Vol:7 No:10 November/December 2006

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SURGICAL NEWS

NOVEMBER/DECEMBER HIGHLIGHTS:

PAGE 34-36
BUDGET 2007
“The budget ensures ongoing investment in Fellows services and educational and research activities.”

PAGE 39
RETIRED SURGEONS
“You would be surprised how many colleagues I now come across at the golf courses.”

PAGE 44
SLEEP DEPRIVATION
“Even after the first night shift, take advantage of the afternoon siesta period.”

PAGE 48-49
SURGICAL NEWS INDEX
The first comprehensive index for Surgical News Volume 7 2006.

Patients from the Eye Clinic, Oecussi, East Timor, pages 26-27

The College of Surgeons in Australia and New Zealand

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“I do need to thank the many Fellows and Trainees who are so committed to the College and the Specialty Groups and who work so hard to maintain standards on behalf of the communities in Australia and New Zealand.”

College of Surgical Specialties

Fellows have heard me state before that in 2006, the College is more than a College of Surgeons; it is a College of Surgical Specialties.

Although the College education and training processes have been accredited by the Australian Medical Council (AMC), the delivery of the specialty specific training within this overarching framework is the responsibility of the Specialties and their respective Boards, as it should be. The Specialties are the agents and according to capacity, deliver all or part of the requirements laid down in the Memorandum of Understanding’s and the Service Agreements. The AMC Accreditation will be reviewed in 2007 and the new, evolutionary Surgical Education and Training (SET) program will be included in this review.

Such an arrangement allows for the College, with its considerable educational expertise, to address the generic educational requirements needed to achieve the nine College competencies (both technical and professional) and to advise on and incorporate modern adult learning techniques. The economies of scale make these processes cost effective, as they influence the educational processes in all the disciplines both before and after the award of the FRACS.

Although we can state with some authority that we are competent at the time of the award of the FRACS Diploma, there is increasing community and governmental pressure for us to assure the public that we are maintaining our skills. Currently, the CPD programs confirm our involvement in Continuing Medical Education (CME), but the peer reviewed audit is the only methodology which assesses outcomes and performance. Increasingly, audits such as the breast and vascular audits must include an outlier component if funding is to be provided by external agencies. It is naive to think that, as has happened in the UK, this process will not escalate. If we wish to retain our self regulation status, we must introduce comprehensive processes to ensure the public that we are maintaining the skills needed for our scope of practice – this is no problem for the majority of surgeons. For the small percentage who drop behind, we need collegiate, remedial programs to re-establish the surgical standards or have the courage to dictate that the scope of practice of the surgeon should be limited. We cannot espouse safety and surgical standards or have the courage to dictate that the scope of practice should not drop behind, we need collegiate, remedial programs to re-establish the communities in Australia and New Zealand.

Next February, prior to Council, the whole Council will meet with the Presidents and the agenda will contain issues of mutual importance with the development of action plans to influence the direction of the College. Ultimately, I believe the College Governance will evolve to enhance this process. I am convinced that professionally and politically, surgeons must remain united. Interestingly there has been some preliminary discussion with the College of Ophthalmologists to reconsider a dual Fellowship, an initiative which has been raised by Younger Fellows of both organisations. Recently, the Ophthalmology College received its AMC Accreditation as well. Many Fellows will be aware of the recent debate within the Australian Orthopaedic Association regarding complete separation from the College, which is perceived by a large number of Orthopaedic surgeons to be irrelevant. Much of what the College does educationally, professionally and politically is not clear to the Fellowship and this is a challenge for Council to remedy this. Further, if Orthopaedic Fellows are unimpressed by the College direction, they should change it. The fact that five of the 25 elected Councillors are Orthopaedic surgeons is a good start. I need to emphasise that all College facilities in the regions are fully available to all Fellows and Specialty Groups. Following the vote two years ago, the Specialty Councillors are all elected and can stand for Office Bearer positions. Rob Black, as a Specialty Elected Councillor, has been elected Chair of the Court and I am sure the College will continue to benefit immensely from this change in the Articles.

Sub Specialisation

The increasing Sub Specialisation within the disciplines affects particularly General Surgery, Orthopaedic Surgery and the larger specialties. Sub Specialisation must be based on standards both in surgical delivery and training but it is important that we do adapt our structures to ensure the training opportunities are maximised and the increasing exposure to formal Post Fellowship training is recognised. The first teleconference for a proposed Divisional Training Board in General Surgery and its Sub-Specialties was held in October with the in-principle agreement to continue to develop the model for effective collaboration in the delivery of pre and post Fellowship training. These initiatives will take into consideration the imperative that in the decentralised environment in Australia and New Zealand, it is essential that we continue to train generalists and cover the emergency surgery requirements.

My own view is that there should be appropriate incentives for surgeons to continue these vital services which can be more demanding than elective surgery and which often involve surgery at night and weekends.
Further, educationally robust post Fellowship training programs which include appropriate assessment processes should be rewarded with a suitable qualification. The current tertiary level Colorectal Program could be used as a model in General Surgery and for example could be extrapolated to other sub-specialty areas including Rural Surgery. In addition, the model which is being proposed can be applied to inter-disciplinary areas such as Trauma where a Sub Divisional Training Board could have both a pre and post Fellowship component, with relevant representation from Boards of the current disciplines which award an FRACS.

Surveys

Recent surveys of Fellowship opinions are proving very helpful in influencing the decisions of Councillors. The results of the latest survey are being compiled and analysed to document the preferred directions expressed by the Fellowship. Importantly, the issues of career transition are being raised. Establishing a practice in cost competitive times is a core concern. There are retirement issues as well in a world where senior Fellows still may not have given adequate attention to long-term financial planning. The “Winding Down from Practice” workshops also provide advice and opportunities regarding the many activities that can be accessed in the retirement years. We are also keen to encourage Fellows in this phase of their career to contribute to the basic skills courses. The College does charge substantial subscriptions but has improved the delivery of the many available services. The College is the Fellowship and Council is committed to modernisation with the provision of the best range of services for its Fellows. I do thank people for their feedback and would encourage all Fellows to communicate their views both generally and to particular Councillors.

Government Regulation

You will be aware that the College is exiting from the Australian Competition and Consumer Commission (ACCC) Authorisation. However, the threat of increasing government legislation and regulation will remain. I have communicated with many people recently about the increasing bureaucracy present within the UK system. The initiatives are poorly co-ordinated, experimental and require considerable administrative resources. It is my observation that the initiatives are as much about the drive to gain control of the profession as they are about maintaining high standards of surgical training. Unfortunately, this is being repeated with enthusiasm by the governments in Australia and New Zealand. As I go around the country attending various College and Specialty activities, I am continually impressed by this enthusiasm for excellence. There are retirement issues as well in a world where senior Fellows still may not have given adequate attention to long-term financial planning. There are retirement issues as well in a world where senior Fellows still may not have given adequate attention to long-term financial planning. The CPMC and the College have prepared submissions emphasising these views.

We need to refine the current system, not radically change it. Currently, it works reasonably well and ensures that the public is protected. Many of the problems related to health care delivery and the workforce have resulted from governments and the bureaucracy ignoring professional advice.

Cowlishaw Symposium

I attended the Biennial Cowlishaw Symposium on Saturday, 28 October 2006. The Cowlishaw collection at the College is a bibliophile’s delight. It is a major medical collection of great value. The presentations must all be related to the books in the collection and Wyn Beasley delivered the Kenneth Russell Memorial lecture which was entitled “An Approach to the Natural (Hippocratis Coi medicorum omnium longe principis. Ex ædibus Francisci Minitii - 1525)” in great style. A highlight for me, was the presentation by Nick Doslov on the tedious, meticulous restoration of a 17th Century leather bound volume entitled “De Chirurgie Ende Alle de Opera Ofte Wercken van Mr Ambroise Paré (C van Breugel & H Laurentz, 1636)”. This was a most delicate process which had great appeal to all the surgeons present.

Seasons Greetings

In the last edition of Surgical News for 2006, I do need to thank the many Fellows and Trainees who are so committed to the College and the Specialty Groups and who work so hard to maintain standards on behalf of the communities in Australia and New Zealand. As I go around the country attending various College and Specialty activities, I am continually impressed by this enthusiasm for excellence. There have been major changes in 2006 and we are poised to introduce the new training program which is being positively embraced. It is worth emphasising that SET is evolutionary and a refinement of the current program, not radically changing the well-tried systems.

I do wish you all the best for the Festive Season and I have no doubt that in the profession of surgery, 2007 will be another exciting and challenging year.

CORRECTION

In the October edition the ASERNIP-S article precede read ‘Simulation can be an effective supplement to supervised training.’ This was not a direct finding of the review.
Surgical Education and Training Discussion Document

This document has been produced to stimulate discussion regarding the proposed introduction of Surgical Education and Training Program (SET)

Available on the College website: www.surgeons.org on the College home page click on the heading The Surgical Education and Training (SET) Program and that will take you to the Discussion Document.

To Fellows and Trainees,

The new Surgical Education and Training program will be a substantial advance for the College. Its aims as detailed in this discussion booklet are many but in particular we hope to streamline surgical training and involve the nine disciplines with which the College awards its diploma as early as possible in the training initiatives.

No change of this substance occurs without concerns being raised particularly by the Supervisors who provide the training on a day by day basis or the Trainees who are embarking on a surgical career. The College has clearly communicated its intent through workshops, articles in Surgical News and presentations at many meetings. This has involved not only Fellows and Trainees but representatives of Government and Departments of Health. Much useful feedback has been received.

The outcome of this process to date has been to prepare this fuller Discussion Document that will answer a substantial number of the concerns raised. Importantly it will also raise more questions about which the College is keen to know, understand and respond. This will be achieved in a number of ways over the coming weeks.

Firstly there will be workshops in all regions to provide opportunity for College staff to discuss the Discussion document and seek feedback. Secondly a specific enquiries contact will be established at SETenquiries@surgeons.org

It is hoped that with this feedback the documentation can be completed to enable the opening of pre-SET in January 2007, the selection of Trainees for SET in 2007 for the commencement of SET in 2008. Importantly the Australian Medical Council will be accrediting the program in August of 2007. Obviously the implementation of this program is now critical and we specifically request the implementation type question. In answering these we will ensure the successful commencement of the program.

I look forward to your feedback

Professor Ian Gough
Censor in Chief
Upcoming Council Elections

A call for nominations for the College Council will be with you in December. It is therefore timely for me to provide you with detailed information of the timetable for those elections (refer Table 1) and to remind you of the potentially significant amount of change that could occur on the College Council.

The timing and process for the conduct of Council elections is dictated by the Articles of Association and therefore the timeline for Council elections provided has been constructed accordingly.

Table two details Council Members Terms of Office. You will note that six current Councillors are in the final year, i.e. they will have completed nine years on Council in May, 2007. These Councillors are Patricia Davidson, Russell Stitz, Andrew Sutherland, Peter Woodruff, Ross Blair and myself. There is provision within the Articles, however (specifically Article 5(b)) that allows for any Councillor elected to one of our Office Bearer positions (i.e. President, Vice President, Censor in Chief or Treasurer) within their ninth year to serve an additional year, i.e. to be a Councillor for a total of 10 years.

The role of Councillor is both demanding and rewarding. Obviously there is the requirement to attend the three Council meetings each year at the end of February, June and October. Councillors are also ex-officio members of their local state/regional committees, and consequently expected to attend these meetings. Service on other College committees is also usual – such as one of the Resources, Educational or Fellowship related committees (e.g. the Board of Specialist Surgical Training, International Committee, etc).

Personally, I would like to publicly acknowledge how rewarding my time on Council has been. I consider it a great privilege to serve the Fellowship and our College and can sincerely recommend the experience. It is stimulating and enriching to work with a range of committed colleagues from all specialities and regions.

I do encourage you to, at the very least, fully participate in the election process, and, if you are on for a real challenge, put yourself forward for Council. I can promise it will be a personal highlight! We, the Fellows, are the College and our involvement is our greatest asset.

The next few years will be particularly challenging as the College negotiates our way through the implementation of the new SET program and our decision to re-assess our authorisation by the ACCC. The community requirements for surgery will change, as will surgical technology and non-surgical therapy. Pressures to regulate our training and performance will continue. Our patients will still need and deserve the high standard which is recognised in “FRACS”. The need for strong and dedicated leadership will continue.

Stephen Deane, Vice President

Table 1 – Timetable for 2007 Council elections

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fri 17 Nov 06</td>
<td>Email notification to Council members advising them of coming election and seeking confirmation of their intention to retire, remain or stand for re-election. Under Article 6 (iv) – the transitional provision – three Specialty Elected Councillors are up for re-election. In accordance with the draw, they are the Cardiothoracic, Orthopaedic and Paediatric Specialty Elected Councillors.</td>
</tr>
<tr>
<td>Fri 24 Nov 06</td>
<td>Deadline for notification of intentions from Council members to be returned by fax or email</td>
</tr>
<tr>
<td>Mon 4 Dec 06</td>
<td>Call for nominations document to printer</td>
</tr>
<tr>
<td>Fri 8 Dec 06</td>
<td>Call for nominations document mailed to Fellows. Courier to Wellington office for posting in NZ</td>
</tr>
<tr>
<td>Tues 6 Feb 07</td>
<td>Closing date for receipt of faxed nominations (at least 85 days before AGM 9 May 2007)</td>
</tr>
<tr>
<td>Wed 7 Feb 07</td>
<td>Ensure all nominees have received emailed CV form for return by Tues 20 Feb 07</td>
</tr>
<tr>
<td>Tues 13 Feb 07</td>
<td>Closing date for receipt of original nominations forms (at least 78 days prior to AGM). Closing date for receipt of CVs and photos</td>
</tr>
<tr>
<td>Wed 14 Feb 07</td>
<td>Compile CVs, photos and other ballot documentation</td>
</tr>
<tr>
<td>Tues 21 Feb 07</td>
<td>All election documentation to printer</td>
</tr>
<tr>
<td>Thurs 8 Mar 07</td>
<td>Post ballot papers to all Fellows (at least 60 days before AGM)</td>
</tr>
<tr>
<td>Wed 11 Apr 07</td>
<td>Ballot closes 5.00 pm (28 days prior to AGM)</td>
</tr>
<tr>
<td>Thurs 12 Apr 07</td>
<td>Receive couriered ballots from NZ</td>
</tr>
<tr>
<td>Fri 13 Apr 07</td>
<td>Counting of votes. President to contact candidates. CEO to email notification of results to Fellows.</td>
</tr>
<tr>
<td>Wed 9 May 07</td>
<td>4.00 pm AGM. New Councillors take office</td>
</tr>
</tbody>
</table>
## Table 2 – Terms of Office for Current Councillors

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Region</th>
<th>First Elected/Last Re-elected</th>
<th>Due for Re-election</th>
<th>Maximum Possible Term (To May)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Elected Councillors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ross Blair</td>
<td>Vascular</td>
<td>NZ</td>
<td>*1998 /1999</td>
<td>2005</td>
<td>---</td>
</tr>
<tr>
<td>Ian Civil</td>
<td>Vascular</td>
<td>NZ</td>
<td>2003</td>
<td>2006</td>
<td>2009</td>
</tr>
<tr>
<td>Trish Davidson</td>
<td>Paediatric</td>
<td>NSW</td>
<td>1998</td>
<td>2004</td>
<td>---</td>
</tr>
<tr>
<td>Stephen Deane</td>
<td>General</td>
<td>NSW</td>
<td>1998</td>
<td>2004</td>
<td>---</td>
</tr>
<tr>
<td>Ian Dickinson</td>
<td>Orthopaedic</td>
<td>QLD</td>
<td>2002</td>
<td>2005</td>
<td>2008</td>
</tr>
<tr>
<td>John Graham</td>
<td>Vascular</td>
<td>NSW</td>
<td>2006</td>
<td>---</td>
<td>2009</td>
</tr>
<tr>
<td>Mike Hollands</td>
<td>General</td>
<td>NSW</td>
<td>2006</td>
<td>---</td>
<td>2009 /2012</td>
</tr>
<tr>
<td>Jim Powell</td>
<td>Orthopaedic</td>
<td>NSW</td>
<td>2006</td>
<td>---</td>
<td>2009 /2012</td>
</tr>
<tr>
<td>Russell Stitz</td>
<td>General</td>
<td>QLD</td>
<td>1998</td>
<td>2004</td>
<td>---</td>
</tr>
<tr>
<td>Andrew Sutherland</td>
<td>Orthopaedic</td>
<td>SA</td>
<td>*1998 /2000</td>
<td>2006</td>
<td>---</td>
</tr>
<tr>
<td>Bruce Waxman</td>
<td>General</td>
<td>VIC</td>
<td>2000</td>
<td>2006</td>
<td>---</td>
</tr>
<tr>
<td><strong>Specialty Elected Councillors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anand Dixit</td>
<td>Cardiothoracic</td>
<td>TAS</td>
<td>*2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mike Sexton</td>
<td>General – representing rural surgeons</td>
<td>NZ</td>
<td>*2006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geoff Davies</td>
<td>Expert Community Advisor</td>
<td>QLD</td>
<td>*2006</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* denotes first co-opted
# denotes the draw conducted at June 2005 Council meeting to cover the transitional arrangements to stagger the terms of the first cohort of Specialty Elected Councillors under Article 7(b)(iv)
The questions this month have been selected from a number of the Vascular Surgery modules. Vascular Surgery is the first specialty to publish interactive, online self-assessment MCQs linked to each of their modules on the College website.

The MCQs can be found at the end of each module and provide feedback on performance in each question.

