Welcome to the first edition of Surgical News. I hope you will find this monthly publication will keep you up-to-date with issues affecting you and your colleagues. It is designed to provide more timely information than was possible in the Bulletin, which was produced three times a year. It will also be made available to the public via the media and to health bureaucrats as a means of making our College more accessible.

I anticipate that surgical societies and associations will also use Surgical News to convey messages to colleagues and the general community.

We are very keen to involve all Fellows and your contributions and feedback are necessary and most welcome.

Please address any correspondence to:
The Editor;
Surgical News, RACS,
Spring Street, Melbourne, Victoria, 3000,
or e-mail us at surgeons.sec@racs.edu.au.

Bruce Barraclough

Surgery in East Timor, see page 3.
President to head national safety group

RACS president, Mr Bruce Barrclough, is to head a $5 million project established by the nation's health ministers last year to improve the safety of Australia's health care system.

The Australian Council for Safety and Quality in Health Care is being established with core Federal Government funding of $5 million over five years. The group includes two other Fellows of the College - Professor Cliff Hughes and Professor Bryant Stokes - as well as representatives of other doctor groups, health executives and representatives of the Commonwealth, state and territory health departments.

At its first meeting in February members of the group began the task of developing a national strategic plan to address safety and quality issues.

"While human error is inevitable, we need to follow the examples of other high-risk industries and have systems in place to minimise the consequences of those human errors," Mr Barrclough said.

Another aim of the group is to coordinate quality improvement activities taking place around Australia so the results of good studies and projects are shared between the health services of all the states and territories.

Mr Barrclough said it was exciting to be part of a group which will have such a major impact on the nation's health system.

"It involves federal and state health departments so it's involving all of the different systems in which we work," he said. "It gives us the chance to take a global view and get people to work together as a team."

"The federal, state and territory health ministers have for the first time said that safety is core business of the health system."

In a media release issued when the group was formed, the federal health minister, Dr Michael Wooldridge said that by working together, governments, health providers and community representatives could avoid the duplication of efforts and make better use of expertise in different areas.

"The new council will set the agenda for health care safety and quality in Australia and provide national leadership to reduce the risk of adverse events occurring in the health system," Dr Wooldridge said.

"It will initiate research and identify strategies to improve health services."

A major role of the group will be to reduce risk at the so-called boundaries of the health system - between general practitioners and hospitals, between different areas of a hospital and between hospitals and the community or nursing homes.

"We need to look at other high risk industries and improve the systems in which we work," Mr Barrclough said.

The role of the council and the tasks that it will address are to:

- Provide advice to health ministers on a national strategy and priority areas for safety and quality improvement.
- Negotiate with the Commonwealth, states and territories, the private and non-government sectors for funding to support action in agreed priority areas.
- Develop, support and facilitate national actions in agreed priority areas.
- Widely disseminate information on the activities of the Council, including reporting to health ministers and publicly at agreed intervals.

The ministers agreed that they would contribute to the funding of relevant projects on safety and quality in health care which flow from an agreed national strategy.

Breaking in a new government
changing times in New Zealand

A new century, a new Government, a new Minister of Health and her new views of the health system. A time of major change greets the College's New Zealand Committee as it settles into 2000.

The new Labour-Alliance coalition Government and its Minister of Health, Mrs Annette King, have big things planned for a health system.

Instead of the split funder-provider system, where the Ministry of Health made policy decisions and the Regional Health Authority distributed funding, the new Government has promised to spend $4 million bringing both the policy-makers and the fund-distributors back under one roof.

The new Government has also promised to undertake more community consultation through the formation of groups that will have a say in the allocation of local health funding.

One of the big ongoing issues to be raised with Mrs King is the development of national clinical priority access criteria. The Government wishes to use these to decide, first, if patients will receive surgery funded from the public purse and, second, the "waiting time" before this surgery will be provided.

To discuss these and other issues affecting surgery, Mrs King is to meet on 14 February with College representatives including RACS president, Professor Bruce Barrclough, RACS Chief Executive, Dr Vin Massaro, RACS New Zealand chairman, Mr Pat Bechian and RACS New Zealand's executive officer, Ms Justine Peterson.
Surgery in East Timor

Major Mick Campion and Group Captain Greg Bruce, were still there, thus doubling the staff available.

Brigadier Atkinson said combining both general and orthopaedic surgery was both an individually enhancing and satisfying experience.

"How often do we talk to one another in civilian life around the teaching hospitals?" said Brigadier Atkinson. "Now we are sharing all of our daily activities. The whole is greater than the sum."

Brigadier Atkinson and Lieutenant Colonel Rosenfield are part of a specialist team which also includes an intensive care specialist/anaesthetist (Major David Evans), a physician/tropical medicine expert (Colonel John Flynn). Their tour of duty encompasses five weeks out of civilian practice - one week updating expertise with weapons and military protocol and four weeks in East Timor.

"An Australian construction engineer at some roadworks (was) racing along with two East Timorese children in a wheelbarrow with grins so wide they were just about chowing their earlobes off!"

"I am still of the view that doctors and live ammunition are not a good mix as we carry out our duties with loaded weapons," said Brigadier Atkinson.

"It does, however, underline the fact that the mission is potentially dangerous, although as yet, I have not felt as threatened as in South Vietnam or Rwanda, where weapons were more openly brandished and the potential of mine injuries was very real. No landmines in this place so far!"

Their facilities - a portable operating theatre, intensive care facility, pathology, physiotherapy, psychology, x-ray, primary health, dental and wards - are all set up in the grounds of the Dili museum. The museum’s artifacts not pillaged in the riots are stored at the back of the museum with Australian museum experts already cataloguing and photographing specimens that are a priceless heritage for the East Timorese.

More than 1100 patients have already been through the hospital. Most have been medical patients with a high number of malaria and dengue fever cases.

The operative work has been steady, with minor skin grafts and removal of external fixations. There are 130 Australians and 21 Singaporeans who are providing a resuscitation team and other primary health care.

The international cooperation extends to all the other countries involved in this United Nations-mandated mission and includes Australians, New Zealanders, Thais, Koreans, Filipinos, Canadians and Kenyans.

Brigadier Atkinson described spectacular scenery from precarious roads in mountainous areas of East Timor, with children waving happily from roadside stalls and villages looming out of the mist.

"Two lasting memories will be a rider on a Timorese pony galloping in and out of the mist like a ghost and an Australian construction engineer at some roadworks racing along with two East Timorese children in a wheelbarrow with grins so wide they were just about chowing their earlobes off!" said Brigadier Atkinson.

"A country that produces soldiers like this must be doing something right."

Brigadier Atkinson said the organisation was "transervice" - an integrated group of navy, army, and airforce medical people who are either part-time or full-time.

"This is a landmark in the development of our service and probably a role model for other nations trying to recruit medical specialists into a difficult but challenging environment," Brigadier Atkinson said.

"As a profession, we have a privileged and relatively secure economic position and service in East Timor is an opportunity to put something back and help secure peace in this region which is a great investment for our children."
Government reverses graft audit requirement

A Government initiative which made payment of patient rebates for endoluminal aortic surgery dependent on surgeons submitting audit data to the Health Insurance Commission has been reversed.

