions.

The chair was made for Thomas G. Millar FRACS (1900-58). Thomas Millar was born in Charleville, and educated at Clayfield College and Brisbane Grammar School. He graduated MB BS from the University of Melbourne in 1923. In 1928 he gained a Diploma in Laryngology and Otology in London, where he worked at the Middlesex Hospital. In the same year he gained his FRCSEd, and he was elected to Fellowship of this College on 21 September 1931. He held various posts in hospitals in Melbourne, including the Alfred, the Austin, the Dental, the Eye & Ear, the Children’s and especially the Royal Melbourne, where he was RMO 1923-24, Registrar 1924-25, and Assistant to the ENT Department 1927-48. He served as consulting ENT surgeon to the RAAF during WW2, with the rank of Squadron Leader.

The chair consists of a circular seat with arms and a backrest on a base with four legs. The seat is mounted on an axe and a set of bearings, and can rotate on the base in a full circle. Above the backrest is a headrest, adjustable for height and horizontal angle. Originally this headrest was carried on a timber slide which fitted into the backrest, and its height could be adjusted to twelve or so positions by means of a peg. However, at some time in the past this has been removed, and replaced by an iron slide running in a tube, all held onto the backrest by two clamps. The headrest itself consists of two pads covered in leather. The chair is made of silky oak stained dark brown. The seat is fitted with a green cushion, and there is a matching circular stool mounted on castors for the examiner.

The height of the chair, not including the adjustable headrest, is 110cm, and it measures 60cm at its widest part. The stool is 50cm high and 39cm in diameter.

This interesting and historic piece was presented in December by Hugh S. Millar FRACS, son of T.G. Millar, and himself an eminent ENT surgeon. It is an important link with a distinguished Fellow from the early years of the College.
Seventh Australasian Day Surgery Conference

THE AUSTRALIAN DAY Surgery Council (ADSC), in association with the Australian Day Surgery Nurses Association and the Australasian Day Surgery Association, held a conference at the Grand Hyatt Melbourne on Friday 10 and Saturday 11 November 2006. The theme was “Today, Tomorrow and Beyond”.

This was an important meeting for all health professionals working in day surgery settings, both in “stand alone” centres and integrated centres and attracted a multidisciplinary audience of 500 delegates including surgeons, anaesthetists, nurses and day surgery managers.

Over 50 invited speakers presented during the two days which included plenary sessions, concurrent specialty sessions and a series of workshops.

Providing an insight into the future of ambulatory surgery beyond our shores was International Guest Speaker Dr Dick de Jong, a General Surgeon from The Netherlands. Dr de Jong’s current role as Managing Director of the Division of Ambulatory Surgery and Short Stay Surgery at Vrije University Medical Centre and position of President of the Local Organising Committee for the 2007 International Association for Ambulatory Surgery (IAAS) Congress in Amsterdam provided for great depth in his presentations which were thoroughly enjoyed by delegates.

The Organising Committee was overwhelmed by the support from the industry with over 50 companies involved in the exhibition. Booths were very well attended by delegates who took the opportunity to discuss new products and technologies with industry representatives. The professional support from our Conference Organiser, the College Conferences and Events Department, will be ongoing with the Local Organising Committee for the 8th IAAS Congress in Brisbane in 2009.

This biennial Congress will be held at the Brisbane Convention Centre from the 3 – 6 July and it will be the first time that the Southern Hemisphere has hosted this International Meeting. Over 1500 delegates from Europe, North America and the Asia-Pacific area are expected to attend a multidisciplinary program for surgeons, anaesthetists, nurses and day surgery managers. As a prelude to this Congress, plans are underway for “Day Surgery” as a theme at the College ASC in Hong Kong in 2008.

Hugh Bartholomeusz, President
Wendy Adams Vice-President
Iaas 2009 Organising Committee

Further information: Caroline Handley, RACS Conferences and Events Department, E: caroline.handley@surgeons.org or T: +61 3 9249 1273


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Note particularly the reduced time in which anaesthesia informed consent may be obtained. Given the importance of discharge and post-operative information, in the context of Day Surgery procedures, there is an additional need to inform and warn patients upon discharge in relation to the need for continuing treatment and attention, warning signs which may require readmission or doctor call out. Because the patient will not be under the care of the hospital post procedure, the patient will need far greater information than might normally be the case.

General information sheets and prepared literature may be of assistance, but should not replace proper communication with the patient on an individual basis.

Discharge and Follow-up
This highlights the need for proper discharge and follow up policies and procedures.

Notwithstanding that the patient has left the care of the Day Surgery facility, there can be a continuing liability for the care of the patient. There is certainly a duty to provide greater information and advice regarding post procedural issues (including warning signs, readmission and continuing medication).