A results summary is also maintained as a record of the performance of each trainee in Vascular Surgery on each module. The trainees are required to have attained a pass on each set of MCQs prior to sitting their Fellowship Examination.

A feature of this site is the provision of an explanation or a reference for further reading.

Questions

1. Early graft infections are usually associated with:
   Select the most appropriate response (True or False) (more than one answer may be correct)
   a. aortoenteric fistulas
   b. positive cultures
   c. virulent organisms
   d. graft thrombosis

2. Late onset graft infections are:
   Select the most appropriate response (True or False) (more than one answer may be correct)
   a. typically the result of contamination at the time of operation
   b. secondary to haematogenous and/or seeding from enteric contents
   c. usually secondary to coagulase positive staphylococci
   d. more frequently secondary to staphylococcus aureus organism

3. A 63-year-old man presents with an asymptomatic carotid stenosis. No significant past medical history. BP 160/100 on three occasions.
   A. This man would benefit from treatment for hypertension T/F
   B. If you wish to treat this patients which would be the most appropriate agent:
      Select the most appropriate response (True or False) for each (more than one answer may be correct)
      a. ACE inhibitor
      b. Angiotensin II receptor blocker
      c. Beta blocker
      d. Ca channel antagonist
      e. Diuretic
      f. Nil

4. Type I diabetic patient with HbA1c 6.9%. BP 120/80mmHg. Chol 3.9. Admitted in for infrainguinal bypass. Usually on ultralente insulin 48 units night with six units actrapid three times daily before meals.
   The best pre-operative regime would be:
   a. Fast with 5 per cent dextrose infusion. Half dose ultralente night prior to surgery. Continuous insulin infusion to keep BSLs less than 10 mmol/L. Test for ketones six-hourly. T/F
   b. Fast with N saline IVT. Hold all insulin night before surgery. Use sliding scale actrapid four-hourly. Test for ketones daily. T/F
   c. Fast with 4 per cent D 1/5 NS IVT. Hold usual insulins. Continuous insulin infusion to maintain BSLs <10 mmol/L. Test for ketones six-hourly. T/F

5. A 63-year-old patient maintained on warfarin following two confirmed episodes of DVT/PE in the past six months is scheduled for elective colectomy for diverticular disease.
   Which of the following options is best for management of anticoagulation in the perioperative period?
   Select the most appropriate response (more than one may be correct)
   a. Continue warfarin peri-operatively
   b. Stop warfarin five days prior to surgery and recommence post operatively
   c. Stop warfarin five days prior to surgery, change to LMWH 100units /kg bd until 24 hours prior to surgery and resume LMWH/warfarin postoperatively
   d. Stop warfarin five days prior to surgery, recommence warfarin as soon as possible after surgery and use usual prophylaxis with calciqura 5000u bd or equivalent dose LMWH over peri-operative period.
   e. Stop warfarin five days prior to surgery and use retrievable IVC filter during perioperative period.

Answers on Page 38
A Fellowship in paediatric hand surgery

Guy Dowling left for London in December 2004 to undertake a Hand Surgery Fellowship with the assistance of funding provided through the Hugh Johnston Travel Grant.

On 7 July last year Mr Dowling was at Kings Cross Station when the terrorist bombs were detonated on the city’s rail system. Mr Dowling returned to his flat at Goodenough College before making his way to the nearby Hospital for Sick Children at Great Ormond Street where he was based for his Fellowship year.

With the city in gridlock and all communications shut down to prevent further remote-controlled detonations, scores of critically injured people were being ferried from the nearby Russell Square Station to a makeshift casualty in the cafeteria of the Children Hospital.

“All communication systems had been compromised. Accurate information wasn’t available. We had no idea whether we would be treating 60 people or 600, whether it was a random attack, separate events or a co-ordinated attack. Bear in mind that this was a kid’s hospital with no emergency department. We were operating on adults with paediatric equipment on the dining tables in the cafeteria; tiny little chest drains for bilateral pneumothoraces; little cannulas and catheters; GOSH (Great Ormond Street Hospital) wasn’t part of the emergency protocol; there was tremendous improvisation,” Mr Dowling said.

“One of the more confronting aspects of all this was that some of the staff from the hospital were among the wounded,” Mr Dowling said.

He said the skills learned from the College’s highly regarded Emergency Early Management of Severe Trauma (EMST) course were invaluable. “If I had not done the Surgical Trauma course I think I would have found the situation much harder to deal with in terms of being able to cope with scores of critically injured people needing immediate attention. It was enormously helpful in terms of prioritising patients.”

Mr Dowling was in London to undertake a Fellowship in paediatric hand surgery under the supervision of the renowned international expert Mr Paul Smith. While there he developed a new classification for paediatric hand function. “While I was a Plastic Surgery Registrar I developed an interest in hand surgery and more specifically the congenital hand problems in children,” he said.

“The current classification systems are largely based on the appearance of the hand and have only limited usefulness. I developed the idea of a system that focuses more on the functional ability of the child’s hand. The aim was to develop a simple, rapid and reliable method for scoring paediatric hand function.

With Paul Smith, Mr Dowling proposes distilling the process of analysing hand function down to the analysis of seven tasks;

- place the hand in space
- place the hand flat on a surface
- grasp
- turn palm upwards
- manage a rudimentary pinch
- manage a precision pinch
- undertake fine manipulative skills.

“The competence with which these seven tasks are performed can then be scored; 0, 1 or 2; you can do it (2), you can sort of do it (1) or you can’t do it at all (0).”

“A maximum score is therefore 14. It’s like a Glasgow Coma Scale of hand function.”

He said the system might improve communication between specialists, GPs, allied health professionals and parents and allow for clearer decision-making in determining surgical intervention.

“We believe it allows for a more accurate clinical assessment of a child’s disability.” Mr Dowling said an article describing the system was under consideration for publication by the Plastic and Reconstruction Surgery Journal in the US.

Mr Dowling said he was grateful for $3500 travel grant. “This funding paid for my tickets to get there but it is not so much the value of the money but the show of support that is important.”

The Travel Grant is provided via a bequest of the late Eugenie Johnston and is designed to assist deserving Fellows and Trainees of the College gain specialist training overseas.

Mr Dowling now has a public and private practice in the South eastern suburbs of Melbourne.
When the state of Victoria enacted a Companies Act in 1928 that seemed suitable, and the choice of Melbourne for the College headquarters had been agreed, the College was registered as a company in the state of Victoria, obtaining incorporation – as the College of Surgeons of Australasia – on 24 October 1930. By this time, however, the College had applied, through the vice-regal channels in both its countries, for the prefix “Royal” to be attached to its name. This was seen as a stratagem for obtaining the status of a Royal College without incurring the restrictions and convolutions involved with a Royal Charter. On 23 December 1930 the Royal permission was obtained – through the two vice-regal channels.

But two other distinctions were “in the pipeline” by this time. Earlier in 1930 the Council had approached a Melbourne antiquarian, E Wilson Dobbs, about the design of a possible coat of arms, and by April he had drafted something close to what was finally granted. Hugh Devine visited Britain in 1930 (almost a month each way by sea, such visits were a major undertaking) and Dobbs’s design, forwarded by air mail, overtook him there. Devine was dined at the Garrick Club by the president of the English College, Lord Moynihan, and members of his Council; he reported on the activities and pretensions of the young Australasian College, and so impressed his audience that they resolved to present a Mace to their colonial cousins. (In 1920 the gift of a Mace to the American College, in recognition of surgical links forged during World War I, had set some sort of precedent for such a splendid gesture.)

This prospective gift made the matter of a grant of arms one of urgency: Devine reported to his friend Alan Newton, “Fagge and others, and I might add myself, also think that if we are ever going to get a grant of arms we ought to get it at once so that it can be put on the mace.” (Fagge was a vice-president of the English College; it would be he who brought out the Mace and handed it over.) Suddenly four processes were bustling along, each tending to get in the way of another: incorporation, the Royal prefix, the arms and the Mace. An official drawing of the new grant was produced by the College of Arms, and passed on 10 October 1930 to Omar Ramsden, who had been commissioned to fashion the Mace. This was followed by prompt notification of the Royal assent, but that arrived when Ramsden was able to do no more than prefix “Royal” to the existing name. On the other hand, the work of the herald painter does not admit of amendment, so the Letters Patent which bear the date 30 January 1931 were past the point of no-return, and thus grant arms to the “College of Surgeons of Australasia” – with no “Royal” at one end and no pleonasm at the other.

It remained for the College to introduce its Royal prefix into its incorporated title under the Victorian Companies Act. The opportunity was taken by the Council of the time to change the wording about so as to produce the “Royal Australasian College of Surgeons” and the public notification of this change proved useful when the original Letters Patent were presumed lost and a replacement was sought in the 1970s.

These various processes made a Royal Charter unnecessary; but Geoff Down has recorded that Devine, the Irishman, continued to yearn for the prestige it might confer, and indeed petitioned the King (George VI, son of the monarch who had conferred the Royal prefix) in 1939. The outbreak of war rearranged imperial priorities and the matter lapsed.

In the early 1980s, Mervyn Smith, then PRACS, sought Royal patronage for the College. (HRH The Duke of Edinburgh had become Patron of the Edinburgh College in 1955, and various royal personages have been Honorary Fellows of the English College, though it does not have a Patron.) In 1983 it was agreed that HRH The Prince of Wales would become this College’s Patron, and he was inducted in the course of a visit to Melbourne in 1985. Unfortunately the event did not coincide with a Council meeting, but those office-bearers who could be present joined in a function at Government House. Geoff Down reports that “the patronage of the Prince of Wales confers additional prestige on the College, but imposes no legal burdens.” He notes the Prince’s “express wish that he be kept informed of the work of the College” and he observes that the courtesy of furnishing HRH with a brief report annually “seems to have lapsed”. If we recall Prince Charles’s generous foreword to The Mantle of Surgery, and the well-crafted video with which he extended his greetings at the
"As to the retention of the prefix "Royal", it needs to be understood that, as long as either or both our countries retain an involvement with the monarchy, any move to abandon our status as a Royal College would be considered offensive by many Fellows – and should indeed be considered offensive by all."

College’s 75th jubilee celebrations, we have to deplore such a lapse and urge the prompt revival of the courtesy.

As to the retention of the prefix “Royal”, it needs to be understood that, as long as either or both our countries retain an involvement with the monarchy, any move to abandon our status as a Royal College would be considered offensive by many Fellows – and should indeed be considered offensive by all.

And that leaves the question of the name, both in full and as it would translate into postnominal letters. The proposal to substitute “Australian and New Zealand” or “of Australia and New Zealand” for the present version deserves examination, against the criteria that I listed at the beginning of this paper. Neither of the proposed versions is more accurately descriptive in geographical terms; neither is as concise as the existing name. (Worst of all for New Zealanders, an Australian using the term “Australian College” could claim to be half-right!) It is disturbing to find the stealthy insertion (at the foot of the cover page of recent issues of Surgical News) the legend “The College of Surgeons in Australia and New Zealand”. Furtive efforts at change seldom attract respect.

Finally, postnominal letters: who would wish to put FRANZCS on his/her letterhead? – even in a report from Assisi, it would be marked down. (And even Republicans ought to shudder at FANZCS, for all the good dropping the “R” would do.) Until or unless a euphonious name for the combination of our two countries comes into use, let us avoid blundering into another name change.

It is a pity that ANZAC bears such overtones of military courage and heritage as to preclude its use, because such a crisp term would avail us well, quite apart from leaving the postnominal letters undisturbed. But until someone gives us an everyday equivalent of ANZAC, let us abide by the injunction of Lucius Cary, the second Lord Falkland, who died in 1643 fighting at Newbury:

When it is not necessary to change, it is necessary not to change.

And if I may offer a contemporary corollary to this:

Change that does not improve is fit only for politicians.
Whereas early ancestors and conquerors viewed a nomadic existence as being essential to gaining life experience and land, the views held by surgical Trainees these days is often quite varied. It would be ideal to assume that Trainees see it as an opportunity to gain a broader platform, a wider range of clinical experience and operative techniques. However, the reality is that while most appreciate the experience they gain, many view the act of relocation as a stressful and expensive exercise.

There are many factors in the relocation process which generate stress. Commonly flagged items include term duration discrepancies between various states, orientation, hand-over, accommodation, transport, salary sacrificing and award conditions, and recreation and lifestyle factors. Loan and spousal/offspring commitments often compound an already stacked deck of cards. A lack of time to ensure an adequate transition is a recurrent theme.

The costs involved in relocation are considerable. On top of packing and removalist fees there are costs involved in setting up new utilities and services. There are costs involved in moving cars and pets. There is often a requirement to visit the new location to arrange rental accommodation, day care and schooling prior to commencement. Sick leave and long service leave entitlements are lost, a cost often forgotten.

RACSTA identified relocation as being an important issue for Trainees early in its conception. Through subgroup allocation RACSTA has developed a number of initiatives to support Trainees undergoing relocation. To relieve stress and anxiety a database is being developed which will draw upon Trainees’ “local knowledge” to provide potential colleagues with information about the hospital and state health systems in that region, where to stay, where to play and who to call. To help with costs RACSTA has brokered a deal with Grace Removals, developing a corporate alliance, allowing trainees access to cheaper rates, personal packing consultants and even someone to do your shopping at the other end prior to arrival if time is tight. Discussions with relevant health boards and review of accreditation standards are other ongoing cost-related initiatives.

Through the above initiatives it is hoped that the transition between jobs runs smoothly and the stress associated with relocation is reduced. Although quite small in nature, the steps gained so far suggest that larger ones can be achieved. The aim is to ensure that surgical Trainees focus on the job at hand, drawing the most they can from the experiences on offer. As Napoleon said in July 1812 in Vitebsk; “Do you think I have come all this way to conquer these huts?” One can only hope that Trainees can adopt a similar attitude, albeit in a cheaper and less stressful manner.

If you are relocating and want to speak to Grace Removals please contact them on 1800 014 016 or via email racs@grace.com.au. A specialist RACS account manager will handle your enquiry.

I’m going where?

The issue of relocation is one that touches many trainees within the surgical profession.
Court cases have considered that a doctor can be liable for negligent acts of their office staff.

One case concerned a receptionist who, when advised of the symptoms of a patient (even though the patient was not present), failed to refer the issue to the doctor for action or suggest to the patient that other steps were appropriate.

Australian courts have already determined the responsibility of doctors in relation to the non-receipt or non-follow-up of medical reports and tests which confirmed that when requesting tests or seeking reports, doctors must have a system to ensure that the test results are received and communicated to the patient, or that the reports are received, analysed and appropriately acted upon.

A case in NSW also confirms the liability of the doctor for the acts or omissions of their office staff - in this case a general practitioner potentially being responsible for the actions of his receptionist.

The factual situation was disputed. In summary, a wife presented at a general practice seeking an appointment for her husband to visit the doctor following symptoms of a severe headache.

There is some dispute whether the patient’s wife conveyed a sense of urgency, and what symptoms were communicated.

However, the court accepted that her husband had had an unusually severe headache, and, uncommonly, had asked his wife for a migraine tablet. In fact, the husband had been suffering from headaches during the previous month although it is not clear that this was communicated to the receptionist.

The Court also accepted that the receptionist gave the impression that she was an experienced medical receptionist when there was evidence that this may not have been the case. The allegation was therefore made that the receptionist, through inexperience or failure to refer the symptoms to the doctor, failed to arrange for an appointment or checkup with the doctor in a timely way.

The husband, with the headache, did not meet the appointment and died from an aneurysm shortly thereafter.

Evidence was presented that had the headache been followed up and the aneurysm detected, a different result may have occurred.

The court accepted that the patient and his wife had no medical knowledge that would have enabled them to appreciate the risk, but that if the receptionist had consulted the doctor and advised him of the specific symptoms of a severe headache, the doctor would have appreciated the risk.

Even though neither the doctor nor receptionist saw the patient, a duty of care existed. The court accepted that a GP has the responsibility to ensure that patients seeking appointments are properly prioritised.

A doctor should have guidelines in place so that if a patient’s medical condition may be of an urgent nature the receptionist knows to consult the doctor to determine if the patient should be seen urgently.

The court also concluded that a medical receptionist separately owes a duty of care to the patient to ensure that if a patient presents with an urgent medical condition the patient will be seen in a timely manner. If the doctor is unavailable, and a patient presents with an urgent medical condition, the receptionist should refer the patient elsewhere.

Notwithstanding this duty, in this case, the court confirmed that neither the doctor nor receptionist breached their duty. The court concluded that the receptionist acted reasonably and prudently in allocating an appointment within the timeframe set. The risk of the patient suffering the aneurysm was not “foreseeable” and, accordingly, neither the doctor, nor his receptionist, breached the duty of care that they owed to the patient.

The court accepted that the doctor had instructed the receptionist on how to appropriately perform duties at the surgery and that she been appropriately trained in dealing with such issues as bookings, handling of complaints, and determining the priority of patients.

Implications

The implication for doctors is, therefore:

1. A doctor’s practice as a whole, including staff, must be aware of the issue of prioritisation of patients.
2. A doctor has a responsibility to ensure that office staff are appropriately trained in the prioritisation of patients.
3. In appropriate cases, office staff must refer symptoms or issues to the doctor for a decision, or arrange for immediate or timely review through an alternative medical practice, emergency department or hospital clinic.
4. Doctors should be aware of the difficulty relating to patients who “present by proxy”, either through a member of the family presenting on their behalf, or by telephone conversations.
The role of Workforce Assessment Unit

After extensive research and collaboration with important surgical groups, the Workforce Assessment Unit is lending its support to the development of a sustainable surgical workforce.