The president of the College, Mr Bruce Barraclough, said many vascular and general surgeons had been concerned to see the new requirement in the latest Medicare Benefits Schedule.

After considerable effort by the College, including direct representation to the Health Minister, Dr Michael Wooldridge, the requirement to send audit material to the HIC was dropped.

Instead, a national audit will be conducted by the College through the Australian Safety and Efficacy Register of New Interventionsal Procedures - Surgery (ASERNIP-S).

"While it was of great concern to us that the arrangement linking patient rebates to audit compliance by the surgeon was recommended to the minister without consultation with the College, it was pleasing to see how quickly the decision was reversed," Mr Barraclough said.

"The department and the minister accepted our argument that we were not confident that the confidentiality of the data could be maintained and that in fulfilling the requirements of the data form, patients would face unfair delays in receiving rebates.

"There is now more understanding of audit processes and purposes."

Mr Barraclough said ASERNIP-S was designed and managed by surgeons to improve surgical care and information sent to it had appropriate protection under federal legislation.

He said, however, that the College had agreed that a minimum of 95 per cent of endovascular repair for abdominal aortic aneurysms would be entered into the ASERNIP-S audit.

"It is very important for surgeons involved in this procedure to contribute data on all patients to the audit so that appropriate national benchmarks can be determined and appropriate information fed back to those participating in the audit process," Mr Barraclough said.

ASERNIP-S

ASERNIP-S. What is it?

ASERNIP-S is a three-year, $1.3 million pilot project that began two years ago to assess the safety and effectiveness of new surgical technology and techniques.

Under ASERNIP-S, vital outcome data on new surgical procedures is collected and assessed. Surgeons are then advised on the procedure's level of safety and efficacy and under what circumstances it can be used.

Fellows have access to the information on the ASERNIP-S Web site which can be accessed via the College's Web page. Consumer information, complete with a glossary of medical terms, is also prepared.

Results can be accessed via the College's Web site at www.racs.edu.au or by telephoning ASERNIP-S on 08 - 8239 1144.

Procedures that have been reviewed

Lung volume reduction surgery
Laparoscopic live donor nephrectomy
Minimally invasive parathyroidectomy
Ultrasound-assisted lipoaectomy
Note: ASERNIP-S is coordinating national data collection on certain procedures

Procedures under review

Laparoscopic-assisted resection of colorectal malignancies
Intravaginal slingplasty for urinary incontinence
Off-pump coronary artery bypass surgery with the aid of tissue stabilisers
Laparoscopic gastric binding
Endoscopic modified lothrop procedure for chronic frontal sinusitis
Clinical practice guidelines are under development for the ABBI system

Procedures awaiting RACS Council endorsement

Percutaneous endoscopic laser discectomy
Minimally invasive techniques for relief of bladder outflow obstruction
Arthroscopic subacromial decompression using the holmium: YAG laser
EMST kit a winner…

Just ask Brian!

The team that saved Brian Manyweather's life.
- Ian Elbourne, Bruce French, Valerie Malka and Rob Campbell.

On November 27th last year, electrical ducting installer Brian Manyweather, of Tahmoor in NSW, had two occasions to celebrate: his 23rd wedding anniversary, and his 43rd birthday the day before. Now, he has something else to celebrate on that date. It’s the day he died and the day he was brought back to life, thanks to four surgeons and the new RACS Early Management of Severe Trauma (EMST) Kit.

If Brian had to suffer a cardiac arrest anywhere, he couldn’t have picked a better place. He was spending the weekend with his wife at Australia’s oldest health retreat, at Medlow Bath in the Blue Mountains. By coincidence, 19 surgeons from all over Australia were also at the retreat, attending a 3-day RACS workshop in ‘Leadership, Management and the Law’.

When Brian collapsed outside the conference centre, a staff member raced into the workshop session and called for help. “For a moment, we thought it was an exercise,” said Westmead trauma specialist (and EMST instructor) Valerie Malka, “but when we realised she was serious, four of us just got up and ran.”

Those four were Valerie, general surgeon Ian Elbourne, neuro-surgeon Rob Campbell, and cardio-thoracic specialist Bruce French. When they got to Brian, his body was blue and cold, “in dreadful condition”, as Valerie Malka puts it. In fact, Brian was already clinically dead.

As the surgeons examined Brian, Bruce French ran to his car where he kept his EMST Kit and in the freezing drizzle the four worked on Brian until paramedics arrived. For 35 minutes they applied CPR, using the vent mask and oropharyngeal and nasopharyngeal airways provided in the EMST Kit, and wrapping him in the kit’s ‘space blanket’. On arrival the ambulance crew went through the ventricular fibrillation protocol, using the cardio-defibrillator carried on-board, and on the third shock Brian developed a cardiac rhythm and pulse, and they were able to put him on oxygen and transport him to hospital. During the journey, he actually regained consciousness and was able to respond to instructions.

Today, it’s difficult to tell that Brian was so close to death. Doctors at the Nepean hospital near Penrith are monitoring his progress, but he is, to quote wife Kerry, “as fit as a fiddle”. As Bruce French puts it, “The statistical survival rate of people in ventricular fibrillation away from hospital is between three and five percent. I’ve never heard of anyone surviving after 35 minutes of VF in an isolated location. Brian has to be the luckiest man of the last century.” Bruce and his colleagues give full credit to the EMST Kit, which enabled them to administer CPR without compromising the patient’s well-being.

Kerry and Brian can barely find words to express their gratitude for their second chance at life. On January 2nd their first grandchild, Austin James Brian, came into the world; were it not for those four surgeons and the EMST Kit, it’s almost certain that Brian would not have been there to greet him.

EMST courses still growing

The Early Management of Severe Trauma (EMST) program has continued and consolidated its work over the past year, and is looking forward to a further extension of its provider courses in the coming calendar year.

According to Kathleen Hickey, manager of the EMST programme, the courses are already heavily subscribed, with a waiting list of some 900 applicants, effectively booking out the courses for the next 12 months.

“In line with our policy of increasing the number of provider courses by five each year, we’ll be offering a total of 64 such courses during 2000, each catering nominally to 16 participants”, Ms Hickey said.

Between 1998 and 2000 some 62-42 people have completed the EMST courses throughout Australia, New Zealand and Papua New Guinea, which range from 1½-day refreshers through to 2½-day student courses, to 3½-day courses for instructors.

The courses, which are heavily skills-based, provide a protocol-based method of assessment and treatment of severely injured patients. The instructors are all doctors from various specialities, but with a special interest in trauma care, who volunteer to conduct the courses.

The EMST courses are recognised as the standard in trauma care within Australia. As Kathleen Hickey says, “They are especially valuable here, given the nature of our geography and the scattered population”. In support of this, she cites the current waiting list, which shows that 2.5 per cent of those awaiting training courses are GPs, and of those almost all are rural-based.
In February, the WA Committee of the College moves into CTEC, a unique, state-of-the-art training facility for health professionals located in the picturesque grounds of the University of Western Australia.

CTEC is a joint venture between the RACS, the Royal College of Surgeons, UWA, the WA Health Department, the Centre for Anaesthetic Skills and Medical Simulation (CASMS) and the Hill Surgical Workshop.

In addition to the WA Committee of the College, CTEC will house the Australian Society of Anaesthetists, the Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians.