There may be a need to ensure that appropriate monitoring arrangements are in place with appropriate follow up and verification of post discharge care. For example, a facility may be responsible to ensure that the care that is available to a patient in the home or other environment, post discharge, is appropriate.

This may be particularly difficult in the rural or regional context, where the patient may be far away from medical facilities in the event of some future emergency.

There will certainly be an obligation to ensure that continuing treatment is provided, including continuing service delivery, prescriptions and referrals.

General
Given the growth in the number of Day Surgery facilities and the number and type of procedures carried out through them, there will no doubt be many medical legal cases in the future which deal with and identify particular risks and obligations which differ from those in the usual hospital context.

However, it is important to remember that most of the ordinary obligations currently imposed on our hospitals, both public and private, will apply in the main to the Day Surgery facility. And, given the reduced contact hours with patients in the Day Surgery environment, some of those duties and obligations will be heightened. It is therefore important that the risks be identified, addressed in a risk management context, and continuing review be undertaken.

continued from page 32
We have hit an era where the visibility of medical leadership outside statutory health service roles have been very low.

Sir Liam Donaldson Chief Medical Officer, Department of Health (11 February 2005)
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The Travel Grant is provided to enable outstanding surgeons from the Asia/Pacific region to attend the Annual Scientific Congress of the RACS to be held in Christchurch, New Zealand on 7-11 May 2007, and for hospital visits in the host city.

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- Precedence will be given to Surgeons from the Asia/Pacific regions that have been formally invited to participate in the RACS International Forum.
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- The successful surgeons will be required to supply a report at the conclusion of the Congress on their experiences.

Applications must include:

- A letter of application, including the reasons for applying and anticipated benefit and a brief curriculum vitae.
- Two written supporting professional references.

The Travel Grant will consist of registration to the Annual Scientific Congress and up to $2,000 towards travel expenses and accommodation.

Nominations must reach the following address no later than Wednesday 28 February 2007:

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Wrong Site Procedure

The most common wrong site error is operating on the wrong side. A frequent scenario is for the incorrect operative site to be prepared and draped prior to the arrival of the surgeon in the operating room, resulting in, for example, wrong knee arthroscopy or wrong side hernia repair.

Sometimes the wrong side is chosen in paired organs such as the kidneys or lungs because of a mistake in viewing X-Rays. Side-markers may have been wrongly placed on the films by the radiographer, or may not be visible because the X-Ray beam has been coned to improve definition, leaving the side marker out of the field. In the case of kidney operations careful observation of other reference points to true laterality, such as the gastric gas bubble and checking with a second observer may help to avoid such errors. Although the correct lung is usually easily identifiable on chest X-Rays, mediastinal or cardiac pathology may distort the appearances sufficiently to allow an error.


The “time out” technique, in which a pause is called by the operating team leader immediately before commencement of an operation in order that all OR staff have an opportunity to hear announced the planned procedure and site, is also strongly recommended.

Wrong digit procedures may be avoided by the use of unambiguous identifiers – in the case of fingers, the best description is thumb, index, long, ring, little fingers. Wrong level laminectomy may be avoided by the use of intra-operative image-intensification X-Ray.

Retained instruments, parts of surgical equipment, unintended retained surgical material.

Despite meticulous instrument-counting procedures, retained surgical instruments such as scissors or retractors, sometimes of extraordinary size, continue to make newspaper headlines. In NSW, this has been the stimulus for a revision of the technical standard for theatre counts (NSW Health Standard TS10), but problem areas remain. Detachable blades from self-retaining retractors are occasionally left inside patients – should they be counted as well as the instrument itself?

New instrumentation and new techniques turn up novel problems. There have been four instances of retained “Murray Cod” plastic retractors, used as an aid to abdominal wall closure in obese patients, in NSW hospitals in the past two years.

Lost portions of endoscopic instruments, such as staplers, may lead to the need for conversion to an open operation if they are recognized.

The most significant risk factors for retained instrument are patient obesity, an unplanned change in the operation and an emergency procedure 2.

Positioning injury

The responsibility for safe positioning of the anaesthetised patient to avoid injury is shared between anaesthetist, surgeon and nursing staff. The increasing complexity of surgery has led to the use of elaborate and sometimes contorted positioning with consequently increased risk of injury. The excellent monograph “Positioning the Surgical Patient” (Anderton et al, Butterworths, London 1988) contains detailed descriptions of how to avoid positioning injury and should be read by all OR staff.

Burns

Although burns from electrocautery apparatus are now less frequent due to more sophisticated equipment with built-in sensors and better education in their use, they still occasionally occur. As simple a step as twisting the active diathermy lead around a towel clip may lead to induced current in the clip if the diathermy output is very high, resulting in a skin burn. Instrumental insulation failure is particularly likely to cause visceral injury in the moist conductive environment of laparoscopy.