Purpose

The College’s 2005-2006 strategic plan expressed our reasons for being active in the area of Workforce Assessment. They included the development of workforce statistics and sharing information with the Fellowship, establishing co-operative projects and sharing of information with Specialist Societies, Associations and Regional Committees/Boards, and completing a workforce census of the Fellowship.

The Workforce Assessment Unit now has considerable experience in research and collaboration with important surgical groups and now sees its main goal to support the Fellowship in the development of a sustainable surgical workforce. The Unit seeks do this in four main ways:

1. Understanding through measurement: Using qualitative and quantitative information to develop a deep understanding of the composition of the surgical workforce and the issues that impact on it.
2. Evaluation: Based on evidence, evaluate the current and future requirements of the surgical workforce, to ensure its sustainable development.
3. Planning for the future: Contribute to the planning of College’s activities so that they fit with the current and future needs of the surgical workforce, in metropolitan, regional and remote communities throughout Australia and New Zealand.
4. Advocacy and involvement: Promote the issues and involve our Fellows in supporting the development of a sustainable surgical workforce, particularly through the Specialist Societies, Associations and Regional Committees/Boards.

Activities of the Workforce Assessment Unit

The range of activities of Workforce Assessment Unit over the past 12 months is described here:

1. The College census of the surgical workforce: The census report has been an important tool, helping to advocate for surgeons, for their patients and communities. The purpose of the census is to detail the scope of work of Fellows of the College, track changes in working hours and work patterns (including reduced hours / retirement intentions), and gain a more accurate picture of the present and future requirements in regional, rural and remote locations.

2. Reporting on College activities and other external reporting: The Activities Report is a descriptive document provided for the community which details statistics on the College’s activities in education, assessment and the surgical workforce. Education data include details on Basic Surgical Trainees (BST); Transitional Surgical Trainees (TST); and Specialist Surgical Trainees (SST), with associated accredited BST hospitals and SST accredited hospital post listings. New and Active Fellowship numbers and International Medical Graduate assessments are also described. The report is updated for each Council meeting. The Unit also reports activities to external bodies, such as the Medical Training Review Panel, a national body which sets and measures expectations related to general aspects of medical training in Australia.

3. Information and resources: A significant activity of the Unit has been the building of data files and literature and media collections related to the surgical workforce (e.g. source data from the Australian Bureau of Statistics – demographic data; Australian Institute of Health and Welfare – hospital data; Medicare – operation and procedure data). This information from outside the College is important in interpreting our own data and in making suggestions about surgical workforce trends.

4. Surgical job advertisements, tracking research pilot: The Workforce Assessment Unit has been piloting a tracking research exercise into advertisements for surgical positions within Australia. The aim of this research is to develop an understanding of the location-specific requirement for surgeons within Australia and to
assess the current availability of surgeons to fill these requirements. By monitoring the recruitment of surgeons, the degree to which the immediate supply of surgeons is meeting the current demand can be observed. A process for the identification of advertisements has been developed by sampling 15 job websites.

5. Mapping access to surgical services in Australia: To ensure that the needs of regional and remote communities are adequately assessed by the Unit, surgical distribution mapping research is being undertaken. The aim of this is to identify the location of surgical clusters by specialty throughout Australia, establish the population capacity of each cluster and determine how large a cluster needs to be in order to provide easy access to the community and sustainability for the surgeons.

6. Rural surgical issues: A range of reports and presentations have been created that examine the rural surgical workforce. Examples of material produced on the topic include the Non-metropolitan Workforce Report and the Regional, Rural and Remote Surgery – Census 2005 Report as well as presentations made by John Graham at the College 2006 Annual Scientific Congress.

7. NZ SNAP project: The NZ Surgical Needs Analysis Project is being undertaken by the NZ National Board and seeks to estimate the number of surgeons which New Zealand is likely to require in the future, at the level of District Health Board area and surgical subspecialty, by considering the current workload and the community's need for surgical service. The final report of the project is expected to be available in mid to late November. Review of the Census of Australian Fellows and the New Zealand SNAP project will greatly assist in the design and effectiveness of future surveys.

Workforce Assessment Unit Research Agenda

The current research plan for the Workforce Assessment Unit is focused in three areas:

1. Establishing a reliable model for projecting the required number of surgeons and surgical Trainees needed between 2006 and 2015 to address a “true expected gap” in surgical service delivery. Short-term strategies to deal with the more immediate projected reduction in emergency surgical service delivery need to respond to this true expected gap between surgeon retirements and surgeon graduations.

2. Determining practical solutions to address workforce challenges in metropolitan and rural communities.

3. Involving specialty surgery groups and surgeons sitting on other workforce expert panels in the College planning process and ensuring that our College’s understanding contributes to discussions in other medical workforce planning forums.

The projection models will enable the College to be better equipped when interpreting recommendations proposed by external bodies including the Health Workforce Principal Committee and the Australian Medical Workforce Advisory Committee. Information from our own experts within our Fellowship will assist in our understanding of factors influencing the demand for surgery in each specialty and in each region.

Planning for the graduation of surgeons with the skills and styles and in the numbers to at least meet the needs of our communities in Australia and New Zealand in the future requires a really good crystal ball. In the absence of such a device, projections based on real data are essential. Let us also recognise that we are doing this in the context of a substantial global shortage of surgeons.

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 was 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, the College

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

Contact Lindy Moffat / lindy.moffat@surgeons.org / +61 3 92491224
Wyn Beasley has been brave enough not only to put his Latin up for inspection but to come to at least a partial defence of maintaining the current name of the College. I support several of his arguments – the name should indeed define us with precision while being as concise as possible – but cannot agree with his conclusion.

Precision must surely require that a title is understood and the word “Australasia” fails on this count. Even lexicologists cannot agree on its meaning. Wyn quotes different definitions from just one source (the Oxford Dictionary) from different decades. If other sources are included the definition becomes even more diverse – Australasia can be anything and everything south-east of Asia.

It is manifestly obvious that the current name fails to define the College with precision. There is no question that this is the surgical College for Australia and New Zealand and its name should make this clear to any interested party.

The College has shown its willingness to assist with surgical training and the delivery of services in neighbouring countries but any suggestion that the surgeons in those countries are therefore part of and represented by this College is surely a hangover from our colonial past.

Wyn has kindly reported the history of the College name and I’m sure had many, including myself, searching our dictionaries for the meaning of “pleonasm”. The College founders clearly realised “Australasia” was not readily understood and that it was necessary to identify in the name that this did include New Zealand. I am definitely not advocating for the reinstatement of the pleonasm – that would fail both requirements, for precision and for conciseness.

The World Wide Web allows easy access to a considerable amount of information and some very superficial “research” into the College name reveals it is indeed correct that it is predominantly Australians who use the incorrect College name. Googling “Royal Australian College of Surgeons” in the Australian web pages brings up over 900 references. A very superficial scan of these reveals the misnomer in the websites of a number of Fellows, many Australian universities, the AMA, several Australian specialist surgical societies, most of the State and the Federal health departments, websites of other Medical Colleges and, regretfully, even a section of this College is guilty in this regard. In contrast, Googling the same in the New Zealand web pages brings up just over 30 references, including that same section of this College.

Times have changed and the idea of joint representation of Australia and New Zealand under a single Australasian flag (as happened for the 1908 and 1912 Olympic Games) seems quite laughable. Our sporting battles are a source of fierce trans-Tasman rivalry and reflect our strong individual sense of nationhood.

This is not simply a New Zealand whinge, it is an issue of substance that relates to accuracy and fairness to a significant section of the Fellowship. The term Australasia was first used in 1756 by Charles de Brosse. Would it not be appropriate to lay it to rest on the 250th anniversary of its initial usage? Unlike Wyn, I think the change would result in a major improvement. When did a politician do anything as sensible as this? As for the post nominal that will result, I’m sure we can all survive with a marginally less euphonious acronym for our Fellowship.

I would urge all Fellows to support a change in the College name when this is put to the vote.

“Bringing New Zealand out in the open”

The College needs a name that defines it accurately.

STONNINGTON DAY SURGERY

Stonnington Day Surgery (fully accredited and registered) – 2 state of the art operating theatres – 13 first and second stage recoveries. Full set-up for plastic surgery, but would consider other disciplines as well. Sessions available now.

Enquiries to Evelyn Blake (DON) on (03)9508 9509.
During the past three years, Perth plastic surgeon Mr Alister Turner has had to operate on five women suffering complications from “cheap” breast enhancement surgery undertaken overseas as part of the new multi-billion-dollar medi-tourism phenomenon.

Two of the women had suffered deflated implants within six months of the surgery, two had badly positioned implants and one woman had to have the stitching around the nipple removed. Mr Turner said he found having to do such corrective surgery frustrating, in that each procedure took up valuable theatre time.

“All of these women had to go back to theatre and that clearly is a drain on resources and raises the question of who should pick up the bill. These are not easy operations anyway and for surgeons who are not experienced they are fraught with little problems. Clearly the implants being used were inferior from those allowed in Australia and the quality of surgery left much to be desired,” he said.

Mr Turner also said he doubted if the women, most of whom he believed had the surgery done in Thailand, would spread the message about the risks of medi-tourism. “They were embarrassed, they felt silly and understood that they had made the wrong decision, but the nature of this new industry seems to be that people think it is cheap, risk-free and private. I don’t think very many people would be telling their friends about what had gone wrong,” he said.

Mr Turner is not alone either in his experience of having to fix the surgical errors made overseas or in his mounting frustration. A survey conducted earlier this year by the Australian Society of Plastic Surgeons indicated that 35 plastic surgeons from across the country had treated patients with complications upon their return to Australia.

These ranged from people suffering “hideous scars” to infected implants, a failed tummy tuck and a woman who lost her hair after undergoing a brow lift. And given that the survey was undertaken in January, when most surgeons are on holidays, the Society said at the time that the findings indicated just the tip of the iceberg.

Since then it has been in close consultation with the Department of Foreign Affairs in an attempt to have warnings regarding medi-tourism made more public – either through a publicity campaign or via warnings on the Department’s website designed for travelers. It says the embarrassing nature of the mistakes means that warnings are unlikely to be spread via word of mouth.

Discussion is also under way as to whether such corrective surgery should be paid for out of the public purse while the Department of Foreign Affairs earlier this year also raised concern at the burden such surgical errors was placing on embassy staff.

Thailand, Malaysia, Indonesia and the Philippines are now believed to be the most common destination for Australian medical tourists with dedicated travel companies now established in Australia to promote and arrange such “tours”. Most are designed around a hotel stay with minimal time in hospital and little – if any – surgical follow-up. Other destinations include Argentina, Iran and the Ukraine.

It has been reported that the World Health Organisation believes the new industry could be worth up to a staggering $40 billion globally with new medi-cities being constructed in the Middle East and Asia to meet the demand. Stories have also emerged of people travelling to India for heart surgery and hip replacements with other countries offering “cheap” cosmetic dental work.

The President of the Australian Society of Plastic Surgeons, Dr Bill Cockburn, said there were a number of pressing concerns relating to the new industry including the lack of post-operative care, the use of inferior products and the absence of a professional analysis of a patient’s requirements well before the patient arrives in a foreign hospital booked in for surgery.

“A lot of people who come in for cosmetic surgery do so because they believe they need a procedure done to correct a problem,” Dr Cockburn said.

“But if they go to a qualified plastic surgeon, often they will be advised that the procedure they want may not be appropriate. For example, they may want liposuction but if they have a weight problem liposuction will not help. This level of advice and consultation does not happen in medi-tourism. You pay, you get, whether it is appropriate or not” Mr Cockburn said.
Dr Cockburn said the Society had just last month successfully lobbied the Government to increase the size and importance of its warnings about medi-tourism on the website designed to warn Australians of various risk factors in countries around the world.

He also rejected claims made recently that the global industry was good for developing countries, in that it brought in Western dollars to fund state-of-the-art medical infrastructure and lured good surgeons back to their countries of origin. “That is rubbish,” he said of the claims. “The profit in this industry is made by the medi-tourism operators, not the wider health industry.

“Take Malaysia for example. It has an estimated 20 plastic surgeons compared to 260 in Australia, so the Malaysian public is under serviced and you could argue that local people are missing out while tourists are being treated. I also find it very hard to imagine that good surgeons will be lured back for this sort of work.”

Dr Cockburn said that the new global phenomenon was causing much concern and debate and was partly driven by extreme make-over-style shows and glossy magazines that portrayed cosmetic surgery as something trivial. “This trivialisation has become so commonplace in our society that some people will spend more time deciding what beauty products to use than on finding a plastic surgeon with the right credentials,” he said.

“However, surgery undertaken as part of these tours is an absolute lottery where in most cases the patient meets the surgeon just before they go into theatre. Some will have surgery of a high standard and some will not – but the question remains as to who should pay when things go wrong.

“And this does not just relate to surgical costs – it relates to the cost of the TGA and the work it does to determine which implants are safe to use compared to copies made in China, it relates to the costs of embassy staff helping those with post-operative complications and the cost to private health insurance or Medicare back here.”

Dr John Quinn, the Royal Australasian College of Surgeons Executive Director of Surgical Affairs, said the new industry commodified surgery and allowed people to purchase a surgical treatment as if they were buying a pair of shoes. He said the College believed there was no need for anyone to go overseas to seek treatment – either because of cost or waiting times – and that standards in Australia were among the best in the world.

“The concern with this development is not only about the quality of surgery but also the standards of infection control in hospitals overseas and viruses or diseases that may be prevalent in different countries. The front of house of these hospitals may be flash but you don’t know what is going on in the back.

“It is not the purview of the College to affect personal decisions but we do want people to make such decisions with their eyes open and in a position to give informed consent.”
AUSTRALIAN INDIGENOUS HEALTH PROGRAM

The Royal Australasian College of Surgeons (RACS) in collaboration with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) are pleased to offer an exciting new learning opportunity for doctors, including international medical graduates (IMGs) caring for Australia’s Indigenous population. This program is proudly supported by the Australian Government, Department of Health and Ageing.

PROGRAM OBJECTIVES
This program will deliver eight on-line education modules, assessment items and discussion forums for registered participants and; two videoconferencing sessions to enable participants to partake in face-to-face discussions to resolve any issues with subject specific experts.

INDIGENOUS CULTURAL FOCUS
We acknowledge the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Framework, Guiding Principles including the following principle:

‘Aboriginal and Torres Strait Islander Peoples have a diversity of cultures, experiences, histories and geographical locations. They are not a homogenous population, and this should be reflected in the design, delivery and evaluation of curricula’.

EDUCATIONAL FOCUS
The focus of the educational modules is to improve the health outcomes of Aboriginal and Torres Strait Islander people within the context of clinical practice. Module One will commence between January and February 2007.

Each of the modules will address the impact of the Aboriginal and Torres Strait Islander culture across the surgical, obstetric and gynaecological disciplines. The following are topics that the program will endeavour to cover:
• Better surgical and O&G care: Getting to know your Indigenous patients’ culture and context.
• Are you being heard?: Effective communication and two-way understanding for patients’ self-management (eg diabetic foot or during treatment for cervical cancer).
• Why patients might not turn up: Understanding your patient’s world view, priorities, and the barriers they face accessing care.
• Why patients might leave hospital early: Understanding relevant hospital, community and family issues and how to deal with them.
• Informed Consent - When, how and why: Effective communication strategies to ensure patients really understand their treatment.
• Finding common ground: Improving your effectiveness by working together with all members of the Indigenous healthcare community.

FEES AND SERVICES
• This program is free to registered participants
• It is not compulsory for participants to complete all eight modules.
• Technical support is available

BENEFITS TO PARTICIPANTS
• Understand how contextual, cultural and communication issues affect Aboriginal and Torres Strait Islander people’s health and health care
• Develop skills to make you a more effective practitioner when working with Aboriginal and Torres Strait Islander people
• Opportunity to receive feedback on specific clinical issues within a cultural context
• One on one learning support with facilitator
• On-line peer support
• On-line information and resources centre
• Continuing Professional Development points and a Certificate of Participation

FOR FURTHER INFORMATION
Please contact the Project Officer,
Phone: + 61 3 9249 1122
Fax: + 61 3 9276 7432
Email: indigenoushealth@surgeons.org
Challenging new role

I have been on the Victorian State Committee (VSC) for five years and was elected to the position of Chair in June, succeeding Peter Choong.

I work as a cardiac surgeon, principally at the Royal Children’s Hospital, and I am an Associate Professor at the University of Melbourne. I’ve been involved in many overseas charitable cardiac surgical trips, and teach on several College courses for Basic Surgical Trainees (BSTs) the Australia and New Zealand Surgical Skills and Education and Training (ASSET), Care of the Critically Ill Surgical Patient (CCISP) and Critical Literature and Evaluation Research (CLEAR). I have also completed a Master of Public Health and am currently doing a Bachelor of Commerce degree part-time through the University of Melbourne.

This new role has been a rapid learning curve, particularly with regard to the way in which the College functions, and the numerous committees and bodies. Fortunately I have excellent support from the other members of our state Executive – Julian Smith, Graeme Campbell and Michael Dobson.

There are several important issues facing the College federally over the next five years, which will be well known to most Fellows – the lack of surgeons in rural practice, the possible entry of new surgical training institutions, the challenges with the ACCC, and the introduction of a new surgical training program (SET) which will significantly change a number of aspects of traditional training. Further important problems facing the College include the issue of how to keep the diverse sub-specialties together, and how to maintain involvement by Fellows in the training schemes run by the College.