The university has funded the building programme, the health department and the Hill Foundation has funded the support services, infrastructure costs and technology and the College is providing intellectual property and teaching. Course funding will be by a user-pays system with industry support.

Danny Hill is a Perth businessman with a special interest in health outcomes based on personal experience. After undergoing surgery in England, he decided he wanted to establish in Perth the Hill Surgical Workshop which would deliver the highest level of skills amongst medical, dental, nursing, scientific and allied professionals. He arranged meetings in 1997 between the Royal College of Surgeons and Perth doctors and the project grew from there.

Originally a $350,000 add-on to the dissecting laboratory in UWA's Department of Anatomy and Human Biology, in just three years the project has grown into a $15 million medical technology building of 2300 square metres. The venture and development has been driven by Mr Richard Vaughan, the Medical Director.

CTEC features anatomy and cadaver-based surgical dissecting facilities, simulation, virtual reality modelling, image acquisition facilities and live operating laboratories.

When fully operational, the facility will have live links throughout Australia and the Indian Ocean rim, with the ability to allow multiple access to courses.

More than 30 courses involving at least 700 participants have already been conducted at the Hill Workshop with attendees from Singapore to New Zealand and all Australian states. CASMS has so far conducted 144 courses with 686 participants.

This year, with the building complete, more than 200 courses are planned with an expected participation of 2000 postgraduates. About 1200 undergraduates are expected to use the inter-related dissecting laboratory adjoining the Hill Workshop.
Overseas Trends in Medical Education

In 1999 the chairman of the then Board of Continuing Medical Education and Recertification, Mr Don Sheldon and Nancy Emmanuel, the head of the department undertook a study tour to review developments and trends in continuing medical education and recertification and make recommendations for the review of the current College programme.

The tour was an extensive one visiting colleges and institutions in the United Kingdom, Canada and the United States. There was also contact with colleagues working in South Africa and Germany at the International Federation of Surgical Colleges Symposium on Education and Training at which Don Sheldon presented a paper.

United Kingdom

In the UK, the role of the colleges has been somewhat overshadowed by the changes implemented as a result of the 'Bristol case'. All staff of the NHS Trusts including specialists will be required to develop Personal Development Plans (PDP) which cover participation in continuing education, clinical audit and personal and professional development. The system is yet to be fully explained but is expected to be implemented sometime this year. The professional development programmes of the various colleges were expected to be accepted as part of the PDPs. The term re-validation was favoured over recertification.

The Royal College of Obstetricians and Gynaecologists has adopted an approach that attempts to make the concept of life-long learning a reality. The College has developed self-assessment tests as well as self-assessment case studies and there are also commissioned articles on selected topics with a self-assessment component published in the College Journal. The College has also introduced verification of data submitted by Fellows with each Fellow being audited once in the five-year cycle. At the conclusion of the five-year programme it is planned to publicly publish a list of Fellows who have met the requirements of the programme. Fellows who do not meet the requirements would lose their Fellowship.

Canada

In Canada, the Royal College of Physicians and Surgeons of Canada will implement a new programme commencing in 2000. The aim of this programme is to support fellows who undertake a continuous planned professional development programme. Completion of the programme will be mandatory for admission to, and renewal of, Fellowship in the College. At the end of the current five-year cycle, a public register will be published of all Fellows who have successfully participated in the programme. The College also plans to conduct an audit of 3 per cent of Fellows annually.

United States

In the US, the American Board of Medical Specialties has set up a Task Force on Competence, which is expected to report in April this year. All 24 primary and conjoint boards endorse the principle of recertification and are at various stages of implementation. Some boards are issuing time-limited certificates which means that recertification will be necessary to retain specialist status.

At the conclusion of the study tour, it was obvious that there was an increasing interest in the post qualification education of specialists. This interest was not confined to specialist colleges but was being shown by governments, regulatory authorities and by consumers.

How to measure performance and competence of specialists and provide support for continuing education and professional development were issues which were being discussed in all the institutions visited. There were no definitive answers but there were a number of strategies, which are being put into place.

One of the agreed concepts was life-long learning but there was little evidence of how this was being translated into practice within the context of a specialist's working life, though there was agreement that training for life-long learning should start at the commencement of specialist training. To complement life-long learning there was a need to develop curricula so that specialists had some guidance about developments in science, knowledge or skills about which they ought to be aware.

The specialist societies were seen as having a leading role to play here. Involvement in quality assurance activities and clinical audit were seen to be essential elements of any professional development programme.

The current College programme compares favourably with overseas developments and further development in light of the knowledge gained from the tour will ensure that it remains comparable to programmes in the developed world. Other institutions were impressed by the participation rate of over 95 per cent.

As a result of the findings, the name of the programme has been changed to the Continuing Professional Development programme to signal the new direction that is being taken. The challenge is to develop a programme in consultation with the specialist societies and groups which will support Fellows in their practice, and at the same time satisfy the scrutiny it will undoubtedly receive.

A full report of the tour can be obtained from Nancy Emmanuel, Head, Department of Continuing Professional Development, 61 3 9249 1282

E-mail: nancy.emmanuel@racs.edu.au

A gentle reminder - College Crest

The RACS crest appears in many places in connection with RACS business and events.

Unfortunately, it appears that the crest is occasionally turning up in places where its use is unauthorised.

Fellows are reminded that the College crest is registered by the College of Arms and protected under copyright: its use is commonly taken to mean formal representation of the organisation.

Therefore the RACS crest may not be used without the prior approval and authority of the Chief Executive. In particular, it may not be used in connection with the practices of Fellows, such as on business cards, stationery and the like.

Fellows’ Subscriptions

We are currently implementing the Subscription module as part of the upgrade of the College business information systems. This has resulted in a delay in the production of Fellows Subscription notices for 2000 and it is anticipated that these will be posted to all Fellows by mid February.

If you require any further information please contact the Business Manager, Mr Ian Burke - 03 9249 1200.
Recipients of RACS Research Fellowships and Scholarships for 2000

RACS Foundation John Mitchell Crouch Fellowship
$43,000

The John Mitchell Crouch Fellowship is awarded to an individual, who in the opinion of the Council, is making an outstanding contribution to the advancement of Surgery or Anaesthesia, or to fundamental scientific research in these fields. The grantee must be working actively in his/her field and the award must be used to assist continuation of this work.

It commemorates the memory of the late John Mitchell Crouch, a Fellow of the College, who died in 1977 at the age of 36.

PROFESSOR MICHAEL V AGREZ, FRACS
Professor Agrez became a Fellow of the Royal Australasian College of Surgeons in 1976. His present position is as Associate Professor of the Discipline of Surgical Science in the Faculty of Medicine and Health Sciences, University of Newcastle. Professor Agrez is currently involved in research focussed largely on mechanisms responsible for progression of colorectal cancer, as well as aspects of wound healing.

RACS Foundation John Lowenthal Research Fellowship
$33,500

DR C C TAN (Vic)
Dr Tan obtained her MBBS in 1993 at the University of Melbourne. She will use this Scholarship to study "molecular themes in solid tumors: RTKs, signal transduction & tumour suppressors" at the Royal Melbourne Hospital.

RACS Foundation New Zealand Fellowship
NZ$33,500

DR ADAM BARTLETT (NZ)
Dr Bartlett received his MBChB from the University of Auckland in 1996. This Scholarship will assist him with his research on the role of CD40 Ligand in liver and kidney allograft rejection at the University of Auckland.