All operating suites should have a documented policy for regular inspection and testing of electrocautery equipment in a recognised biomedical engineering facility. It is worth asking your hospital for a copy of such a policy.

Burns due to fire may occur with the use of electrocautery around the head and neck, where there is usually an oxygen-rich environment during general anaesthesia. The ignited material may be equipment such as the endotracheal tube.

Burns due to diathermy ignition of spirit-based skin preparations are insidious because the flame is usually invisible under bright theatre lights. They are now rare but may return with the recent renewed interest in spiritous hand disinfection for operating staff.

Fibreoptic light leads connected to high-powered light sources conduct heat and may rapidly cause burns if the free end is left lying on the operative drapes.
Falls
Falls by an anaesthetised patient off the operating table or a trolley are more likely to occur with unusual positioning and if surveillance by theatre staff is not continuous. Serious injuries such as fracture of the shaft of the femur may occur in a relaxed patient as result of a fall by an unsupported limb (usually resting unsecured on a stirrup).

It should be the rule that no unconscious patient is left unattended on an operating table or on a trolley without raised sides. The aviation analogy is the cockpit arrangement: no matter what the emergency, a specific person must at all times be assigned the task of “flying the aeroplane”.

The increasing use of regional and local anaesthesia has seen the emergence of reports of fall-related lower limb fractures in patients who were allowed to attempt ambulation while affected by unrecognised motor blockade in the lower limbs. After inguinal hernia repair under local anaesthesia, for example, patients should not be permitted to ambulate until it is ascertained that no femoral nerve blockade is present.

Falls of equipment may also be a hazard to patients. The transverse bar of a Goligher sternal retractor may fall resulting in a fractured nose or a fractured larynx. Drip stands may fall vertically in their holders and the crossbar may cause serious injuries.

Medication Errors
Medication errors in the operating room are most likely to involve anaesthesia administration. Particular care needs to be taken when anaesthetists or surgeons are called on to administer unfamiliar medications such as uncommon antibiotics or oncology drugs. For example, fatal misadministration of vincristine via the intrathecal route by anaesthetists has been reported from every surgical specialty.

The Dangers of Changing the Operating List Order
The simple variation in routine caused by changing the published operating list order may provide the setting for serious errors such as mismatched blood transfusion or wrong site surgery. The list order should only be changed for valid reasons and the potential dangers should be recognised by red-flagging the change and ensuring that all relevant people have been notified.

Structure Misidentification and the Deadly Tent
This error is of a type common to a number of surgical specialties. An example is misidentification of the common bile duct for the cystic duct during cholecystectomy, resulting in transaction or resection of the bile duct. This still occurs with an unacceptable frequency of 0.3 per cent. Other examples of misidentification leading to patient injury are mistaken the median nerve at the wrist for a tendon, mistaking the testicular artery for the vas, the internal for the external carotid artery, the axillary artery for one of its branches, or the femoral vein for the long saphenous vein.

“Tenting” of the key structure is often a central element in this type of error.

The unrecognised induction of “tenting” of a critical tubular structure by lateral traction is a well-documented error. In vascular structures such as the axillary artery or the femoral vein this may occur when a branch or tributary is retracted strongly. Traction on the gall bladder and cystic duct may tent the common bile duct. Adherence of the ureter to an inflammatory process such as diverticulitis may lead to tenting of the ureter when the mobilised sigmoid colon is retracted. Failure to recognize tenting often leads to resection of a significant length of the vital structure.

Laparoscopy
In the decade since it became widely popular laparoscopy has accumulated an impressive record of operator-based errors and litigation, often related to visceral or vascular injuries during induction of a pneumoperitoneum or during electrocautery use. Laparoscopic bile duct injuries due to duct misidentification are currently the most common cause of litigation against abdominal surgeons. Techniques for minimising these errors are well-documented but are beyond the scope of this article.

Laparoscopic visceral perforations are characteristically subject to delay in diagnosis, sometimes for appallingly long periods, a feature also seen in 75% of bile duct injuries. A good rule is that any patient whose clinical course after laparoscopy deviates at all from normal should be considered to have a perforated viscus or, in the case of cholecystectomy, biliary leakage, until proven otherwise. Post-laparoscopy diagnoses such as “constipation”, “ileus” or “bowel obstruction” should be viewed with extreme scepticism.

“The increasing complexity of surgery has led to the use of elaborate and sometimes contorted positioning with consequently increased risk of injury.”

Summary
A regularly repeated pattern of operating room errors is identifiable. Knowledge of these patterns and the application of some simple preventative strategies may make a dramatic difference to the error rate. Complacency about error (“it can’t happen to me”) is the greatest danger. A sound basic philosophy is “every person and every piece of equipment in this operating room has the potential to harm my patient”.

Dr Thomas B. Hugh FRCS FRACS
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