The introduction of the new SET program will be quite a major change in surgical training. It may go some of the way to addressing the concerns of the ACCC and the state jurisdictions regarding restriction on Basic Surgical Training (BST) positions, and will streamline surgical training, but it will require a larger commitment by Fellows to the effective training and evaluation of their Trainees. Although the current criticisms related to the numbers entering BST will disappear, it may well be that the focus of criticism is simply moved to the new site of entry to surgical training, the selection for the SET programs.

As an active teacher in College courses for the current BSTs (CCISP, ASSET and CLEAR), I have become concerned by the lack of involvement by Fellows in some teaching areas. I have observed that some of the courses are very dependent on a small group of teachers to run the courses, while other courses are very dependent on older surgeons or semi-retired surgeons for their faculty, and while those Fellows are sincerely thanked and acknowledged for their work, it raises concern about the lack of involvement by many younger Fellows in helping to train the next generations of surgeons. This may parallel the observation by others that many younger surgeons are less attracted to work in the public sector, particularly since the private sector continues to increase its “market share” of healthcare and private practice can be established more readily than in the past.

The retention of all surgical groups (nine) within the College structure will be an ongoing issue, requiring hard work within the College. In some ways, I am concerned that with the new SET program, the more rapid differentiation of Trainees into their chosen fields, with less exposure to general surgery, may reduce the links between groups and exacerbate the apparent lack of connection between the different surgical groups. To quote one of our political leaders, the things that we have in common are far greater than the differences, but this is not always obvious to our Fellows.

In Victoria, the main immediate issue is the organisation of the new Victorian Audit of Surgical Mortality (VASM). Victoria has been a lot slower than most other states in instituting the VASM, although much of this delay has been at the state department level. However, after almost three years, the process is close to fruition and I hope that the contract with the Victorian Department of Human Services can be signed before Christmas. This achievement will be the result of persistent work by many people, but Peter Choong deserves praise for his efforts to push the process along.

As the state election approaches in Victoria, it is very pleasing to see the rebuilding of a number of hospitals by the State Government. We have needed refurbishment of our hospital infrastructure for several years and this appears to be underway at last. The new Royal Women’s Hospital is under construction, the Royal Children’s Hospital plans are under development, and a new hospital for Box Hill is planned. However, there are serious deficiencies in the provision of services to the rapidly growing south-eastern suburbs of Melbourne, which need improved hospital facilities. It is predicted that Melbourne will have the largest population growth of any Australian city in the next 20 years, with an increased population of about 750,000 people and the hospital infrastructure plans need to cater not only for the current demand but for this expected population increase.

However, despite the willingness by the State Government to provide funds for new capital projects and to enter public-private partnerships to build these new hospitals, there continue to be funding deficiencies in meeting the daily needs of patient care. At the same time, inefficiencies in our hospital systems need to be clearly pointed out to hospital administrators, so that we can improve productivity and make the most effective use of the health dollars, thereby maximising the number of people who can benefit.
Conference diary dates

Here are the details of many of the upcoming major surgical conferences. This information is also available on the College website, in the Library area, where new conferences are regularly added. If you know of any other scientific meetings that Fellows might be interested in, please send an email to College.Library@surgeons.org.

Surgery
Australia/NZ
- Provincial Surgeons of Australia 2006 - Annual Scientific Conference
  22 - 25 November 2006 / Kalgoorlie WA Australia
  Contact kimberley.walters@surgeons.org
- Forum: What is the Future of Academic Surgery?
  24 February 2007 / Melbourne VIC Australia
  Contact kimberley.walters@surgeons.org

Overseas
- American College of Surgeons 93rd Annual Clinical Congress
  7 - 11 October 2007 / New Orleans LA USA
  http://www.facs.org
- Health Technology Assessment International 4th Annual Meeting
  17 - 20 June 2007 / Barcelona Spain
  http://www.htai.org/barcelona-2007/
- The Royal College of Physicians and Surgeons of Canada Annual Conference
  27 - 29 September 2007 / Winnipeg Canada
  http://rcpsc.medical.org/meetings/index.php

Cardiothoracic Surgery
Australia/NZ
- Asia Pacific Interventional Advances (APIA) Conference
  30 November - 2 December 2006 / Sydney NSW Australia
- CSANZ 2007 55th Annual Scientific Meeting
  9 - 12 August 2007 / Christchurch New Zealand
  http://www.tcc.co.nz/csanz/
- Australasian Society of Cardiac and Thoracic Surgeons
  17 - 20 October 2007 / Noosa QLD Australia

Overseas
- Society of Thoracic Surgeons 43rd Annual Meeting
  29 - 31 January 2007 / San Diego California USA
  http://www.sts.org/sections/annualmeeting/

General Surgery
Australia/NZ
- NZ Society of Gastroenterology & NZNO Gastroenterology Nurses Section - Annual Scientific Meeting
  15 - 17 November 2006 / Blenheim New Zealand
  http://www.gastro2006.co.nz/
- Clinical Oncological Society of Australia Annual Scientific Meeting
  29 November - 1 December 2006 / Melbourne VIC Australia
  http://www.cosa.org.au/content.cfm?randid=761823
- New Zealand Association of General Surgeons Annual Scientific Meeting
  23 - 25 February 2007 / Napier New Zealand
  http://www.mianz.co.nz
- AUSTRAUMA 2007: The Sting
  23 - 24 February 2007 / Sydney NSW Australia
  http://www.austriaumaconference.org/
- Transplantation Society of Australia and New Zealand
  28 – 30 March 2007 / Canberra ACT Australia
- Endocrine Society of Australia Annual Scientific Meeting
  2 - 5 September 2007 / Christchurch New Zealand
- Colorectal Surgical Society of Australia and New Zealand Annual CME Meeting
  3 - 6 October 2007 / Victor Harbour South Australia
  Contact: jann@csa.org.au
- Australian Gastroenterology Week
  24 - 27 October 2007 / Perth WA Australia
  http://www.gesa.org.au/
- Clinical Oncological Society of Australia Annual Scientific Meeting
  26-29 November 2007 / Adelaide SA Australia

Overseas
- American Burn Association 39th Annual Meeting
  20 - 23 March, 2007 / San Diego California USA
  http://www.ameriburn.org/39thannualmeeting.php
- The American Society of Breast Surgeons 8th Annual Meeting
  2 - 6 May 2007 / Phoenix Arizona USA
  http://www.breastsurgeons.org/Annual_Meeting.htm
- American Transplant Congress
  3 - 9 May 2007 / San Francisco California USA
  http://www.atcmeeting.org/index.php
- American College of Colon and Rectal Surgeons Annual Meeting
  2 - 6 June 2007 / St Louis Missouri USA
  http://www.fascrs.org/displaycommon.cfm?an=9
- 24th Annual Meeting of the American Society for Bariatric Surgery
  11 - 16 June 2007 / San Diego California USA
  http://www.axbs.org/
- Society of Laparoendoscopic Surgeons Annual Meeting and Endo Expo
  September 2007 / San Francisco California USA
- American Association for the Surgery of Trauma
  66th Annual Meeting
  27 - 29 September 2007 / Las Vegas Nevada USA
  http://www.aast.org/annualmeeting/AnnualMeeting.html

Neurosurgery
Australia/NZ
- Spine Society of Australia Conference
  20 - 22 April 2007 / Hobart Tasmania Australia
- NSA Annual Scientific Meeting
  30 September - 3 October 2007 / Gold Coast Queensland Australia

Overseas
- American Association of Neurological Surgeons Annual Meeting
14 - 19 April 2007 / Washington DC USA

• 7th Annual Canadian Spine Society Meeting
21 - 25 March 2007 / Mt Tremblant Calgary Canada
https://spinecanada.ca/public/meeting/index.asp

Ophthalmology
Australia/NZ

• RANZCO Annual Scientific Congress
24 – 28 November 2007 / Perth Western Australia
http://www.ranzco.edu/congresses

• American Academy of Ophthalmology
10 – 13 November 2007 / New Orleans LA USA
http://www.aao.org/annual_meeting/2007.cfm

Overseas

• American Academy of Ophthalmology
21 - 25 March 2007 / Mt Tremblant Calgary Canada
https://spinecanada.ca/public/meeting/index.asp

Orthopaedic Surgery
Australia/NZ

• Combined Scientific Meeting of the Australian Orthopaedic Association and the New Zealand Orthopaedic Association
7 - 12 October 2007 / Gold Coast QLD Australia

Overseas

• 23rd Annual American Orthopaedic Foot & Ankle Society Summer Meeting
11 - 15 July 2007 / Westin Harbour Castle Toronto
http://www.aofas.org/i4a/pages/index.cfm?pageid=1

• Orthopaedic Trauma Association Annual Meeting
18 - 20 October 2007 / Boston MA USA
http://www.ota.org/meetings/07_annualmeeting.html

Otolaryngology Head and Neck Surgery
Australia/NZ

• Australian Society of Otolaryngology Head and Neck Surgery
31 March - 4 April 2007 / Adelaide SA Australia

Overseas

• American Head & Neck Society Annual Meeting
during the Combined Otolaryngology Society Meetings (COSM)
26 - 29 April 2007 / San Diego CA USA
http://www.ahns.info/meetings/

• American Laryngological Association 127th Annual Meeting
19 - 20 May 2007 / Chicago Illinois USA
http://www.cosm.md/

Paediatric Surgery
Australia/NZ

• Australasian Association of Paediatric Surgeons Annual Scientific Congress
(In conjunction with Pacific Association of Pediatric Surgeons)
15 - 20 April, 2007 / Queenstown New Zealand

Overseas

• American Pediatric Surgical Association 38th Annual Meeting
24 - 27 May, 2007 / Orlando FL USA
http://www.eapsa.org/surgeons/meeting_07.htm

Plastic and Reconstructive Surgery
Australia/NZ

• IFSSH & IFSHT Hand in Hand
10th Triennial Congress of the International Federation of Societies for Surgery of the Hand
7th Triennial Congress of the International Federation of Societies for Hand Therapy
11 - 15 March 2007 / Sydney NSW Australia
http://www.hands2007.com/

• Australian Society of Plastic Surgeons and New Zealand Society of Plastic Surgeons Annual Scientific Meeting
Combined with RACS Annual Scientific Congress
7 - 11 May 2007 / Christchurch New Zealand
Contact: donnathompson@plasticsurgery.org.au

Overseas

• American Society for Reconstructive Microsurgery Annual Meeting
13 - 16 January 2007 / Rio Grande Puerto Rico
http://www.microsurg.org/meeting.html

• 62nd Annual Meeting of the American Society for Surgery of the Hand
27 - 29 September 2007 / Seattle Washington USA

Urology
Australia/NZ

• Urological Society of Australia and New Zealand Annual Scientific Meeting
18 - 22 February 2007 / Adelaide SA Australia

• Renal Society of Australasia National Conference
15 - 18 August 2007 / Perth WA Australia

Overseas

• The American Urological Association Annual Meeting
19 - 24 May 2007 / Anaheim California USA
http://www.aua2007.org/

• British Association of Urological Surgeons Annual Meeting
18 - 22 June 2007 / Glasgow Scotland UK
http://www.baus.org.uk/

Vascular Surgery
Australia

• Australia and New Zealand Society for Vascular Surgery – Vascular 2007
August 2007 / Melbourne VIC Australia

Overseas

• Society for Vascular Surgery Annual Meeting
7 - 10 June 2007 / Baltimore MD USA
http://www.vascularweb.org/_CONTRIBUTION_PAGES/Annual_Meeting/index.html

Medical

• Law Institute of Victoria 2006 Medicine and Law Conference
23 - 24 November 2006 / Melbourne VIC Australia

• Third Australian Health & Medical Research Congress
26 November - 3 December 2006 / Melbourne VIC Australia
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Bioengineered skin substitutes for wound management

This information is about the safety and effectiveness of bioengineered skin substitutes for wound management compared with standard dressings and biological skin replacements. It is based on research conducted by the Australian Safety and Efficacy Register of New Intervventional Procedures - Surgical (ASERNIP-S).

The following information is not intended to replace the advice of your doctor, but rather to help you and your doctor make decisions about your care that are best for you.

Main messages

The available information was limited by the small numbers of patients, short follow-up times and differences in the way patient outcomes were reported.

- **Safety:** Bioengineered skin substitutes used with standard treatment are at least as safe (in terms of complications such as infection) as standard treatment alone for the management of venous leg ulcers, diabetic foot ulcers and other wounds.

- **Effectiveness:** There was not enough data to decide whether using bioengineered skin substitutes with standard treatment is as effective in the management of venous leg ulcers, diabetic foot ulcers and other wounds; however, healing time may be reduced for patients with diabetic foot ulcers under this regimen compared to standard treatment. More high quality trials on bioengineered skin substitutes are needed to collect information on standard outcomes for patients over a longer period of time.

(For information on ASERNIP-S safety and effectiveness classifications, please visit the review process page on the website at http://www.surgeons.org/asernip-s)

Conventional treatments for wounds

Wounds heal in several steps. During inflammation, blood flow to the area increases and white blood cells move in to clean up dead cells and fight infection. New blood vessels grow to supply oxygen and nutrients to enable the wound to heal. Special tissue may then be deposited into the wound, which gradually contracts. Each of these steps must be completed for the wound to heal properly and restore the normal skin structure (figure 1).

Some wounds do not heal properly (i.e. the wound has not passed through all the healing steps). Poor healing may be due to lack of oxygen, bacterial infection and pressure on or injury to the wound. Other influencing factors include fluid in the body tissues, infection, circulation problems, tumour, smoking and peripheral nerve disorders. Unhealed wounds need treatment to properly close the skin and minimise pain, infection and scarring.

Management of a wound will depend on the cause

- Venous leg ulcers between the ankle and knee do not heal because veins are not properly draining blood away and the wound cannot receive enough nutrients to heal. One in 1000 Australians suffers from this condition. It is usually treated by resting and elevating the leg and applying compression bandaging and support stockings; surgery may be needed to clean the wound and add a graft.

- Diabetic foot ulcers result from disorders of peripheral nerves, impaired blood supply and poor wound healing. Five to 15 in 100 Australians with diabetes suffer from foot ulcers, which have a risk of infection, gangrene and possible amputation. Treatment involves cleaning up dead tissue, dressings, antibacterial agents and pressure-reducing footwear.

- Other wounds may also arise from trauma, infectious disease, and removal of tumours and skin for grafts. Surgical wounds which do not heal are treated by closing the wound, using dressings, skin flaps or skin grafts.

continued on page 28
While the recent security situation in East Timor forced the postponement of scheduled ophthalmic visits to outlying areas of Suai and Maliana, three teams closely following each other, braved the instability to provide optometry and ophthalmology services in Baucau, Dili and Oecussi in late August and early September.

A small team made up of Ophthalmologist Dr John Kearney, Theatre Nurse Barbara Chantler and Optometrist Andrew Maver visited Baucau for a week. Rather than the usual ten the team was three because of the heightened security concerns.

Dr Kearney, who helped to set up the East Timor Eye Program (ETEP) with Dr Nitin Verma in 2000, said the political situation made this particular trip a challenging experience. “There was a bit of activity around the place because we were there when Major Alfredo Reinado led the mass walk-out from the Dili prison. There were mobs in the street, pelting cars with stones but the biggest problem we faced was that in the last week of our two weeks there, the theatres were filled with people with bullet wounds which limited the work we could do.

A week later another Australian team returned to Dili. Dr Paul McCartney, supported by theatre nurses Alex Shaw and Colleen Hickson were joined by ProVision Optometry Team members Andrew Maver and Micheal Knipe. It was Andrew’s seventh trip since becoming involved as the Australian Co-ordinator of the ProVision Optometry Teams. Micheal Knipe, ProVision Eyecare’s Chair, was making his first visit despite being involved with the program through ProVision for many years.

The Optometry team spent four days in Dili and one in Aileu a small town 90 minutes by car from Dili. All those examined in Aileu in need of surgery were too afraid to travel to Dili for the surgery. The surgical team in Dili performed mostly sight restoring surgery from dense cataract.

The Dili week was followed up by a team visiting the remote enclave Oecussi where conditions are even more basic than in Dili. Ophthalmologists Dr Nitin Verma and Dr Bill Glasson were joined by theatre nurses Barbara Chantler and Vicki Greeks. Optometrist Vin Penny joined Andrew Maver to complete the team. All but Bill Glasson were flown in to Oecussi by UN helicopter. Bill, whose departure from Australia was delayed made the journey by the overnight ferry from Dili. Apparently this was an experience in itself. The financial support of the St John Ambulance, was critical to the success of the Oecusse trip as was the help of the the United Nations, particularly, the support of Lt Col Ross Williamson and Mr John Pottinger (air ops).

The last two months have been hectic but very successful for the program. A total of 780 patients were seen, 621 spectacles were issued and 127 surgical procedures performed. According to the visiting ophthalmologists, the main causes of preventable blindness and visual impairment in East Timor are cataracts, uncorrected refractive error and Vitamin A deficiency. Despite the work already, there is apparently still a backlog of 7500 patients requiring eye surgery in the country.

“In East Timor there is a great need for cataract surgery and procedures to treat other eye diseases. Very little work was done during the Indonesian time which apparently helped create this backlog. In countries where the lifespan is shorter, people tend to get cataracts earlier in life. This means that in East Timor people get them in their 40s and 50s where as in Australia people get them in their 60s and 70s. That is all we know about the increased occurrence of cataracts – that it relates to limited access to medical care and shorter life spans – and everything else is just conjecture,” said Dr Kearney.