Sir Roy McLaughley Surgical Research Fellowship
3 x $32,000

DR A V BIANKIN (NSW)
Dr Biankin received his MBBS in 1992 at the University of New South Wales. He will be researching "Molecular Markers in the Development and Progression of Pancreatic Carcinoma" at the Garvan Institute of Medical Research.

MR STAN B SIDHU (NSW)
Mr Sidhu received his MBBS in 1992 at the University of Sydney and received his FRACS in 1999. He will be researching the Molecular Genetics of Adrenocortical Tumours at the Roff Institute of Medical Research, Royal North Shore Hospital.

RACS Foundation W G Norman Research Fellowship
$20,000

DR INDRAN RAMANATHAN (NSW)
Dr Ramanathan obtained his MBBS in 1993 at the University of Sydney. He will be using this Fellowship to study Energetics and Left Ventricular Function in Diabetic and Ischemic Cardiomyopathy at the Co-operative Research Centre for Cardiac Technology, Royal North Shore Hospital.

RACS Foundation ANZ Journal of Surgery Scholarship $30,000 (Scholarship $25,000 plus an additional $5,000 for Department Maintenance Funding)

DR SIMON BERNARD (Vic)
Dr Bernard obtained his MBBS at the University of Melbourne in 1990. This Scholarship will assist him with his research into the Angiosomes of the Torsos: an Anatomical Study with clinical implications at the Jack Brockhoff Reconstructive Plastic Surgery Research Unit.

RACS Foundation Scholarships 6 @ $30,000 (Scholarship $25,000 plus an additional $5,000 for Department Maintenance Funding)

DR ROSARIO R DONATO (Vic)
Dr Donato received his MBBS at Monash University in 1990. He will use this scholarship to research Prefabrication and the use of growth factors in tissue engineering at the Bernard O'Brien Institute of Microsurgery, St Vincent's Hospital.

MR MICHAEL J FRANCE (SA)
Dr France obtained his MBBS in 1991 at the University of Auckland. This scholarship will assist with his investigation of alternative insufflation gases for laparoscopic surgery at the University of Adelaide Department of Surgery.
DR JIM ILIOPOULOS (NSW)
Dr Ilipoulos obtained his MBBS in 1995 at the University of New South Wales. He will use this scholarship to assist with his research into the development of an elastic aortic wrap procedure for the treatment of cardiac failure in patients undergoing CABG at the Prince of Wales Hospital, Randwick.

DR CATHERINE TEMELCOS (Vic)
Dr Temelcos received her MBBS from the University of Melbourne in 1980 and passed her FRACS Part 2 Examination in Urology in 1988. This Scholarship will be used for research into Genito-urinary anomalies in VATER syndrome - an insight into urinary tract development at the Royal Children’s Hospital, Parkville.

DR MICHELLE J THORNTON (NSW)
Dr Thornton received her MBBS at the Newcastle University in 1992. She will use this scholarship to research Crohn’s Disease - modifying anastomotic recurrences - an animal model at the Royal Prince Alfred Hospital.

DR P S MACKIE (Vic)
Dr Mackie received his MBBS in 1993 at the University of Melbourne. His will use this Scholarship to study “The Role of Bisphosphonates as an Adjunct Treatment in the Management of Osteosarcoma” at St Vincent’s Hospital.

DR D E EDIS (Vic)
Dr Edis received his MBBS in 1994 at the University of Melbourne. He will use this Scholarship to study the “Aetiology of Hip Fractures in Elderly Men” at the University of Melbourne.

RACS Foundation Peter King Scholarship $30,000
(Scholarship $25,000 plus an additional $5,000 for Department Maintenance Funding)

DR DRAGOS IORGULESCU (Vic)
Dr Iorgulescu obtained his MD from the University of Bucharest in Romania in 1993 and is currently working at the Geelong Hospital. This Scholarship will assist with his research into the detection of occult bone marrow metastases in non-small cell lung cancer.

Sporting Chance Cancer Research Scholarships
HIH INSURANCE RAELLENE BOYLE SCHOLARSHIP
DR C S K HO (Qld)
Dr Ho obtained his MBBS in 1994 as the University of Melbourne. This Scholarship will enable him to further his research on “the Dendritic Cell Immunotherapy for Human Breast Cancer” at the Mater Medical Research Institute.

VININDEX TUBEMAKERS RAELLENE BOYLE SCHOLARSHIP
DR D S LOCKWOOD (Qld)
Dr Lockwood received his MBBS in 1991 at the University of Queensland. He will use this Scholarship to undertake research into mediators of the host stromal response to hepatocellular carcinoma at the Princess Alexandra Hospital.

RACS Foundation Francis and Phyllis Thornell-Shore Memorial Scholarship $25,000

DR E M MURPHY (SA)
Dr Murphy received her MBBS at the University of Adelaide in 1993. This Scholarship will assist her in her research on the characterisation of the human enteric nervous system and extrinsic innervation of the gut at Flinders Medical Centre.

RACS Foundation Catherine Marie Enright Kelly Memorial Scholarship $25,000

DR MICHAEL VALLELY (NSW)
Dr Valelly received his MBBS in 1995 at the University of Sydney. Dr Valelly will use this Scholarship to study “Endothelial cell activation on Cardiopulmonary Bypass” at the Heart Research Institute.

RACS Foundation Scholarship in Surgical Ethics
$25,000 plus $5,000 Departmental Maintenance

MS SUE PEARSON
Ms Pearson is currently enrolled in a PhD on behavioural medicine and will use this Scholarships to research prooperative information and patient distress: implications for the informed consent process.

Motor Accident Insurance Commission (QLD)
RACS Trauma Fellowship $50,000

DR MICHAEL MULLER (Qld)
Dr Muller obtained his MBBS from the University of Queensland in 1978 and received his FRACS in 1991. He will use this Fellowship to undertake research on improving subcutaneous and splanchnic oxygenation during resuscitation of major burns.

RACS Surgeon/Scientist Programme 10 @ $32,000
plus $10,000 Departmental Maintenance

DR D D MARUCCI (NSW)
Dr Marucci obtained his MBBS in 1994 at the University of Sydney. This is Dr Marucci’s second year under the Surgeon Scientist Program where he is undertaking research on “the Instrument - Tissue Interface” at the University of Sydney.
DR G J FARRANT (NZ)
Dr Farrant obtained his MB ChB in 1993 at the University of Otago. This is Dr Farrant’s second year under the Surgeon Scientist program which he is using to research “the role of the Intestine in the Pathogenesis of Acute Necrotizing Pancreatitis” at the University of Auckland.

DR V MURALIDHARAN (Vic)
Dr Muralidharan obtained his MBBS in 1991 at Monash University. This is Dr Muralidharan’s second year under the Surgeon Scientist Program. He is using the funds to study “the treatment of Colorectal Liver Metastases” at Monash Medical School.

DR M PIRPIRIS (Vic)
Dr Pirpiris obtained his MBBS in 1992 at the University of Melbourne. This Scholarship will enable him to undertake research on “Single Event, Multi-level Surgery in Spastic Diplegia” at the University of Melbourne.

DR A P BARBOUR (Qld)
Dr Barbour obtained his MBBS in 1992 at the University of Queensland. He will use this Scholarship to continue his research into “the Functional Role of CD44 Splice Variants in Tumour Proliferation and Metastasis” at the University of Queensland.

DR R L GRUEN (Vic)
Dr Gruen received his MBBS in 1992 at the University of Melbourne. This Scholarship will enable him to study “the Evaluation of the Delivery of Specialist Surgical Care in Remote Environments” at the Royal Darwin Hospital.

Dr J I ROSSAACK (Dunedin)
Dr Rossaack obtained his MB ChB in 1993 at the University of Witwatersrand and will be working at the Dunedin School of Medicine where he will be studying “The Genetics of Abdominal Aortic Aneurysm”.

DR D BATES (NSW)
Dr Bates received his MBBS in 1994 at the University of Sydney. The Scholarship will enable him to study “the Mouse as a model of Neurovascular Anatomy and Development - The Role of Homeotic Genes and the Neural Crest” at the Murdoch Institute.

MR A J A HOLLAND (NSW)
Mr Holland received his MBBS in 1988 at the University of London, his FRCS in 1992 and his FRACS in 1999. His research will take place at the Douglas Cohen Department of Paediatric Surgery on “Paediatric Trauma.”

DR J A J KING (Vic)
Dr King received his MBBS from the University of Melbourne in 1995. This program will assist with his research on the tumour suppressor merlin. Its role in oncogenesis and as a target for therapeutic intervention at the Royal Melbourne Hospital.

Stuart Morson Scholarship in Neurosurgery
$20,000

DR STEPHEN SANTORENEOS (NSW)
Dr Santorenoes obtained his MBBS at the Adelaide University in 1990. He will use this scholarship to further his training in Neurosurgery at the University of Toronto.

Marjorie Hooper Scholarship $32,000

DR DINESH SELVA-NAYAGAM (SA)
Dr Selva-Nayagam is currently completing a Fellowship in Orbital Disease at the University of British Columbia. He will use this Scholarship to take up a position in the Oculoplastics Unit at Moorfields Hospital, Vancouver.

RACS Foundation Travelling Fellowships
3 @ A$13,500

DR JUSTIN BESSELL (Qld)
Dr Bessell obtained his FRACS in General Surgery in 1998. Dr Bessell will use this Fellowship to travel to the United Kingdom to experience advances in Hepato-Biliary Pancreatic Surgery within the quaternary referral unit of the Leicester General Hospital.

MR LEWIS BLENNERHASSETT (WA)
Mr Blennerhassett received his MBBS in 1989 from the University of Western Australia. He then obtained his FRACS in Plastic Surgery in 1998. This Fellowship will allow Mr Blennerhassett to travel to Boston and take up a one year Fellowships at the Children’s Hospital and Beth Israel Deaconess Medical Centre in Boston, Massachusetts.

MR ANDREW MITCHELL
Mr Mitchell obtained his MBBS in 1984 at Melbourne University and then received his FRACS in General Surgery in 1998. This Travelling Fellowship will enable him to travel to intestinal transplantation centres in Omaha Nebraska and Pittsburgh Pennsylvania.

Lumley Exchange Research Fellowship

DR SEAN MACKAY (Vic)
Dr Mackay obtained his Fellowship of the Royal Australasian College of Surgeons in 1998. This Fellowship will enable him to take up a position as Research Fellows in the Minimal Access Surgical Unit at St Mary’s Hospital London under the supervision of Professor Ara Darzi.
For information on application for positions in the Advanced Surgical Training Programmes of the Royal Australasian College of Surgeons, suitably qualified medical practitioners are invited to contact the following personnel for details relevant to particular surgical disciplines. To meet the appropriate closing date, details should be obtained in advance. Application to the relevant employing authority should also be made.

**General Surgery and Rural Surgery**

Successful applicants in the year 2000 will enter the new Five Year Advanced Training Programme in General Surgery. Formal written applications should be submitted, only formal applications by the due date in the prescribed manner will be accepted. The application must include a structured curriculum vitae, full details of completion of Basic Surgical Training and the names and addresses of three referees. Details of the structured curriculum vitae the structured Interview Process, and details of the new Five Year Training Programme will be provided on initial indication of intent to make application. Successful applicants will be appointed initially to the first year of the Training Programme only. Following satisfactory performance in that year of the programme, the applicant will be considered for reappointment to enter the second and subsequent years of the Training Programme. Applicants for General Surgery who are interested in practising in a rural setting are advised to make application to the Rural Surgical Training Committee, in addition to application for General Surgery. Advanced Trainees with a rural interest may access training in the surgical specialties, a rural surgical mentor and advice on career planning, and funding to attend the Annual Meeting of the Provincial Surgeons of Australia. Apart from Rural Surgery, selection into a subspeciality training in the fourth and fifth years of the programme, will be made during the second and third years by the appropriate Sub-Speciality Selection Committee. Registration of initial intent to apply should be made as early as possible in writing to either the Chairman of the Board in General Surgery for Australian applicants, or the Chairman of the New Zealand Regional Sub-Committee of the Board in General Surgery for New Zealand applicants. In any one year, only one application may be made. Unsuccessful applicants may apply again in another year but a third application would be considered only in special circumstances.

**Australian Applicants**

Registration of intent to apply, and formal application should be made to: Mr. J. Mackay, Chairman, Board in General Surgery, Royal Australasian College of Surgeons, Spring Street, Melbourne, Victoria 3000.

Applications close 30 June, 2000

New Zealand

Mr. L. Civil, Board in General Surgery, RACS, PO Box 7451, Wellington South. Further details in NZRACS Newsletter.

Applications close 31 March, 2000

**Rural Surgical Training Committee, Australian Applicants**

Mr. D. Birks, C/- Department of Surgery, Geelong Hospital, Geelong, Victoria, 3220.

Applications close 30 June, 2000

**Orthopaedic Surgery**

**Australia**


Applications close 7 April, 2000

**New Zealand**

Mr. A. MacDiarmid, NZ Orthopaedic Association, RACS, PO Box 7451 Wellington South.

Further details in NZ Committee Newsletter.

**Urology**

**Australia and New Zealand**

A/Professor R. Millard, Chairman, Board of Urology, Urological Society of Australasia, 177A Albion Street, Surry Hills, NSW, 2010.

Applications close 23 May, 2000

**Cardiothoracic Surgery**

**Australia and New Zealand**

Written applications for the national training programme should be submitted by the due date to the Chairman of the Board in Cardiothoracic Surgery. Applicants are advised to consult the Royal Australasian College of Surgeons publication “Guide to Surgical Training 1996” and obtain advice from the Head of Cardiothoracic Surgery at their hospital, prior to applying. Successful applicants may apply again in another year, but a third application will generally not be considered. Short-listed applicants will be interviewed. The application must include a current curriculum vitae with full details of completion of basic training requirements and three (3) confidential referees reports, each within a sealed envelope. Mr. J. Taitalis, Chairman, Board in Cardiothoracic Surgery, Suite 28, Private Medical Centre, Royal Melbourne Hospital, Parkville, VIC, 3050.

Applications close 26 May, 2000

**Plastic & Reconstructive Surgery**

The Chairman of the State and/or Regional Sub-Committee of the Board of Plastic and Reconstructive Surgery should be contacted. Candidates may apply to only one Sub-Committee.