East Timor Eye Program

The program’s goal is to ensure East Timor becomes self-sufficient in the provision of eye care by 2007 and to eradicate preventable blindness by 2010.
Dr Kearney said that when he first visited Dili in 2001, there were no eye services or specialist facilities and that the ETEP had to start from scratch. He said at that time both the hospitals in Dili and Baucau had holes in the walls of the theatre and unreliable electricity supply while team members had to stay in the wards of the hospital because of a lack of alternative accommodation.

"It was fairly primitive then but there has been some improvement. Now we get power most of the time but when we go to outlying areas we have to take generators with us just in case," said Dr Kearney.

The program is now well into its sixth year and has evolved considerably during this time. It was originally set up as a personal humanitarian aid project, initially funded through personal funds because the need was so acute. Later funding came from Lions, International Red Cross, WHO, Foresight, Rotary and individual donors before the involvement of AusAID. Now coordinated through the College and funded through AusAID, the program aims to ensure that East Timor becomes self-sufficient in the provision of eye care by 2007 and to eradicate preventable blindness by 2010.

Since it was established, the program has provided consultative services to 20,000 East Timorese, performed 2,200 surgical procedures and dispensed 17,000 spectacles. The program is also training an East Timorese Trainee Dr Marceline Correia, who is currently enrolled in the Diploma of Ophthalmology Program at the University of Sydney. It is hoped that he will complete his degree by early 2007. After this, he will go overseas for further training before returning to East Timor as the country’s first ophthalmologist. This is funded partly through the College and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). Dr Verma said “We are currently in the process of finding another young doctor to train so that East Timor will have a reasonable number of ophthalmologists to help ensure its independence and self-sufficiency in eye care delivery”.

Australian volunteer theatre staff also participate in most visits to help train East Timorese nursing staff. The program is also working to help improve the basic medical infrastructure to service the community by establishing a day ophthalmic operating theatre in Dili so that higher volume eye surgery can be carried out without disturbing the main operating theatres. Plans are also being progressed to set up a modern eye clinic there with state-of-the-art equipment including ultrasonography, angiographic and other diagnostic and therapeutic equipment so that patients no longer have to leave the country to receive treatment for more complex and threatening conditions. The eye team is also planning to visit Atambua, a town in the border region of West Timor. This will be the first visit to West Timor.

Dr Kearney said that while the on-going political difficulties being experienced in East Timor were disheartening, the work undertaken by the program was extremely rewarding with problems fading against the delight of people seeing for the first time in years.

“The service advertises our visits through the radio or through various churches around each region and the people get to the hospital for treatment. Some of them have been blind for years. We treated one man this visit for cataracts who was only 36 but had never seen his children. When we removed them and he could see his family the smiles and joy were wonderful to witness,” said Dr Kearney.

For further information on the ETEP - [www.etep.org.au](http://www.etep.org.au)
Skin graft may be either:
• a biological skin replacement which may be taken from elsewhere on the patient (autograft). This is the best replacement for lost skin although there may not be enough available to replace the skin in major wounds, or
• a bioengineered skin substitute.

What are bioengineered skin substitutes?
If a patient needs a graft but not enough autograft is available, bioengineered skin substitutes can be made quickly, which is either:
• grown (cultured) from the patient’s healthy skin cells (and will not be rejected);
• a biosynthetic skin substitute developed to cover the skin surface and encourage growth of blood vessels and wound healing. This can be made in large quantities and has a very low risk of cross-infection.

However, bioengineered skin substitutes are expensive and the practitioner needs experience to decide which material is appropriate. Uncertainty regarding safety and effectiveness of the range of bioengineered skin substitutes led ASERNIP-S to conduct a systematic review to compare them with standard methods of wound management.

What does the research show?
ASERNIP-S looked at the research, which was limited because the studies involved only a small number of patients over short periods of time and didn’t all measure the same patient outcomes. Long-term benefits are unclear. The research suggests:

Venous leg ulcers: Compared to standard treatment, bioengineered skin substitutes used with standard treatment were about the same as standard treatment alone in terms of:
• wound closure, time to heal and reduction in the area of ulceration;
• levels of pain experienced, recurrence of the wound and wound infection.

Diabetic foot ulcers: Compared to standard treatments, bioengineered skin substitutes used with standard treatment in some cases may:
• reduce wound healing time (Apligraf®, Dermagraft®, GraftJack®
  ct®, Hyalograft™, Laserskin™, Orcel™, and Promogran™);
• improve wound closure (Apligraf®, GraftJacket® and Orcel™);
• lower rates of infection;
• result in similar recurrence rates.

Other wounds: Bioengineered skin substitutes were no better than standard treatment, although patients may have reported less pain. Compared to standard therapy:
• Apligraf® produced similar results for wounds from surgical cuts;
• Biobrane® had poorer results when used to cover wounds caused by taking donor skin;
• Promogran™ was as good for pressure sores.

Some of the above skin substitutes may not be available in Australia.

August 2006 (Review publication date)

What is ASERNIP-S?
Australian Safety and Efficacy Register of New Intervventional Procedures – Surgical (ASERNIP-S) is a program of the Royal Australasian College of Surgeons (RACS). ASERNIP-S conducts literature reviews on the safety and effectiveness of new surgical techniques before they are widely used, for example bioengineered skin substitutes for the management of wounds. 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 recommendations on the safety and effectiveness of the procedures, that are endorsed by RACS, sent to hospitals and surgeons in Australia and overseas, and published on the website with summaries for consumers. For further information on bioengineered skin substitutes for the management of wounds, please see the full systematic review on the ASERNIP-S website: http://www.surgeons.org/asernip-s

For more information about ASERNIP-S, please contact: Professor Guy Maddern, ASERNIP-S Surgical Director, PO Box 553 Stepney, South Australia 5069. Phone: 61 8 8363 7513, fax: 61 8 8362 2077 Email: consumer.asernip@surgeons.org

Glossary

Autograft (skin graft): a piece of skin taken from an uninjured area (donor site) of a patient to repair an injured area on the same patient.

Bioengineered skin substitutes: materials with both synthetic and biological components OR products created by manipulating biological tissues to alter them for a particular purpose.

Biological skin replacements: replacing injured skin of a patient with pieces of their own healthy skin.

Bio synthetic skin substitutes: dressings developed to mimic the function of skin that contains human, animal and/or synthetic material.

Inflammation: a normal response to tissue injury characterised by pain (caused by the release of chemicals from inflammatory cells), redness and heat (caused by widening of blood vessels allowing more blood and blood cells to an injured area for repair) and swelling (caused by leakage of fluid from the widened blood vessels). Abnormal inflammation, such as that which occurs when infection is present, results in further tissue damage, delay in healing and poor scarring.

Skin flap: patient’s flap of skin which is still connected to its blood supply and rolled over to cover a wound on the patient. When the flap is firmly connected to the wound base via blood vessels, the flap is disconnected from its origin.

Skin graft: a piece of relatively thin tissue transplanted onto a wound.

Acknowledgments
Figure 1 is adapted from a diagram provided courtesy of Royal Adelaide Hospital – Medical Art & Design, Australia.
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2007 Successful Scholarship and Grant Recipients

The Board of Surgical Research would like to thank all applicants for College scholarships and grants for 2007. Congratulations go to the following successful scholarship and grant recipients.

The College wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding the following scholarships and grants.

Where indicated * scholarship recipients must procure 25 per cent of their scholarship from either their research department or by external award or donation.

- John Mitchell Crouch Fellowship
  Professor Jonathan Golledge FRACS Fellowship Value $70,000
  Professor Golledge is a vascular surgeon at the Townsville and Mater Hospitals and is Professor of Vascular Surgery at James Cook University. In 2002, he established the James Cook Vascular Biology Unit which has received local and national recognition for its research success. The Fellowship will assist Professor Golledge in his current research on abdominal aortic aneurysms, atherosclerosis, intermittent claudication and varicose veins.

Francis & Phyllis Thornell Shore Memorial Scholarship*
  Dr David Gyorki Scholarship Value Stipend $50,000
  Departmental Maintenance $5,000
  Topic: Identification of breast stem cells and investigating their role in cancer.
  Supervisor: A/Professor Geoffrey Lindeman

Roy and Marjory Edwards Scholarship*
  Dr Dayan de Fontgalland Scholarship Value Stipend $50,000
  Departmental Maintenance $5,000
  Topic: The sensory innervation of the human colonic mesenteric and submucosal blood vessels: morphology, neurochemistry, pharmacology and nociceptive.
  Supervisor: Dr David Watchow FRACS

RACS Foundation WG Norman Research Fellowship*
  Dr James McLean Scholarship Value Stipend $50,000
  Departmental Maintenance $5,000
  Topic: Can lunate typing be used to determine a choice of operative technique in the management of scapholunate instability.
  Supervisor: Mr Gregory Bain FRACS

Murray and Unity Pheils Travel Fellowship
  Dr David Rangiah FRACS Fellowship Value $10,000
  Dr Rangiah will use the Fellowship to gain further skills in ano-rectal, pelvic floor and laparoscopic colorectal surgery. He will be based at the Royal Alexandra Hospital, Paisley, in Scotland.

Lumley Exchange Research Fellowship
  Dr Raffi Qasabian FRACS Fellowship Value $60,000
  Dr Qasabian is a specialist vascular surgical trainee who will be undertaking a fellowship year with the Department of Vascular Surgery at St Thomas’ Hospital in London. St Thomas’ Hospital is one of the largest teaching hospitals in London and is an international centre of excellence in endovascular thoracic stent grafting. He plans to pursue research projects related to stent grafting based on patient data collected by St Thomas’ Hospital.

Stuart Morson Scholarship in Neurosurgery
  Dr Martin Wood FRACS Scholarship Value $20,000
  Dr Wood will be undertaking post-fellowship training in the sub-specialty of paediatric neurosurgery in Paris.

Hugh Johnston Travel Grant
  Dr Cuong McKay FRACS Scholarship Value $3,500

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Hugh Johnston Travel Grant
  Dr Cuong McKay FRACS Scholarship Value $3,500
CONROD-RACS Trauma Fellowship
Professor Michael Schuetz FRACS
Fellowship Value $50,000
Topic: Benchmarking trauma care performance in a tertiary hospital in Queensland to European trauma centre: Using the European Trauma registry as a model.
Supervisor: Professor John Bell

Raelene Boyle Scholarship - Sponsored by Sporting Chance Cancer Foundation *
Dr Benjamin Namdarian
Scholarship Value Stipend $50,000
Departmental Maintenance $5,000
Topic: Correlation between plasma levels of endothelial cells and prostate cancer prognostic factors.
Supervisor: Dr Chris Hovens

Plastic and Reconstructive Surgery Research Award – Funded by Plastic and Reconstructive Surgeons
Dr Michelle Locke
Dr Locke has been concurrently awarded the Plastic and Reconstructive Surgery Research Award and the RACS Foundation Research Scholarship.
Scholarship Value $25,000
Topic: Mesenchymic adult stem cells: their potential in wound healing and plastic surgery.
Supervisor: A/Professor Rod Dunbar

Research Scholarship in Military Surgery - Funded by the Department of Defense, United States of America.
Dr Peter Watson
Scholarship Value $US40,000
Dr Watson has been selected to participate in an International Surgical Exchange to work on combat casualty care resuscitation research.

Bequest and Sponsor Funded Scholarships and Grants

All recipients of RACS Foundation funded scholarships must source the equivalent of 25% of their scholarship from either their research department, an external award or donation.

RACS Foundation for Surgery Funded Scholarships
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- Finance
- Purchase
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- Founded and developed by a Surgeon and a Practice Manager, we understand your needs.
- Our approach is diplomatic and we are sensitive to your ongoing patient relationships.
- Our commissions start at 15% and are only paid on successful recovery.
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Australian Government Directory of Services for Older People

The 2006-07 edition of this Directory is now available.

The Directory is published annually by the Department of Health and Ageing and is a concise and user-friendly information source, providing information on the wide range of Australian Government services offered to older Australians.

Having all this information available in one publication ensures current, reliable, and comprehensive information is easily accessible for doctors, older people and their carers.

This Directory will be of assistance to all doctors who have older patients as it will assist in the finding of appropriate services for these patients.

Doctors who want to obtain free copies of this Directory should contact National Mail and Marketing on (+ 61 ) 2 6269 1080, by email nmm@nationmailing.com.au or contact the Aged Care Information Line on 1800 500 853. Previous versions of the Directory should be replaced with the 2006-07 version.

The Directory can also be viewed online at: http://www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-directory.htm
COMPUTERISATION

McDonald CJ, Ann Intern

Computerisation can create safety hazards: a bar-coding near miss

This article provides a case study of a patient who was mistakenly given the bar-coded identification wrist label of another patient who was admitted at the same time. It is estimated that for 1 in 1000 admissions information on the wristband will be incorrect, either because errors occur in data information at registration or that the wrong wristband is placed on the wrong patient. In this case, a nurse took a blood sugar level (BSL) at the bedside for patient A (a diabetic patient) and results were immediately transferred electronically to patient B’s (a non-diabetic patient) electronic medical record. The BSL was 33.3mmol/l, prompting the intern to write the patient up for a sliding scale insulin regimen. It was only through a chance interjection by patient B’s resident that the insulin was not given. It was a near-miss. Recommendations following investigation of the incident included double checking wrist labels when they are put on the patient’s wrist (a control measure), and reiterating to doctors the importance of considering an error rather than assuming that the bar-coding system would not have caused the error.

This case study highlights the many little things that can go wrong to create a big problem. While computer systems have the potential to improve patient safety, they may create new kinds of errors if not accompanied by well-designed and well-implemented cross check processes.

Take-home message: This near miss was a result of human error: a lack of vigilance in cross checking and validating abnormal results. The problem was compounded by staff having blind trust that the scanning system was accurate. The computer system worked exactly as it was intended.


Gold Service Award

John Henderson received the gold service award for long and meritorious service to the College, during Council Week. Perhaps you have seen him behind the lens during the Annual Scientific Congress (ASC), amongst other College events. John’s photographs are an unequalled record of surgical colleagues and friends dating over 20 years.

John Henderson was born in Gundagai but grew up near Tamworth. At the age of 15, his family moved to Geelong and Geelong has remained at the centre of his family and professional life ever since. John’s entire consultant surgical career was spent in Geelong, both as a Visiting Surgeon on the staff of Geelong Hospital and in private practice.

John’s interest in photography began with the family Kodak Box Brownie camera and he owned his first camera when the age of 16. Photography has remained a major interest for him with clinical photography starting when he was at the Royal Children’s in 1958. Surgical Conference photography began in 1981 at the Provincial Surgeons of Australia (PSA) meeting in Traralgon and he has scarcely missed compiling a photographic montage of that meeting since. In 1996, the Annual Scientific Congress was in Melbourne and the convener, the late Peter King who was on the planning committee, asked John to take the photos for the ASC in the same way that he had been photographing the PSA meetings and John agreed. Every year since John has been an enthusiastic and dedicated recorder of the social aspects that are such an important part of the Fellowship of the College. It is John’s photos that comprise the photographic spread in the edition of Surgical News that follows each ASC.
The College budget for 2007 was reviewed and approved at the October meeting of Council. This budget is the culmination of a process which commenced in June this year when Council considered and approved the strategic initiatives for 2007. The budget determines the resource allocation to fund the operations of the College for the coming year.

Council’s aim is that there will be either self funding or minimal cross subsidisation between College activities. A costing model is used to explain where costs lie and to allocate costs of the Relationships and Resources Divisions to the operating Divisions namely Fellowship and Education.

2007 will see the introduction of the new Surgical Education and Training program and will be the last year of selection of trainees into the Basic Surgical Training program. Aspiring surgical trainees will be able to express an interest in a surgical career by registering for so-called pre-SET commencing in January 2007. Selection into SET will occur in August 2007 to commence in 2008. At the present time the financial implications of these changes are not fully defined therefore a contingency of $500k has been included in the budget for 2007 to cover these activities.

The College continues to maintain a strong financial position and has budgeted for a modest surplus of $431,000 in 2007. This is after the returns of the investment portfolio are distributed to research grants and scholarships and the balance transferred to the Foundation for Surgery or the Investment Reserve. Council continues its policy of not relying in investment returns for normal operational revenue.

The 2007 Budget ensures ongoing investment in Fellows’ services and educational and research activities while ensuring an overall organisational structure and facilities appropriate for our professional organisation.

2006 Activity

In 2006, there has been considerable activity across the College operations including:

- Planning and development of the SET program.
- Improving the relationships with the Specialist Surgical Societies and Associations related to Specialist Surgical Training and the operation of the Service Agreements.
- The decision not to seek ACCC Authorisation for the new SET program or seek reauthorisation related to accreditation of training posts and assessment of IMGs when these lapse.
- Development of the Trainee Association.
- Further growth in Surgical Trainee and Continuing Professional Development courses.
- Commencement of new projects with the Commonwealth Government including the Outer Metropolitan Training Project and Surgical Morbidity and Mortality Audits.
- Renewal of the $7.9 million AusAid program administered by the College in Timor Leste.