**Australia**

- Mr. I. Carlisle, Suite 26, Cabrini Medical Centre, Isabella Street, Malvern, VIC, 3144.
- Mr. J. Vankerveld, 2nd Floor, North Shore Medical Centre, 66 Pacific Highway, St. Leonards, NSW, 2065.
- Mr. K. McLernon, “Alexandra”, 201 Wickham Terrace, Brisbane, QLD, 4000.
- Mr. M. Moore, Calvary Hospital, Strongways Terrace, North Adelaide, SA, 5006.
- Mr. M. Hansen, 7 Richardson Street, West Perth, WA, 6005

Applications close 7 July, 2000

**Neurosurgery**

**Australia, New Zealand and Singapore**

Written applications should be submitted by the due date to the Chairman of the Board of Neurosurgery. Please telephone/email Professor Andrew Kaye for details of the structured curriculum vitae, providing an email address, if possible, for sending. Please consult the Royal Australasian College of Surgeons publication “Guide to Surgical Training, 1996” and obtain advice from the head of a training unit, prior to applying. Successful applicants may apply again in another year. A third application may occasionally be considered but subsequent applications will not, Prof. A. Kaye, Chairman, Board of Neurosurgery, Royal Melbourne Hospital, Grattan Street, Parkville, VIC, 3050.

Tel: (03) 9342 8218 or Fax: (03) 9347 8332

Email address: andrew.kaye@nwhcen.org.au

Applications close 12 May, 2000

**Vascular Surgery**

**Australia and New Zealand**

Mr. J.M. Quinlan, Chairman, Board in Vascular Surgery, “Alexandra”, 201 Wickham Terrace, Brisbane, QLD, 4000.

Tel: 07 3832 4639 Fax: 07 3832 4130

Applications close 31 May, 2000
RACS on the Web

The RACS Internet site - found at www.racs.edu.au - continues to grow every week.

While the public is welcome to visit the site, there are also areas set aside for Fellows, trainees and RACS staff which can only be accessed via a user name and password.

Some of the new developments include:

- Information about the RACS Annual Scientific Congress 2000. Abstracts can be submitted online and delegates can even find out where to stay in Melbourne.
- Access to the RACS Virtual Congress. Leading-edge technologies enable surgeons who are unable to attend the ASC to access presentations, “meet” delegates and other participants, and to participate in online forums and polls.
- A full text of the RACS Infection Control in Surgery policy document.
- The RACS Policy Manual. The first four chapters are now available online and additional chapters are being added weekly.
- An open calendar service. Conferences and events of interest to surgeons can be submitted and, if deemed appropriate, published in the calendar.
- Early Management of Severe Trauma programme pages. These provide information and registration forms for courses. The pages have been updated with new text and links.
- Redesigned RACS product page. Pictures of gifts and memorabilia produced by the college are displayed with an order form.
- Links to affiliated organisations such as the Australian Safety and Efficacy Register of New Interventionsal Procedures - Surgical (ASERNIP-S) and Interplast Australia.

If you have any queries about the RACS Internet site, please contact the RACS Web Site Administrator, Michael Filippidis, on 03 - 9429 1273 or e-mail him at michael.filippidis@racs.edu.au.

RACS Ties Up Travel Scheme With Ansett, Diners Club & Hotel Chains

As mentioned in his editorial in the recent edition of the Bulletin, the Chief Executive, Dr Vin Massaro, has commenced the introduction of the RACS Member Benefit scheme with the signing of an extremely competitive deal with Ansett Australia and Diners Club, which will offer a range of benefits to participating Fellows and their partners. This will ensure that Fellows of RACS receive maximum value from their RACS membership.

All Fellows will be offered a free Ansett Business Card (Diners Club) which offers substantial travel discounts for all eligible people using Ansett travel accounts for private travel in association with the Traveland Leisure travel scheme for holiday packages.

Current holders of Qantas Club membership (except Life Members) will receive equivalent membership in Golden Wing for the remainder of the membership period.

Under the agreement, from 1 March all RACS corporate travel will be booked through Ansett as the College’s Travel Manager using the College account; the travel discounts will be available for this travel.

The agreement with Diners Club will provide an Ansett Business Card (Diners Club) for all Fellows, Trainees and staff for private use upon application.

The College has also secured government rates for accommodation with a number of hotel chains Australia-wide, which will result in savings on accommodation in the region of 35%–50%. (See detailed accommodation rates elsewhere in this edition of Surgical News.)

Full details of the agreement will be released to Fellows in the coming weeks, and will appear in future editions of Surgical News.

RACS Accommodation Rates - 2000

The RACS receives government rates with the following chains:

(These represent savings of between 35% and 50% off the rack rate)

1. Hilton - Australia, New Zealand & Worldwide
   Bookings: 1800 222 235
2. Marriott, Sebel, Quay West Hotels Austria, New Zealand & Worldwide
   Bookings: 1800 291 239 & in Sydney (02) 9231 3522
3. Inter-Continental - Australia, New Zealand & Worldwide
   Bookings: 1800 533 888
4. All Seasons Hotels - Australia wide
   Bookings: 1800 333 966
5. Oakford Hotels - Australia wide
   Bookings: 1800 819 237
6. SPHG GROUP HOTELS - Australia, New Zealand & Worldwide
   Bookings: 1300 363 300 - Quote Bonus Card #222 249 000
   Parkroyal - Centra - Travellodge - Mirvac
7. STARWOOD HOTELS & RESORTS - Australia, New Zealand & Worldwide.
   Bookings: 1800 073 335 Westin - Sheraton

*When making a booking with any hotel, remember to mention you are using the Royal Australasian College of Surgeons' Government rates.

Any questions regarding College Accommodation can be directed to:
Ms Nerea Huidobro on (03) 9249 1205

MEETINGS

Full details of meetings for 2000 and beyond are available on the College Home Page at http://racs.edu.au under Calendar. The database can be searched by specialty as well as by month.
The medical colleges are involved in extensive training programs for medical practitioners. Colleges and teaching hospitals must invaribly ensure that trainees are adequately exposed to a range of practical situations involving the care and treatment of patients.

Teaching hospitals invariably have a "consent form", which discloses the fact that the hospital is a teaching hospital, and that occasionally trainees and junior practitioners may carry out some tasks. I am not aware of any hospital which has any more sophisticated arrangements to deal with the issues of trainees and "informed consent".

Consent
A doctor who carries out a procedure on a patient, without the patient's consent, is, in legal terms, guilty of assault or battery. The doctor can be sued for failing to obtain the patient's approval for the physical treatment undertaken. (This rule, of course, varies in emergency situations.)

Informed Consent
Since the decision of Rogers v. Whittaker in 1992, the Australian High Court has confirmed that simple consent is not enough. The law has recognised that a doctor has a duty to warn a patient of a material risk inherent in any proposed procedure or treatment. The Court has formulated the standard for doctors as follows:

"A risk will be considered material if, in the circumstances of the particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it, or if the medical doctor is, or should reasonably be, aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

When considering the need to inform the patient of a particular risk, doctors should therefore consider two separate matters:

1. Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?
2. Is the doctor aware, or should the doctor be reasonably aware, that this particular patient would be likely to attach significance to that risk?

The Courts have placed a high burden on doctors to ensure that all material risks are considered, and that the particular circumstances of the patient are considered.

Delegation
Of course, doctors in busy hospitals do not act in a perfect world, and do not have unlimited time in which to properly consider all of the issues and risks, no matter how remote, that may affect the patient's decision.

Many doctors, unwise, sometimes delegate the task of explaining the risks to patients to assisting doctors, trainees or other hospital staff. Doctors are entitled to delegate this responsibility to others, but they bear the liability if the others do not properly advise patients. Doctors, who leave "informed consent" to assisting or junior doctors, run the risk that the other doctors do not do the job properly.

It is clearly the responsibility of the treating doctor to obtain informed consent from the patient, and to advise the patient of all material risks. If this is not done properly, the treating doctor bears the legal responsibility.

Doctors who rely simply on consent forms, hospital administration or other bureaucratic processes, run a substantial risk. "Consent should be obtained by the person who will touch the patient. The doctor who delegates his responsibility to a hospital employee, such as a nurse, takes the risk that the consent obtained may be inadeguate." (Picard Legal Liability of Doctors and Hospitals in Canada (1994) pages 66-67.)

Trainees
There is now sufficient case law to suggest that one of the material risks involved in any procedure, which ought to be advised to patients, is the fact that it may be undertaken by a trainee or inexperienced doctor, rather than the treating consultant or proceduralist. Several American and Canadian cases raise these issues:

In Buie v. Reynolds (Oklahoma), the judge noted, "A resident did perform the operation thereby engaging in a type of ghost surgery which is condemned by the law as malpractice and by the American Medical Association as a fraud and a deceit and a violation of a basic ethical concept. A surgeon may not, says the AMA article, permit surgery residents in training, to perform operations on private patients under the supervision of the patient's surgeon without the knowledge or consent of the patient."

In Guehr v. Jabbar (Illinois), the resident appeared to have performed the majority of the surgery. The Court noted that, where an unauthorised surgeon operates, it is a battery upon the patient.

In Pugley v. Privette (Virginia), a surgeon was held liable in battery for operating on a patient, despite the fact that the patient had signed a consent form. The patient had insisted that her own physician do the operation, rather than the actual surgeon involved.

In Burk v. Sandors (British Columbia), the Court refused to allow the "highly technical assault claim", where there was no damage or actual negligence in the treatment of the patient by the doctor, that the patient had not consented to.

A comment in Considine v. Camp Hill Hospital (Nova Scotia) by the Court was that it was "quite incredible" that the operating surgeon had never spoken to the patient prior to the surgery - even though there was no actual negligence shown in the surgery performed.

The question arises: whether the fact that a trainee or inexperienced doctor was involved in the procedure, or may be carrying out some or all of the procedure, is a material matter which ought to be disclosed to the particular patient, in the particular case.

The recent decision of the High Court of Australia in Chappel v. Hart provides clear support for the proposition that such disclosure is required. Chappel v. Hart is a case in which it is alleged that Mrs Hart was not warned of the particular risks of a procedure. Mrs Hart said that, if warned of the risks, she would not have undergone the procedure. The case is very similar to Rogers v. Whittaker. It was alleged that the doctor was of average experience in relation to the particular procedure, and that more experienced doctors may have produced a better result. It seems implicit from the case, although it was not finally decided, that Mrs Hart should have been warned that the doctor was only of average competence in relation to this procedure, and that there were more experienced surgeons available. It was stated:

"If the foreseeable risk to Mrs Hart was the loss of an opportunity to undergo surgery at the hands of a more experienced surgeon, the duty would have been a duty to inform her that there were more experienced surgeons practising in the field."
Later, it was stated:

“Mrs Hart swore that if she had been told by (the doctor) of the risks to her voice, she would not have gone ahead with the operation by him. She would have sought further advice. She would have wanted the operation performed by the most experienced person available. Professor B was posited as such a person. The evidence showed that he had performed many more operations of this kind than (the doctor) had.”

Ultimately, the Court’s decision did not determine this issue. However, it provides a telling argument for the suggestion that a doctor might have to warn the patient of the fact that they are junior or inexperienced in relation to particular procedures.

If it is, therefore, material that a doctor may have to disclose their relative level of experience, then it can clearly be a matter for disclosure that a trainee or inexperienced doctor was to undertake some or all of a medical procedure.

Most of the community will accept that public hospitals are training hospitals, and that junior doctors and trainees must gain experience and learn under supervision. However, the Courts are likely to also require that patients be adequately informed when a trainee or junior doctor is performing a procedure, and probably the level of supervision involved.

It would not be sufficient that a general consent form indicated that the hospital was a training hospital, and that certain procedures would be undertaken by trainees from time to time. Such a general formulation or general advice would not satisfy the requirements for the informed consent to be specific to the patient in the particular circumstances.

Of course, patients can be advised in a way that it is non-threatening and does not jeopardise the training situation which applies in hospitals. Patients can be advised that a junior doctor will be undertaking the procedure, under close supervision of the consultant, and with the consultant available to monitor and step in when necessary.

As noted above, general consent forms are largely irrelevant to the process of informed consent itself. The form is merely a sign that a consent process has been undertaken. It is the verbal and other communication that goes on between doctor and patient which represents the informed consent, and not the form or any signature. (In many cases, the consent form is only worth the paper it is printed on!)

The requirement to inform patients when a trainee or junior doctor is involved will be greater in circumstances where the patient is clearly nervous about the outcome, requests more information about the procedures and who may be undertaking the procedures, or otherwise exhibits concern and interest. Other principles of informed consent should be considered:

- Would the risk (of a trainee doctor being involved) influence the decision of a reasonable person in the position of the patient?
- Is the risk of the trainee’s involvement so slight (because the procedure they are undertaking is so simple) that no reasonable person would be influenced by it?
- Obviously, the more drastic the intervention or procedure undertaken by the trainee or junior doctor, the more necessary it would be to inform of the risks and consequences.
- The desire for more information by a patient necessitates greater disclosure, even if the patient says they have no desire for such information.

- Obviously, the existence of emergency situations, or lack of opportunity for proper counselling or discussion can effect the obligations to disclose. In an emergency environment, the information that may be disclosed may be minimal or not possible at all.

Whilst the issue has not been finally determined by the Australian Courts, there is sufficient support in Australia and international cases for the requirement that patients be properly-advised when trainees or junior doctors are involved in procedures. This is particularly so where the procedure is complicated, substantive, or where minimal supervision may be involved. The extent of disclosure required is still to be determined by the Courts. However, I believe it is now clear that where an inexperienced trainee or junior doctor is undertaking a procedure, it would be a “material risk” which should be part of and disclosed in the “informed consent” process, and the patient advised accordingly.

I recognise that this has substantial implications for the training programs of medical colleges and for procedures in training hospitals. However, these implications must be faced, and appropriate systems and adjustments developed to deal with this issue.

(acknowledge the contribution of Patrick Joyce, Solicitor with Russell Kennedy, Solicitors, in the development of this article.)

Michael Gorton,
B.Com, LL.B., FRACS (Hon), FANZCA (Hon)
College Honorary Solicitor
Partner - Russell Kennedy, Solicitors

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News from the Medico Legal Interest Group

More than 460 Fellows have joined the College’s Medico-Legal Group that was formed last year at the Annual Scientific Congress in Auckland.