2007 Budget

The Budget for 2007 was developed within the following parameters:

- The budget to be in surplus.
- Adherence to the Budget Strategy approved at the June 2006 meeting of Council.
- Subscriptions to be increased by CPI to $1,915 (3.2%).
- Cross subsidisation of activities will be minimised or made apparent.
- The subsidy for projects administered by the College will be $309k.
- New projects are not to be subsidised unless strategically important.
- Estimated return on the College investments of 10%.
- The unallocated investment return will continue to be retained for future College initiatives including re-establishment of the College Foundation for Surgery.
- BST Annual Fees to increase in line with CPI (will cease with the introduction of SET).
- Course fees will increase by around 10% to move towards full cost recovery.
- SST Fees will increase by 10% in light of cross subsidy issues and specialist society concerns.
- The Treasurer’s contingency will be $125k.
- A SET contingency will be $500k.
There will be a modest increase in College staff in 2007. These occur principally in areas funded through outside sources including grants and AusAid funding which cover about one third of total expenditure on salaries and wages.

Total expenditure on salaries and wages will be $11,000,000 in 2007. Total numbers of employees 152 (EFT)

- Resources 18
- Relationships 44 * includes State/NZ offices
- Education
  - BST 12
  - SST 25
- Fellowship
  - Fellowship & Standards 18
  - Research & Audit 21 * mainly funded by grants
  - External Affairs 14 * mainly funded by grants or ASC

These include five Fellows of the College namely

- Dean (0.6 EFT)
- Executive Director of Surgical Affairs (0.5 EFT x 2)
- ASC Coordinator (0.3 EFT)
- Clinical Director of Victorian Skills Centre (0.2 EFT)

Other expenditure from College operating revenue will include

- Consultants Fees - $1,008k ($1,010k) -  
  - $584k for clinical/medical support and assessments, often supplied by Fellows, and $426k for external consultants.
- Travel & Accommodation – $3,072k ($2,776k)
- Property maintenance – $995k ($986k)
- RACS scientific visitors program – $428k ($390k). This is a benefit for all Fellows with many scientific visitors attending specialty society meetings.
- College research scholarships – $695k (2006 – $689k)  
  - $546k also provided from committed Bequest funds.

Balance Sheet

As at 31 December 2007, the College Net Assets will be $42,061k compared to $40,773k forecast for 31 December 2006. During the period, the Investment Reserve is budgeted to increase by $837k to a total of $5,605k, reflecting investment return on funds not already committed to Research Scholarships and Grants or transferred to the Foundation for Surgery.

College Properties

During 2006 and into 2007 maintenance upgrades continue in SA, NSW and Victoria to bring the College buildings up to an acceptable standard. This has been a challenge given the heritage nature of these properties. In the future Facilities Maintenance Programs will ensure all properties are maintained appropriately on a continuing basis.

The budget for 2007 has provided for renovations of the ‘Stables’ building at the NSW Regional offices, totalling $350k. The Queensland building is now fully owned by the College having recently purchased the share owned by the College of Anaesthetists. The refurbishment/redevelopment of the Queensland property have been postponed until 2008 while options are being developed for consideration by the Regional Building Committee and the Resources Division.

The ANZ debt related to the East Wing will be reduced by a further $1m in 2007 to $2m.

The NSW funds received for the Eastern Skills Facilities (ECHTEC project) were repaid in 2006. However, the remaining funds from the Commonwealth are held in trust by the College pending advice from the Government regarding their intentions for East coast skills facilities.

In Closing

This year has seen significant progress and achievements in activities outlined in the Strategic Plan. These initiatives outlined above will ensure that the College to continues to move forward in 2007 with a planned operating surplus of $431k.

I would like to thank my Deputy on Council (Mr Keith Mutimer) for his support during 2006 and his carriage of property matters. I also extend my warm thanks to the Honorary Advisers of the College, Mr Robert Milne, Mr Doug Oldfield OAM, Mr Brian Randall, Mr Anthony Lewis and Mr Ken Welfare for their ongoing advice and support. The financial success of the College particularly in property and investment matters relies heavily on their contributions. We continue to receive excellent service and support from our stockbrokers Goldman Sachs J B Were through their representative on our Investment Committee Mr Graham Hope.

I would also like to thank the management and staff of the Resources Division for their commitment and hard work in support of my role.

The College continues to maintain a solid financial position with its activities in 2006 and into 2007 being funded from sustainable revenue sources.

Andrew Sutherland
Honorary Treasurer
## 1. Subscriptions & Entrance Fees

<table>
<thead>
<tr>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2007 Annual Subscription</strong></td>
<td>$1,915</td>
</tr>
<tr>
<td>payable on 1 January 2007</td>
<td></td>
</tr>
<tr>
<td><strong>Fellowship Entrance Fee</strong></td>
<td>$5,550</td>
</tr>
<tr>
<td>payable in full (10% discount applies) or over 5 years</td>
<td></td>
</tr>
</tbody>
</table>

## 2. Examinations & Training

### Basic Surgical Training

- **Annual Training Fee (Year 1, 2, 3 & 4)**: $2,400
- **Registration Fee (Y1)**: $1,400
- **CCrISP Course (Y1)**: $1,740
- **Website Fee - Distance Learning Program (Y1)**: $2,080
- **ASSET Skills Course (Y1)**: $1,740
- **EMST Course (Y2)**: $1,900
- **BSE Examination**: $3,990
- **Clinical Examination Fee (Y2)**: $1,495

### Exam Pending / Interruption Administration Fee

- **Registration Fee**: $585

### Specialist Surgical Training

- **Annual SST Fee**: $3,900
- **Fellowship examination fee**: $5,280

## 3. Other Fees

<table>
<thead>
<tr>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appeals Lodgement Fee</strong></td>
<td>$3,500</td>
</tr>
<tr>
<td><strong>CLEAR Course</strong></td>
<td>$910</td>
</tr>
<tr>
<td><strong>EMST Course Fees</strong></td>
<td></td>
</tr>
<tr>
<td>- Provider</td>
<td>$1,900</td>
</tr>
<tr>
<td>- Refresher</td>
<td>$1,210</td>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td></td>
</tr>
<tr>
<td>- Provider</td>
<td>$NZ 1,900</td>
</tr>
<tr>
<td>- Refresher</td>
<td>$NZ 1,210</td>
</tr>
<tr>
<td><strong>International Medical Graduates</strong></td>
<td></td>
</tr>
<tr>
<td>- Fee - paper based assessment</td>
<td>$2,475</td>
</tr>
<tr>
<td>- Fee - paper based assessment &amp; interview</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>MOPS - Maintenance of Professional Standards</strong></td>
<td></td>
</tr>
<tr>
<td>- Australia</td>
<td>$1,410</td>
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<tr>
<td>- New Zealand</td>
<td>$NZ 1,410</td>
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<tr>
<td><strong>Occupational Training Visa</strong></td>
<td>$440</td>
</tr>
<tr>
<td><strong>Overseas Trained Doctors Fees</strong></td>
<td></td>
</tr>
<tr>
<td>- Oversight - onsite</td>
<td>$3,755</td>
</tr>
<tr>
<td>- Oversight - remote</td>
<td>$11,280</td>
</tr>
<tr>
<td><strong>Accommodation and Meals Allowance - plus GST</strong></td>
<td>$275</td>
</tr>
</tbody>
</table>

### Notes

1. All New Zealand fees, including Examinations undertaken in New Zealand, are subject to the Goods & Services tax of 12.5%.
2. All Australian Fees will be subject to GST of 10% except approved Education courses.
3. Examination & training fees have been approved by the Australian Taxation Office as GST free for all courses relating to the awarding of the RACS Fellowship.
5. Subscriptions and Fees marked within asterisk (*) may be paid to the College by 4 equal instalments during the year by AMEX, Visa or MasterCard credit cards only. Further details will be made available when fees are raised.
Ever wonder why Younger Fellows of the College gather each year for a retreat? Well, wonder no more! Nominations are now being sought for the 2007 Younger Fellows Forum, which will be held at Clearwater Resort in Christchurch, New Zealand.

Why not join in for two and a half days of discussion and debate on issues that concern Younger Fellows? Have your voice heard by the College - we want your input!!!

Please complete the nomination form and return by fax or mail to the College Younger Fellows Secretariat before Friday 15 December 2006. For more information, please call the Secretariat on +61 3 9249 1212 or visit the College website [www.surgeons.org](http://www.surgeons.org).

Please note: Younger Fellows are Fellows of the College within ten years of gaining Fellowship.

---

### Nomination Form

2007 Younger Fellows Forum  
4-6 May 2007, Clearwater Resort at Christchurch, New Zealand (prior to the College ASC in Christchurch 2007)

| Name: | ........................................................................................................................................................................... |
| Sex: M / F | Year of Fellowship: ................................. |
| Contact Address: | ........................................................................................................................................................................... |
| Telephone: | .......................................................................................................................... |
| Mobile: | .......................................................................................................................... |
| Facsimile: | .......................................................................................................................... |
| Email: | .......................................................................................................................... |
| Surgical Specialty/ Areas of Interest: | ........................................................................................................................................................................... |
| Proportion of clinical practice time: | ......,% Public Sector   ......,% Private Sector |
| Dietary Preferences (for catering): | ........................................................................................................................................................................... |
| Preferred Name (for name badge): | ........................................................................................................................................................................... |

**STATEMENT** (please tick):  
I am a Younger Fellow of the Royal Australasian College of Surgeons (within ten years of gaining Fellowship) and have not previously attended a Younger Fellows Forum.

Signature: .......................................................................................................................... Date: .../.../......

Thank you for your nomination to attend the 2007 Younger Fellows Forum; selection is finalised in January 2007. If your circumstances change and you wish to withdraw your nomination, please contact the Younger Fellows Secretariat at the College.

Please submit your nomination to the Younger Fellows Secretariat by Friday 15 December 2006:

- **Post:** RACS  
  Spring Street  
  MELBOURNE VIC 3000  
- **Telephone:** +61 3 9249 1212  
- **Facsimile:** +61 3 9276 7432  
- **Email:** kegan.barlow@surgeons.org

**Please note:** Delegates will be required to pay for the cost of their transport to Christchurch. Transport to and from the venue will be covered by the College, along with accommodation, meals and activities during the Forum. Although families are a great support, the Forum will be a delegate only activity. Accommodation for delegates will be twin-share.
Surgical Q & A Answers

Answers

1. a. Ortoenteric fistulas  FALSE
   b. Positive cultures  TRUE
   c. Virulent organisms  TRUE
   d. Graft thrombosis  FALSE

Early prosthetic vascular graft infections are typically caused by the more virulent micro-organisms, such as S. aureus, E. Coli, Pseudomonas, Klebsiella, Proteus and enterobacter with the usual causative organisms being those with high virulence. They present with clinical manifestations of sepsis.

Infected graft thrombosis is a feature of late onset graft infections.

2. a. Typically are the result of contamination at the time of operation  TRUE
   b. Secondary to haematogenous and/or seeding from enteric contents  TRUE
   c. Usually secondary to coagulase positive staphylococci  FALSE
   d. More frequently secondary to staphylococcus aureus organism  FALSE

Prosthetic grafts most commonly become infected at the time of implantation either by contamination from the surgical team or by colonised micro-organisms on the patient.

Late prosthetic vascular graft infections are the result of two possible mechanisms. Firstly, by haematogenous seeding from a septic focus elsewhere or becoming infected with enteric contents following a graft-enteric erosion.

The causative organism is commonly coagulase negative, S. epidermidis.

3. a. TRUE
   b. a-e are TRUE, f. is FALSE

It would, however, also be appropriate for any of these medications to be used in the initiation and maintenance of antihypertensive therapy. The Heart Foundation Guidelines for the treatment of hypertension (2004) confirm that the most important property of these drugs is to lower blood pressure. He has no other indications for ACEI (eg diabetes, previous IHD or CVA). Important contraindication such as asthma for betablockade or cardiac failure for Ca channel antagonists must be ascertained prior to medication commencement. The target level for blood pressure in diabetics, people with renal disease, or clinically evident cardiovascular disease is <130/85, and in the non-diabetic population of 140/90.

4. a. TRUE
   b. FALSE
   c. FALSE

The important point here is that a person with Type 1 diabetes requires the presence of insulin at all times to avoid becoming ketoacidotic, and the potentially disastrous complications associated with that. Tight blood sugar control has been shown to reduce complication rates in several conditions including cardiac ischaemia and cardiac surgery, thus aiming for BSLs of less than 10. A concomitant 5% dextrose infusion allows for continual insulin to be given while aiming to avoid hypoglycaemia. The administration of a half dose of the usual long-acting insulin allows some insulin to be available continuously, thus avoiding ketoacidosis. The long half-life of ultralente (24 hours) also means that dose interruption would require five half lives (in this case five days) for the ultralente again to reach steady state, so continuing this, even at reduced doses, makes for more even diabetic control and good pharmacodynamic sense.

5. The correct answer is d. The use of a perioperative retrievable filter is also worth considering

A distinguished career

Former Surgeon Ing Ting divided his professional and personal life between two cultures. Now he is enjoying a less hectic life in retirement.

I came to this country as a private student in 1955. Having matriculated from Coburg High School in the same year, I studied Medicine in the University of Melbourne and qualified MB BS in December 1961. I trained mainly at the Royal Melbourne Hospital (RMH) and had the rare honor of serving under at least two future Presidents of the College, among other great teachers. I became a Fellow of the College in May 1966, having passed the finals in Sydney.

I left for my native Sarawak/Malaysia in 1967. I remember with fondness the initial euphoria and keen-ness of a young surgeon who relished practicing his craft both here and in Sarawak during those early years, working through long and ungodly hours, much to the chagrin of the nursing and other theatre staffs. Soon I discovered that I needed the afternoon nap as much as everybody else, and more regular hours were kept. As the euphoria dissipated, sober reflection followed, especially on the costly business of educating our three young children. I entered private practice with some continuing honorary attachment to the Sarawak general hospital.

We sent our son and later our daughters to boarding schools in Melbourne from year 10 onwards. We decided to uproot ourselves to be with our children during their tertiary years. Our son John trained as an Architect, whereas our two girls, Joanne and Carol, virtually retraced my footsteps through Melbourne Uni and the RMH. However, neither could be enticed into a surgical career!

I followed the family down in the middle of 1990. Australia had changed. The Aussie dollar had fallen below the USD, Medicare had come in, and the old honorary consultants were now receiving “fees for service”. Registration was easy enough, but referrals took longer to come. However, I was able to combine outpatient surgery with Medico-legal work and some hospital practice for the next 15 years or so until my retirement in 2005. Of course none of us is free from the unending administrative minefields a Fellow has to negotiate, the high expectations of our patients and the explosion of “knowledge” in the media. I certainly felt it, and the “push” factors did help make my decision to retire earlier rather than later. Of course the Medical Indemnity crisis of a few years ago was a rude wake-up call that even our retirement nest-egg might not be safe!

You would be surprised how many of our colleagues I now come across at the golf courses, “for the exercise”. In addition, I have gardening and child minding duties. I have always wanted to learn some classical Chinese which can take up any amount of time. Then there is the local church that involves at least three evenings and Sundays. We now spend about two months a year outside Australia, traveling and visiting. Lastly, I still browse through the ANZ Journal of Surgery, the Surgical News and the MJA, to keep in touch. Still, retirement is a very individual thing.
CLINICAL COMMITTEE

WE NEED YOU!

as an examiner for the Basic Surgical Training examination

Sign up today as a Clinical examiner, it only involves a maximum of two sessions per year!

What is Involved?
Giving up your time on two mornings per year!

What are the benefits?
You help your College
You help your Trainees.

Do I get CPD points?
Absolutely! at the rate of one point per hour.

Do I get paid?
Sadly not, but travel and accommodation are reimbursed by the College.

Can anyone do the job?
As long as you have the FRACS you’re welcome!

Do I need training?
Yes, but it is very easy!

How do I sign up?

To register your interest contact the following individuals at the College;

Lorraine Jennings
Contact: +613 9249 1245
lorraine.jennings@surgeons.org

Dawn Sutton
Contact: +64 4385 8247
dawn.sutton@surgeons.org

WHY ARE YOU NEEDED?
The training, education and assessment of surgical trainees has changed markedly over recent years. Included in these changes is an assessment of clinical competence. An important part of this involves passing the Clinical Examination previously known as the OSCE which is now assessed by you, our Fellows.

To improve the reliability and scope of this exam we have increased the number of assessed stations to 16 and with over 35 candidates sitting in some centres it has become necessary to run two concurrent or back to back exams in some cities. This requirement for more examiners is the reason we are actively recruiting.

WHAT DOES THE EXAM INVOLVE?
The Clinical Examination comprises 16 assessed stations, four history taking, four communication, four examination and four procedure stations. Each station has a set task for the candidate to complete and this is conveyed to each at the commencement of the station. Your task is to assess the competence of the candidate’s performance according to a pre-set proforma and an overall competency assessment which is tailored to each of the four station types. In any given exam it is anticipated you will only need to participate at one station. It is expected where possible that you will act as an examiner in an area outside of your specific sub-specialty field, for example a Urologist would not routinely be assigned to a station with supra-pubic catheterisation as the required procedure.

Each station will usually have a surrogate patient/assistant who will assist with the examination and who will have printed, specific instructions to follow; these are also provided before the exam commences.

Additional material such as specific equipment, props, writing and other utensils will be provided by the College of Surgeons and occasionally by the examination venue. All you need to bring on the day is yourself!

An additional role of the examiner is to provide the Clinical Committee who design and review the examination questions with feedback information regarding the question/task and in particular means by which the questions can be improved. This is achieved by filling in a simple, single sheet form at the end of the examination. All comments and suggestions are routinely reviewed by the Clinical Committee and usually result in the questions being modified for future exams.

We take these comments seriously.