This is perhaps a reflection of the growing incidence of litigation involving surgeons which has seen professional indemnity insurance increase markedly in some specialties.

The Medico-Legal Group is considering the range of issues that affect surgeons. These include:

- Risk management.
- Medical negligence.
- Expert witnesses.
- Training programs in both court and medical areas.
- Assessments in worker’s compensation and motor accident injuries.
- Accreditation of surgeons for medico-legal work

According to the chairman of the group, Mr James Pryor, the Medico-Legal Group was formed because of the increasing incidence of litigation involving surgeons and because of the need to train surgeons in giving expert evidence in court, irrespective of their surgical knowledge and skills.

“We have recognised that times change and the College has to prepare surgeons for this new era,” Mr Pryor said.

He said the issue of litigation against surgeons and other doctors had become a major factor in rising medical defence premiums.

“One purpose of the group is to make surgeons aware of the issues current in litigation and to assist them in their practices so that they may minimise problems,” Mr Pryor said.

“Another area is to train them in presenting information in court.”

Presenting information in court is to be a major theme of medico-legal sessions at the 2000 Annual Scientific Congress in Melbourne. The guest speaker (the Victorian Workcover Authority Visitor) is Dr Robert Hanson III of the Maryville Orthopaedic Clinic in Tennessee who will explore the impact of expert evidence and assessment.

The Medico-Legal Group is also investigating accreditation of expert witnesses and the College establishing its own “expert witness” list.

The Medico-Legal Group was formed after the immediate past president of the College, Mr Colin McRae, asked a group of surgeons to write a submission and to form some guidelines on the issue. The current College president, Mr Bruce Barracough continued the project. A submission was made to Council and a formal constitution was proposed and ratified.

The group’s executive is made up of James Pryor (chairman), Ray Hollings, Anthony Buzzard and Ross Blair. A working party made up of members from the states and New Zealand has been formed and members are responsible for special areas of interest. The members of the working party are: Sol Levitt, John Simpson, William Coman, Russell Broadbent, Leehde Hoare, Michael Franks, Neil Cullen, Gary Speak, Ian Russell, Chalm Williams, Neil Berry and the advisor on the Impairment Guide is Hunter Fry.

The group now puts out a newsletter which can be accessed on the College Website - www.racs.edu.au. Fellows are invited to express their views by contacting Ms Nancy Emmanuel at the College on 9249 1200 or e-mail her at nancy.emmanuel@racs.com.au.
Transplantation Surgical Training Program

The R.A.C.S. will approve 2-3 Post-Fellowship Trainees to undertake a two year clinical training programme in Transplantation Surgery. Training can be in liver transplantation, liver and kidney transplantation, kidney and pancreas transplantation or kidney transplantation.

Fellows or Part II trainees wishing to apply for selection should write directly to the Chairman of the Training and Accreditation Committee, at the address below, submitting:
1) The names and addresses of two referees who will attest to the applicant’s suitability to enter the training programme.
2) Curriculum Vitae.
3) Details of any contributions to the specialty of Transplant Surgery such as publications or research work.
4) Preferred Transplant Units if known.

Fellows who are selected into this scheme will be “matched” as far as possible to those Transplant Units providing the transplant experience the applicant seeks. Final appointment and salary arrangements will be negotiated with the employing hospital authority.

On completion of the two year training programme a Post Fellowship Certificate in Transplantation Surgery will be awarded by R.A.C.S.

Applications close on 26 May 2000 for appointment to the 2001 Programme. Applications or enquiries should be forwarded to;
Professor D.E. Scott, FRACS, Chairman
Training & Accreditation Committee for Transplant Surgery
C/O Mrs. R. Martocca
Royal Australasian College of Surgeons
Spring Street, Melbourne Victoria 3000, Australia
Telephone: (03) 9249 1247  Fax: (03) 9249 1240

Lost Fellows

The College has been unable to contact a number of Fellows during the past year.

The Fellows are:
ARNOLD Malcolm Roger Stewart
AU Ting Wah
BONNER-MORGAN Robin Peter
CHARI Parawasti Ranga
CHOW Peng Hwee
DARBY Graeme Keith
DENNING Ben
EASTON Frederick William
FEELY Kevin Joseph
FINNIS Nicholas David Mowbray
GREER John Herbert
GUMLEY Graham John
IMEOKPARIA Ejareghere Michael
ISMAIL Abdul Majid
LELA Mala Perumal
MACLEOD Pearl Anna Inglis
MAHER Samir Mohamed Amin
MANTZIROS Nicholas
MITROFANIS Chritsos
NG Peter Eng Pin
O’DONOVAN Terence Gregg
PAROULARIS Michael John
POLLOCK Graeme James
QUINN Anthony Gerard
RASANAYAGAM Ronald Thuraiasingam
RAYNER George Halyer
RICH Gordon Francis
ROBINSON Peter Lawrence
RYDER Derek Raymond
SIEMENOWICZ Richard
SMART Graham Frederick
SULLIVAN James Anthony
SWEELEY Noel Vincent
TAN Teng Kook
THOMPSON Neil George Hugh
THOMPSON Harold Roberts
TI Thiow Kong
VLAKARI Emmanuel
WALTER Leonard Rex
WILSON Michael Keith
WISE Gordon Michael
WONG Kwok Shing Patrick

If you are included on the list, or you know the current address of any of the Fellows noted above, could you please advise the Business Manager so that the College records may be updated:

Business Manager: Mr Ian T Burke
Royal Australasian College of Surgeons
College of Surgeons Gardens, Spring Street, Melbourne Phone (03) 9249 1200

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
2000 ANNUAL SCIENTIFIC CONGRESS
MELBOURNE, 7 - 12 MAY 2000

The Melbourne Annual Scientific Congress is to be held at the Melbourne Exhibition and Convention Centre complex from 7 - 12 May 2000.

Features of the meeting will include the Ecumenical Service to be held at St. Paul’s Cathedral on Sunday 7 May 2000. This will be followed by the Convocation in the evening at the Melbourne Exhibition and Convention Centre at which the Former Governor General of Australia, the Right Honourable Sir Ninian Stephen, will be the Syme Orator.

On both Monday 8 May 2000 and Tuesday 9 May 2000 there will be a number of combined sessions with the Australian and New Zealand College of Anaesthetists who are meeting at the Crown Towers Hotel across the Yarra.

The Social Programme includes Sectional Dinners on Tuesday 9 May 2000 and Thursday 11 May 2000 and the Congress Formal Dinner on the evening of Wednesday 10 May 2000. On the evening of Monday 8 May 2000 the RACS will be hosting an evening in the lively Southgate precinct which will include street theatre groups, wine tasting and dining.

A copy of the Provisional Programme, Abstract Submission Form and Registration Form can be found via the College website at the following address: www.racs.edu.au

Registration and abstract submission enquiries can be directed to the ASC Manager,
Mr Kevin Wickham, Telephone +61 3 9859 6899 or Email: racsmel@wickhams.com.au

General enquiries can be directed to the ASC Secretariat, Ms Kate Young,
Telephone +61 3 9249 1200 or Email: kate.young@racs.edu.au

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