WHAT DO I GET OUT OF IT?
Several things, CPD points at the rate of one per hour, but more importantly the knowledge that you are helping the College and participating in the process of selecting our future surgeons and thus helping to mould the shape of surgery to come.
Among the first heritage objects to enter the College’s collections were three items relating to the Lister Wards at the Glasgow Royal Infirmary. These are:

- A Lister carbolic spray engine (“donkey”);
- A replica of the patient’s drinking cup;
- A candlestick.

They were presented to the College by James Hogarth Pringle in 1929.

John Hogarth Pringle was born in 1863, the son of the well-known Sydney surgeon George Hogarth Pringle, who in 1868 introduced Listerian antiseptic methods into Australia. G.H. Pringle was a contemporary of Lister, and with him had been house surgeon to Sir James Syme at Edinburgh. He established a successful practice at Parramatta, where his son John was born, and he decided to send John back to Scotland for his education. After attending Sedbergh School, John Hogarth Pringle graduated in Medicine from the University of Edinburgh in 1885. He became a Fellow of the Royal College of Surgeons of England in 1892, and a Fellow of the Royal Faculty of Physicians and Surgeons of Glasgow in 1899. He was elected Surgeon to the Glasgow Royal Infirmary in 1896, and remained there for most of his career, becoming one of Glasgow’s outstanding surgeons. He retired from the Royal Faculty in 1924 and made a return visit to Australia, at the time when the idea of an Australasian College was gaining momentum. He later returned again to Scotland, living at his home in Stirlingshire until his death in 1941.

In 1924 the managers of the Glasgow Royal Infirmary decided to demolish Wards 24 and 25, where Lister had done so much of his pioneering work in antiseptics in the 1860s. Some of the furniture, fittings and architectural elements were incorporated into other parts of the Infirmary, but the collections of old equipment were dispersed, including the carbolic spray engines which Lister developed to replace the direct contact methods he had previously used. No doubt because of his father’s connection to Lister, John Hogarth Pringle saved several of these items, and some of these he presented to this College soon after its foundation.

The carbolic spray has been described elsewhere (Surgical News Vol.5 No.8, September 2004). The other two items are not quite so legendary, but equally important.

The first is a replica of the drinking cup used to nourish patients in Lister’s wards c1866. It has a narrow body with a handle and a spout. Cups like this were made by Andrew Brown of George Street Glasgow, a sheet metal worker in brass, tin, copper and iron, who also supplied aseptic furniture for hospitals.

The second is an enclosed candlestick. This has a framework over the tray, which limits the length of the candle it can hold. It is fitted with a long handle. The framework could be used to support a translucent fabric cover, which would protect the candle from draughts, and give out a more even light. When operations had to be performed at night, these candles were the only source of illumination in those days.

These objects are significant links to a pioneer of modern surgery. They held significance for John Hogarth Pringle, who, although spending most of his life and career in Scotland, nevertheless retained an affection for his native land. When a College was created in Australasia, he clearly felt that these objects would find a worthy home here, and the College is the richer for his generosity.

Geoff Down, College Curator
The College in partnership with Member Advantage are pleased to provide Fellows and Trainees an exclusive range of lifestyle and financial benefits.

NEW SERVICE FOR RACS FELLOWS AND TRAINEES

RACS Fellows and Trainees can now access AVIS car hire through the College with a specially negotiated package to replace the arrangements with Hertz.

As part of this special package you will automatically receive competitive rates, a reduced excess and can accumulate Qantas Frequent Flyer points.

All you need to do is go to the Member Advantage website www.member-advantage.com/racs and follow the links or alternatively call Avis on 136 333 quoting RACS AWD (Avis Worldwide Discount) number P203701.

SPECIAL LAUNCH OFFER

Your choice with Avis…. $50 off* OR a double upgrade*

Rent a Group E car (e.g. Holden Commodore) or above for 5 or more consecutive days and receive $50 off* the time and kilometre charges.

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Limiting the effects of sleep deprivation.

Medical staff undertaking night-shift duty should try to sleep during the afternoon “siesta” dip in their natural sleep rhythms for optimal function during the night ahead, according to the Director of the Adelaide Institute for Sleep Health, Professor Doug McEvoy.

Professor McEvoy said napping during the afternoon – particularly before the first night shift – could limit the effects of later sleep deprivation and improve concentration and performance. He also said that studies were now indicating that taking shorter naps during the night of work may follow fewer wakeful hours, homeostatic sleep drive is likely to remain elevated during night shifts because of incomplete repayment of the previous sleep debt.”

Professor McEvoy said the Institute for Sleep Health had conducted studies to determine optimal sleep length during a shift which indicated that the ten-minute sleep (about 15 minute nap opportunity) produced improvements over the three-hour post-nap period in all alertness and performance measures.

He said studies were now underway to determine the effectiveness of such “power-naps” in the middle of the night. However, he said all signs were indicating that such short sleep periods improved alertness with less sleep inertia even then. “One to two hour naps are often followed by sleep inertia, during which alertness is impaired for up to one hour,” Professor McEvoy said.

“Therefore the picture emerging from night-shift napping studies is similar to that from the afternoon studies. Very brief naps of ten to fifteen minutes may improve alertness immediately without the negative effects of sleep inertia.”

Professor McEvoy suggested medical staff, even after the first night shift, take advantage of the afternoon siesta period. “We would say that using the mid-afternoon dip would be very helpful because even after days on night shift the normal body clock still affects sleep patterns so that is often the best time to achieve the best results,” he said.

“This could even mean going to bed a little later when people get home after a night shift although sometimes they are so tired that is not possible.”

Professor McEvoy said that even though most hospitals operated on a skeleton staff after hours, nap breaks should be structured in to both safeguard patient care and improve occupational health and safety protections. “There used to be a time when pilots on long-haul flights had a macho attitude toward staying awake the whole flight,” he said.

“Not surprisingly this was found to lead to pilot error and poor decision-making and now there is a system where each pilot has structured nap times during the flight. Serious consideration should now be given to factoring in the same breaks for medical staff both for the welfare of staff and patients.”

Professor McEvoy said to get the best possible sleep, night shift workers should sleep in a room with heavy drapes, limit noise even by the use of ear-plugs and pet out of the bedroom. “This has got to be seen as a dual responsibility between the employee and employer so as to create the safest work environment possible.”
Cowlishaw Symposium

The sixth biennial Cowlishaw Symposium continued its tradition as one of the most significant events on the medical history calendar. This year saw the 6th biennial Cowlishaw Symposium, a meeting that has become one of the principal events on the history of medicine calendar. The College is fortunate to own the collection of historical medical texts that was amassed by Leslie Cowlishaw during the period from the early 1900s, probably until his death in 1943. By 1906 he had already undertaken two world tours and after his graduation he undertook yet another tour during which he acquired a large number of significant works. By 1914 he had obtained many of the printed works in the Collection through his connexions with dealers in London and Europe. The Collection includes a number of volumes published in the 15th century, including an Avicenna Canon of 1497 from Padua and the 1483 Nuremberg De proprietatibus rerum of Bartholomeus Angelicus. In his will, Cowlishaw gave the Royal Australasian College of Physicians the first right of refusal on the Collection, which, for unknown reasons, was declined. Within a month of his death and after some hurried negotiations between John Laidley (the Honorary Secretary of the NSW State Committee of the College) and Ken Russell both acting for the College, and the trustees of Cowlishaw’s estate, the College had secured the complete collection at a price of £2750. In total there were some 2500 items making it notable by world standards and considered to be the best private collection in existence at the time.

In 1996, Wyn Beasley, then Reader to the Gordon Craig Library, initiated the Symposium to make the College’s Cowlishaw Collection better known, both to Fellows of the College and to the wider bibliophilic community. With the endorsement of the President and Council, he invited a group of speakers, all renowned for their interest in historical books and the history of medicine, to participate. Embedded in this Symposium was the eponymous lecture named in the memory of the man who helped to secure the collection for the College and who then set about cataloguing it; Kenneth Fitzpatrick Russell. Thus, the format for the Symposium was set and its popularity has been proved in growing numbers and support over the first decade. The speakers are invited to select one or more items from the Collection on which to base a paper. Over the years this has provided many outstanding papers on medical history and materia medica. The inclusion of the Kenneth Russell Memorial Lecture in the Symposium is entirely appropriate putting it in the context of medical history, a subject dear to his heart, and a meeting centred on the Collection that he took to heart.

The programme for this 6th Symposium satisfied a wide range of tastes ranging from varicose veins to artificial limbs. The research and preparation for each of the papers takes some considerable time and thought and this commitment of the speakers must be acknowledged. Wyn Beasley who made the Kenneth Russell Memorial Lecturer, Nick Doslov, Gabriel Kune, Craig McBride, Sam Mellick, John Royle, Philip Sharp, Donald Simpson and George Somjen.
Unique Byron Bay lifestyle investment …

East on Byron presents a rare opportunity to own a new luxury holiday apartment in Byron Bay. Only 2 fully furnished apartments and 2 beach villas remain from only $1.08m with excellent projected yields. As one of the only tourism-approved resorts at Belongil Beach, an 800-metre beach stroll to Byron CBD, East on Byron is one of those never to be repeated opportunities.

Secure a personal holiday apartment and a high-value investment ready for the Christmas season at East on Byron. Contact Tony Rosenberg at Odyssey Financial Management on 0412 789 747 or (02) 9262 7000.

Byron Bay still a lifestyle investment hot spot

Owning a personal holiday apartment with high investment potential in Byron Bay is only a dream to many. But the latest resort completed in prestigious Belongil Beach represents an opportunity not to be missed.

Citimark Properties’ East on Byron is one of the only developments approved for tourist use in exclusive Belongil Beach, so smart investors will recognise the enormous potential for sustained capital gain, as well as healthy yields.

Byron Bay was reported in the Australian Property Guide earlier this year as achieving 17 per cent increases in property prices year on year for the past decade. Local councils over the years have toyed with the idea of restricting holiday rentals in residential areas. While the latest proposal of this nature was quashed, a resort like East on Byron is protected, making it a rare offering in a very tightly held market.

Eighty-five per cent of the development sold off the plan, with only two of the popular beach villas and two penthouses in the 26-unit resort still available.

Buyers in the resort have tended to be investors wanting to get a foothold in the bullish Byron Bay market, before prices are completely beyond reach. The spectacular beach villas are for sale from $1.08 million, while the penthouses are priced from $1.5 million. Filling a niche luxury holiday market in Byron, each beach villa has a lock-up garage; outdoor stainless steel BBQ and sink built into the balcony; and is fully furnished.

The cosmopolitan Byron Bay town centre is only 800m along the beach, and East on Byron is positioned amidst two acres of native landscaping and features a billabong style pool and spa.

The villas are administered by experienced 24-hour onsite managers, who can facilitate rental of your apartment throughout the year as well as organising your own personal stay in your private villa.

The resort is home to the locally-famed Belongil Beach Café and Deli, so guests need not leave the tranquil surrounds to track down good food and coffee.

For enquiries about securing one of the last remaining East on Byron villas, contact Tony Rosenberg at Odyssey Financial Management on 0412 789 747 or trosenberg@ofm.com.au
Outstanding Service Award

Last month, following his announcement to step down as Chair of the Board of Vascular Surgery, Associate Professor Robert Fitridge received the Outstanding Service Award and commemorative lapel pin for his contribution to the College.

“The Chair position is very demanding and I think it is time to step down. I will continue with the curriculum activities,” the 47-year-old, who will remain a member of the Surgical Education and Training (SET) Working Party, said.

When I asked Assoc Prof Fitridge for his curriculum vitae, I did not expect to receive the equivalent of a comprehensive research paper. What impressed me the most as I read through it was the dedication he has for vascular surgery.

He has, perhaps, authored, co-authored, and edited more research papers, abstracts and book chapters than Ernest Hemingway has novels and newspaper articles combined.

Like Hemingway, the surgeon’s passion has taken him around the world from India and Europe to teaching, visiting and consulting in a number of regional areas in South Australia. Here Assoc Prof Fitridge helps run a very busy diabetic foot service visited by surgeons, podiatrists, endocrinologists and other related clinicians.

He also works as a Consultant Vascular Surgeon and head of Vascular Surgery at the Queen Elizabeth Hospital in Adelaide, Consultant Vascular Surgeon at the Lyell McEwin Hospital, and lectures at the University of Adelaide.

His research interests include reperfusion injury and prediction of systemic inflammatory responses (SIRS) and sepsis following major vascular surgery, and the evaluation of endovascular AAA repair (ASERNIP-S reference surgeon).

“I have enjoyed the curriculum development and development of teaching initiatives as well as being involved in all the processes which have made the College training programs much more robust,” he said.

Assoc Prof Fitridge has also co-edited a new textbook, for several years.

“Our current vascular textbooks are not strong in the basic sciences field, so we decided to put together a basic sciences textbook using national and international experts as many of the contributing authors,” he said.

Assoc Prof Fitridge said the book will provide the “ideal reference material” for the basic science (level 1) modules. “We hope that the development of vascular curricula internationally will also find the textbook useful, and we also hope to provide the textbook to vascular surgeons and trainees in developing countries where vascular surgery is relatively underdeveloped,” he said.


Urszula Smaczna

Postgraduate Diploma in Surgical Anatomy

A joint qualification of The University of Melbourne and the Royal Australasian College of Surgeons, the Postgraduate Diploma in Surgical Anatomy course is taught by staff of the Department of Anatomy and Cell Biology at the University of Melbourne and supported by the ongoing involvement of Fellows as examiners and tutors.

The recent 2006 graduation ceremony held at the College, attended by keynote speaker, Associate Professor John Collins, saw the winner of this year’s Albert Coates Memorial Prize for excellence, Dr Glen Guerra, report that “Undergraduate medical students aspiring to a career in surgery may have a significant lack of anatomical knowledge”.

Dr Guerra, who tutored students in anatomy at the University of Melbourne while studying, reports the highlight of the course as being the dissection time. “Cadaveric dissection is integral to a clear understanding of human anatomy. Undergraduate medical students currently have minimal dissection, and are significantly disadvantaged. The course is a great educational experience for those aspiring to a career in surgery.”

Providing students with the opportunity to perform a supervised dissection of relevant areas on a cadaver, this program is tailored to each participant, particularly those intending to take College examinations involving Anatomy, at both basic and advanced levels. Almost all candidates who have successfully completed the Postgraduate Diploma in Surgical Anatomy have passed the RACS Part 1 Examination at their first attempt.

Offering a hands-on surgical perspective on anatomy, the post graduate course provides Trainees with practical experience in this important aspect of surgical training.
<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Surgeon Kelvin Kong</td>
<td>18</td>
</tr>
<tr>
<td>Adverse Events in Victorian hospitals</td>
<td>36</td>
</tr>
<tr>
<td>Australian Competition and Consumer Commission</td>
<td>3</td>
</tr>
<tr>
<td>Australian and New Zealand Audit of Surgical Mortality</td>
<td>4</td>
</tr>
<tr>
<td>Australia Day Council</td>
<td>32</td>
</tr>
<tr>
<td>ASSET Course</td>
<td>8</td>
</tr>
<tr>
<td>ASSET for Basic Surgical Trainees</td>
<td>26</td>
</tr>
<tr>
<td>ASERNIP-S</td>
<td>24</td>
</tr>
<tr>
<td>ASERNIPS Surgical Simulation</td>
<td>6</td>
</tr>
<tr>
<td>ASC Sydney 2006-10-11</td>
<td>26</td>
</tr>
<tr>
<td>ASC</td>
<td>32</td>
</tr>
<tr>
<td>ASC Wrap Up &amp; Photos</td>
<td>18</td>
</tr>
<tr>
<td>ASC Christchurch 2007</td>
<td>21</td>
</tr>
<tr>
<td>ASC Report 2006-10-11</td>
<td>25</td>
</tr>
<tr>
<td>Australian Medical Association (AMA)</td>
<td>16</td>
</tr>
<tr>
<td>Australia Day Honours</td>
<td>36</td>
</tr>
<tr>
<td>ANZ Journal of Surgery</td>
<td>8</td>
</tr>
<tr>
<td>ANZ Journal Perspectives from the Specialties</td>
<td>6</td>
</tr>
<tr>
<td>Barratt-Boyes, Brian</td>
<td>33</td>
</tr>
<tr>
<td>Beasley, Wyn NZ Office</td>
<td>34</td>
</tr>
<tr>
<td>Beasley Wyn</td>
<td>5</td>
</tr>
<tr>
<td>Beasley Wyn</td>
<td>10</td>
</tr>
<tr>
<td>Brownstein, Edward</td>
<td>36</td>
</tr>
<tr>
<td>Bignell, John</td>
<td>42</td>
</tr>
<tr>
<td>Bintine John</td>
<td>34</td>
</tr>
<tr>
<td>Burstin Perry</td>
<td>50</td>
</tr>
<tr>
<td>CanMEDS</td>
<td>8</td>
</tr>
<tr>
<td>Castleden, Bill</td>
<td>29</td>
</tr>
<tr>
<td>Cato, Alex</td>
<td>10</td>
</tr>
<tr>
<td>Christie, Peter – Obituary</td>
<td>34</td>
</tr>
<tr>
<td>CGSIP Course Scholarship</td>
<td>25</td>
</tr>
<tr>
<td>Chambers Roger</td>
<td>32</td>
</tr>
<tr>
<td>Cregan Patrick</td>
<td>40</td>
</tr>
<tr>
<td>Clery, Ken</td>
<td>15</td>
</tr>
<tr>
<td>Communications and Courtesy</td>
<td>33</td>
</tr>
<tr>
<td>Continuing Professional Development</td>
<td>27</td>
</tr>
<tr>
<td>Conference Diary Dates</td>
<td>20</td>
</tr>
<tr>
<td>College Collection – Catheters</td>
<td>41</td>
</tr>
<tr>
<td>College Website – New Features</td>
<td>22</td>
</tr>
<tr>
<td>College Fees</td>
<td>40</td>
</tr>
<tr>
<td>Cooper, Eric</td>
<td>31</td>
</tr>
<tr>
<td>College Name Change Wyn Beasley</td>
<td>5</td>
</tr>
<tr>
<td>Cough, Daniel</td>
<td>25</td>
</tr>
<tr>
<td>COORDis Clinical Information System</td>
<td>12</td>
</tr>
<tr>
<td>CPD Update</td>
<td>14</td>
</tr>
<tr>
<td>Chief Justice Murray Glesson Examining Values</td>
<td>18</td>
</tr>
<tr>
<td>CGSIP – 100 courses</td>
<td>14</td>
</tr>
<tr>
<td>Cregan Patrick</td>
<td>13</td>
</tr>
<tr>
<td>Couture Jean</td>
<td>38</td>
</tr>
<tr>
<td>Council Elections</td>
<td>6</td>
</tr>
<tr>
<td>College name change</td>
<td>17</td>
</tr>
<tr>
<td>Cochrane, Andrew</td>
<td>21</td>
</tr>
<tr>
<td>Conference Diary Dates</td>
<td>22</td>
</tr>
<tr>
<td>College Budget</td>
<td>34</td>
</tr>
<tr>
<td>Cowlishaw Symposium</td>
<td>45</td>
</tr>
<tr>
<td>Davidson, Andrew</td>
<td>25</td>
</tr>
<tr>
<td>Defining and Assessing Satisfactory Performance</td>
<td>32</td>
</tr>
<tr>
<td>Difficult Patients</td>
<td>32</td>
</tr>
<tr>
<td>Dowling, Guy Hugh Johnston Travel Grant</td>
<td>9</td>
</tr>
<tr>
<td>Eddy, Howard</td>
<td>35</td>
</tr>
<tr>
<td>Environment – Doctors For</td>
<td>29</td>
</tr>
<tr>
<td>Elective Surgery in the Public Sector</td>
<td>26</td>
</tr>
<tr>
<td>Electronic Surgical Handover</td>
<td>37</td>
</tr>
<tr>
<td>Email Address</td>
<td>10</td>
</tr>
<tr>
<td>Email Communication</td>
<td>30</td>
</tr>
<tr>
<td>Emmett, Tony</td>
<td>40</td>
</tr>
<tr>
<td>Eyimina Phillip</td>
<td>30</td>
</tr>
<tr>
<td>Expert Witnesses</td>
<td>37</td>
</tr>
<tr>
<td>Education Report</td>
<td>10</td>
</tr>
<tr>
<td>International Medical Graduates – Assessment</td>
<td>8</td>
</tr>
<tr>
<td>Integrated Surgical Training</td>
<td>8</td>
</tr>
<tr>
<td>CanMEDS</td>
<td>8</td>
</tr>
<tr>
<td>Surgical Education and Training (SET) Update</td>
<td>8</td>
</tr>
<tr>
<td>Curriculum Documentation &amp; Process</td>
<td>26</td>
</tr>
<tr>
<td>SET The role of Psychometric Measures</td>
<td>8</td>
</tr>
<tr>
<td>Educating Safer Doctors</td>
<td>24</td>
</tr>
<tr>
<td>Find-A Surgeon on the website</td>
<td>14</td>
</tr>
<tr>
<td>Frohlich West Chair of Surgery</td>
<td>11</td>
</tr>
<tr>
<td>Female Examiners</td>
<td>7</td>
</tr>
<tr>
<td>Fitzgibbons Robert</td>
<td>47</td>
</tr>
<tr>
<td>Hamilton David</td>
<td>22</td>
</tr>
<tr>
<td>Heritage Report</td>
<td>41</td>
</tr>
<tr>
<td>Catheters</td>
<td>41</td>
</tr>
<tr>
<td>St Mark’s Mallet</td>
<td>41</td>
</tr>
<tr>
<td>Museum of Surgery</td>
<td>29</td>
</tr>
<tr>
<td>Thane, Philip</td>
<td>38</td>
</tr>
<tr>
<td>Portrait of Sir Gordon Gordon Taylor</td>
<td>41</td>
</tr>
<tr>
<td>Glasgow Royal Infirmary</td>
<td>41</td>
</tr>
<tr>
<td>Human Tissue Disposal of</td>
<td>16</td>
</tr>
<tr>
<td>Human Tissue – Recycled</td>
<td>17</td>
</tr>
<tr>
<td>Hugh Johnston Travel Grant</td>
<td>40</td>
</tr>
<tr>
<td>Henderson John</td>
<td>50</td>
</tr>
<tr>
<td>Information Technology</td>
<td>20</td>
</tr>
<tr>
<td>International Medical Graduates Assessment</td>
<td>10</td>
</tr>
<tr>
<td>IMG Surgeons of Interest</td>
<td>22</td>
</tr>
<tr>
<td>International Outreach</td>
<td>14</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>20</td>
</tr>
<tr>
<td>Pakistan – Earthquake Aid</td>
<td>18</td>
</tr>
<tr>
<td>Operation Open Heart</td>
<td>18</td>
</tr>
<tr>
<td>Cambodia – Tim Keenan</td>
<td>14</td>
</tr>
<tr>
<td>East Timor – David Hamilton</td>
<td>22</td>
</tr>
<tr>
<td>Specialist Medical Aid Symposium</td>
<td>24</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>26</td>
</tr>
<tr>
<td>Palestine Alan Kerr</td>
<td>18</td>
</tr>
<tr>
<td>International Pacific Islands Alec Cato</td>
<td>10</td>
</tr>
<tr>
<td>East Timor Eye Program</td>
<td>24</td>
</tr>
<tr>
<td>Indigenous Health Program</td>
<td>13</td>
</tr>
<tr>
<td>Informed Financial Consent</td>
<td>6</td>
</tr>
<tr>
<td>International Society of Aesthetic Plastic Surgery</td>
<td>24</td>
</tr>
<tr>
<td>Integrated Surgical Training</td>
<td>8</td>
</tr>
<tr>
<td>Improving Indigenous Health</td>
<td>20</td>
</tr>
<tr>
<td>Iraqi Freedom Operation – Jeffery Rosenfeld</td>
<td>18</td>
</tr>
<tr>
<td>Infection Control</td>
<td>15</td>
</tr>
<tr>
<td>John Mitchell Crouch Fellowship</td>
<td>5</td>
</tr>
<tr>
<td>John Mitchell Crouch Fellowship</td>
<td>22</td>
</tr>
<tr>
<td>Keenan, Tim</td>
<td>14</td>
</tr>
<tr>
<td>Kerr Alan</td>
<td>18</td>
</tr>
<tr>
<td>Lady Gordon Taylor</td>
<td>42</td>
</tr>
<tr>
<td>Legal Issues in Specialist Recognition</td>
<td>26</td>
</tr>
<tr>
<td>Louis Waller Scholarship – Vine Rane</td>
<td>29</td>
</tr>
<tr>
<td>Mahajni Arun</td>
<td>33</td>
</tr>
<tr>
<td>Mendelson, Bryan</td>
<td>24</td>
</tr>
<tr>
<td>Mentoring Scheme</td>
<td>10</td>
</tr>
<tr>
<td>Medico Legal</td>
<td>33</td>
</tr>
<tr>
<td>McDermott, Frank</td>
<td>29</td>
</tr>
<tr>
<td>Museum of Surgery</td>
<td>29</td>
</tr>
<tr>
<td>Morreau, Phil</td>
<td>17</td>
</tr>
<tr>
<td>McEvoy Doug</td>
<td>44</td>
</tr>
<tr>
<td>National Bowel Cancer Screening</td>
<td>34</td>
</tr>
<tr>
<td>National Institute of Clinical Studies</td>
<td>29</td>
</tr>
<tr>
<td>National Breast Cancer Audit</td>
<td>31</td>
</tr>
<tr>
<td>National Trauma Registry</td>
<td>9</td>
</tr>
<tr>
<td>New Online Library Resources</td>
<td>18</td>
</tr>
<tr>
<td>New Trainees Association</td>
<td>9</td>
</tr>
<tr>
<td>NZ College Office</td>
<td>34</td>
</tr>
<tr>
<td>NZ Health Minister – Meeting</td>
<td>5</td>
</tr>
<tr>
<td>NZ Commerce Comission</td>
<td>7</td>
</tr>
</tbody>
</table>
NZ New Board Chair, Cathy Ferguson Pg 5 No: 8
NZ Research Fellowship Thodhar Vasudevam Pg 11 No: 9
NZ New Medical Workforce Pg 20 No: 9
NSW Doctors Orchestra Pg 34 No: 5
Nwosu, Sebastian Pg 17 No: 6
Nguyen Minh Hung Pg 14 No: 8
Obrien Paul Pg 28 No: 2
Operating Theatre Music Pg 34 No: 3
Operation Open Heart Pg 18 No: 4
Osteoporosis Pg 27 No: 5
Online Journals Pg 25 No: 9
Overseas Operations Pg 18 No: 10
Pacific Islands Surgeons Meeting Pg 6 No: 4
Pakistan -Earthquake Aid Pg 20 No: 2
Perry Chris Pg 37 No: 8
Professor Chris Christophi
Professional Development Pg 16 No: 1
Professional Development courses and workshops 2006 Pg 12 No: 2
Project China Pg 37 No: 1
Project China, David Watson & Justin Bessell Pg 20 No: 3
Project China Wuhan Children's Hospital Pg 22 No: 9
Productivity Commission Pg 3 No: 2
Piloting a Performance Program NZ Pg 5 No2
Pyke, Christopher Pg 17, No: 7
Patel Chandra Pg 21 No: 9
President’s Report
Australian Competition and Consumer Commission Pg 3 No: 1
Australian and New Zealand Audit of Surgical Mortality Pg 4 No: 1
Productivity Commission Pg 3 No: 2
Workforce Survey Pg 3 No: 3
Informed Financial Consent Pg 3 No: 4
Task Transfer Pg 3 No: 4
The Clinical Team Pg 4 No: 4
ASC Pg 3 No: 5
Anatomy Pg 3 No: 5
Governance Pg 3 No: 5
Communication Pg 4 No: 5
Fellowships Pg 3 No: 6
Training Posts Pg 3 No: 6
Council of Australian Governments (COAG) Pg 3 No: 7
National Accreditation Pg 4 No: 7
ACCC Pg 5 No: 7
ACCC Moving beyond it Pg 3 No: 9
Surgical Specialities Pg 3 No: 10
Government Regulation Pg 4 No: 10
Queen's Birthday Honours Les Bokey Pg 12 No: 1
Queen's Birthday Honours Pg 17 No: 6
RACS Foundation, Andrew Davidson Pg 25 No3
RACS Foundation Anita Skandarajah Pg 13 No: 4
Raine John Pg 35 No: 8
Rane, Vinay Pg 29 No: 7
Rashid Prem Pg 8 No: 5
Regional Chairs 2007 Pg 4 No: 6
Risk Management Strategies Pg 27 No: 9
Road Trauma Pg 8 No: 9
Retirement
Retirement – Problems Ken Clezy Pg 15 No: 2
Life After Surgery Tony Emmett Pg 40 No 3
Brownstein, Edward Pg 36- No: 4
Shearman, Brian Pg 34 No: 5
Watts, Harry Pg 33 No 6
Preparing for Retirement PG 34 No 6
Roger Chambers Pg 32 No 7
Arum Mahajini Pg 33 No: 8
Jean Couture Pg 38 No: 9
Rhodes Scholars Pg 31 No: 2
Royal Hobart Hospital Pg 41 No: 1
Rowan Nicks Scholarship – 2007 Pg 27 No: 2
Rowan Nicks Scholar Harjit Singh Pg 10 No: 4
Rowan Nicks Godfrey, Mugati Pg 29 No: 5
Rowan Nicks Scholar Sebastian Nwosu Pg 17 No: 6
Rowan Nicks Phillip Eyimina Pg 30 No: 9
Regional News
New South Wales Phil Truskett Pg 25 No: 7
Queensland Chris Perry Pg 37 No8
Australian Capital Territory Chandra Patel Pg 21 No: 9
Victoria Andrew Cochrane Pg 21 No: 9
Rosenfeld, Jeffery Pg 18 No:3
Royal Parade - Nostalgic Vignettes Pg 30 No: 6
Royal Flying Doctors Pg 35 No: 7
Scholarships Fellowships and Grant Opportunities 2007 Pg 16 Vol: 2
Shearman, Brian Pg 34 No: 5
Stidolph, Neville Pg 42 No: 2
Surgeon Scientist Scholarship Pg 25 No: 2
Skandarajah, Anita Pg 13 Vol: 4
Skills laboratory Pg 26 No: 6
Support for Surgeons Group Pg 5 No: 6
Stuart Morlson Scholarship Pg 20 No: 6
Surgical Workforce Census 2005
The Ageing of the Surgical Workforce Pg 6 No: 1
A Retiring workforce Pg 6 No: 2
Surgeons and their working hours Pg 6 No: 3
The Rural View, Demographics & Working Patterns Pg 8 No: 4
The Rural View, Environment & Sustainability Pg 6 No: 5
Examining the Demand for Surgical Services Pg 6 No: 6
Singh, Harjit Pg 10 No: 4
Sir Roy McCallaugh Fellowship Pg 40 No: 5
Specialist Surgical Training Program 2007 Pg 9 No: 3
Surgical Research Grant Pg 7
Shepard, David Pg 15 No: 3
Slave Trade, John Buntine Pg 34 No 9
St Mark's Mallett Pg 41 No: 3
Skills Training (SLS) program Pg 17 No: 7
Surgical Simulation Patrick Cregan Pg 13 No: 8
Support Scheme for Rural Specialist Test Pg 40 No: 8
Shayan, Ramin Pg 42 No 42
Scholarships and Grant Recepients Pg 30 No: 10
Sleep Deprivation Doug McEvoy Pg 44 No: 10
Surgical Anatomy Pg 47 No: 10
Than, Tun Tun Pg 29 No: 5
Triathlon – David Shepard Pg 15 No: 3
Truskett Phil Pg 23 No: 7
Ting Ing Pg 39 No: 39
Trainees Association
New Association Pg 31 No: 1
Current Activities Pg 12 No: 3
Mentoring Pg17 No: 4
The Success of BST Pg 5 No: 5
Suicide Pg 16 No: 5
Inaugural Dinner Pg 17 No: 5
AGM Pg 17 No: 5
RACSTA News Pg 15 No: 6
A look into NZ BSTs expectationas Pg 18 No: 7
Western Australian Report Pg 12 No: 9
Committee Elections 2007 Pg 13 No: 9
Relocation Pg 12 No: 10
Using Email Pg 9 No: 1
Urology – Regional Prem Rashid Pg 8 No: 5
Vanuatu Perry Burstin Pg 14 No: 1
Venous Thromboembolism Pg 28 No: 7
Vasudev ‘Thodhar Pg 11 No: 9
Waiting Lists, Management of - Patrick Cregan Pg 40 No: 6
Warren: Grace Pg 5 No: 4
Watts, Harry Pg 33 No: 6
Website – The Major Hits Pg 12 No: 5
West, Richard Pg 15 No: 7
Weight Loss surgery Pg 28 No: 2
Westmead Trauma Service Pg 17 No: 3
Workforce Survey, President’s Report Pg 3 No: 1
Woman in Surgery – equality? Pg 10 No: 5
Workforce Assessment Unit Pg 14 No: 14
Wound Management Pg 27 No: 10
Younger Fellows
Forum Weekend Away Pg 10 No: 8
Post Operative care and patient discharge Pg 14 No: 9
Liability for your office staff Pg 13 No: 10
Hearing Aid

A team of Australian surgeons and nurses regularly travels around the Pacific treating a range of medical conditions, including hearing loss.

For ear, nose and throat surgeon Perry Burstin it’s a dream fulfilled. ‘For the five years I’ve been coming to Vanuatu I’ve wanted to run a specialised ear, nose and throat training course for the excellent nurses here. This is the first training course of its kind in the Pacific.’

In training: Ear, nose and throat nurses try out the equipment from their specialist medical kits.

Dr Burstin is one of a group of doctors, funded by AusAID through the Royal Australasian College of Surgeons, who travels regularly around the Pacific. He and his colleagues attend to people with conditions that would otherwise go untreated. Medical services in most Pacific nations just aren’t there, primarily because health budgets don’t stretch very far. Surgeons like Perry Burstin not only perform operations and procedures, they stay on to teach local medical staff.

A surgical team recently in Vanuatu’s capital, Port Vila, was treating people with all sorts of health conditions but, in particular, those with hearing problems. Over a week or so, doctors saw more than 100 patients and conducted several operations.

They also made time to train 12 nurses who found the experience of learning from experts invaluable.

The Australian doctors are confident they leave behind a competent group of health professionals. The nurses are proficient in diagnosing hearing loss, running audiology clinics and fitting hearing aids. And to make sure they’re well equipped, the surgeons have donated an ear, nose and throat specialist medical kit to each island. These kits help the nurses identify priority patients, provide preventive care and ensure ear infections, especially in schoolchildren, are treated promptly.

Nurse Andorine Aki is thrilled. ‘These kits have everything we need for our clinics on the islands. We are taking them to rural areas so we can care for more patients.’

Australia has for several years funded medical teams from the Royal Australasian College of Surgeons to travel to the Pacific to treat people in need and to pass on surgical skills.

For further information see www.surgeons.org
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