In the Congo

Dr Neil Wetzig continues to support HEAL Africa
President’s Perspective

As disaster surrounds us, it is a good time to look at our role as surgeons.

This is being written as the floodwaters around Brisbane are starting to recede and the devastation and need for months if not years of re-building is becoming even more apparent.

At the same time as the Queensland disaster is unfolding, flash floods are occurring in Victoria, bush fires have been raging in Western Australia and New Zealand is still coming to terms with two recent natural disasters.

The earthquake that affected Christchurch in September last year destroyed much infrastructure although fortunately few lives were lost. However, the mine-blast at Pike River in New Zealand has overwhelmed the local community with loss of loved ones and a way of life.

To all the people who now have to re-build their lives, we extend not only our sympathy, but also our support in whatever way we can.

Ian Civil
President

If there is something about the New Year that provides us the opportunity to reflect not only on the achievements of the year just gone, the enthusiasm for the days to come, but also our grip on life where nature in her ferocity can literally wrench all away from us?

This is the time of year where cyclones, tsunamis, floods, droughts and bush-fires always seem to be focusing our minds. We may look back to the Cyclone Tracy events in Darwin or the Indian Ocean Tsunami of 2004 for events of enormous magnitude occurring at this time of the year and the annual cycle of natural disasters lingers with us all.

For a complimentary portfolio review, a sample of our research or to find out more about Patersons please contact Senior Investment Advisers Tony Tascone or Marco Longo on 03 8803 0126 or email ttascone@psl.com.au.

www.psl.com.au

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www.psl.com.au
President’s Perspective

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The College and the year ahead

With more state elections and one in New Zealand, the College continues to advocate for Fellows while also working on promoting the FRACS brand.

Keith Mutimer
Vice President

I hope that all Fellows managed to find time to enjoy the festive season and that your year is off to a good start.

Advocacy matters

Your College will continue to advocate on your behalf on matters important to health public policy particularly as those matters pertain to our profession. And 2011 promises to be an interesting year. The Coalition’s win in the Victorian election, and a likely Coalition win in New South Wales this March, throws into doubt at least some aspects of the Commonwealth Government’s national health reform package.

Based on the ATLS® program of the American College of Surgeons, our EMST course is an essential component of our training and also recognised by many other professional bodies. Keeping our skills current and our ability to be “trauma ready” is something the College fully supports.

The College continues to liaise with the offices of the Chief Medical Officers and also the military to ensure that surgical skills have been identified, trained, skills maintained and are available no matter where or when the disaster occurs. Our response to disasters is something that reflects fully on our commitment as surgeons and professionals. Over the past few months I have had cause to reflect a lot on what the public would view as our critical requirements as professionals.

The Honourable Geoff Davies AO who has now retired from our Council as the Expert Community Advisor has challenged all of us with his view that we have much to do to achieve these requirements. Over the next twelve months, I hope to explore these issues more fully.

The paper that he presented at the Annual Scientific Meeting of the Australian Orthopaedic Association in October, 2010, will be printed in a future edition of the ANZ Journal of Surgery. In that presentation he challenged us that although individual surgeons do outstanding work to support various communities and their needs, that as a collective, surgeons may not be perceived as responding to these issues.

How do we ensure that communities of need are identified, their service requirements understood and the health needs of all of our patients are at the fore-front of our requirements? He has left Council with a strong message that we must do more to truly deliver for the community if we wish to retain the privileges of professionals.

I welcome you all to the New Year and extend my best wishes. In 2011 we are challenged not only by the magnitude of nature’s devastation, but also the requirements of our role as surgeons, as professionals, and in support of the community in which we live and work.

Although from a smaller perspective, these events also make us reflect on our commitments and skills as surgeons. All of us have had training in trauma and emergency care. Many of us are still involved with the active assessment and treatment of the critically injured. It is these skills in which the College has provided training and ongoing education for many years.

The Governance and Advocacy Committee are currently developing a position paper in support of the separation of elective and emergency surgery. Based on the fact that social workload, be it elective or emergency, is entirely predictable, the paper’s main argument is that the streaming of patients into distinct surgical streams, and the appropriate allocation of resources to each stream, ensures more timely emergency care and more efficient elective throughput.

Models developed at several Australian hospitals have yielded compelling results, with much more efficient theatre use, shorter wait times in EDs and shorter hospital stays. Much of this is attributable to the fact that a higher proportion of emergency procedures are performed during daylight hours, when consultant-led surgical teams are fresher and more focussed. Significantly, surgeons who were at first uncertain about the new arrangements have quickly become converts, relishing the enhanced work/day balance that comes with a predictable day’s work.

It will be stressed, however, that the success of the new arrangements is more than ever dependent on the principle of the surgical team and a commitment to robust and comprehensive handover.

The College will continue to pose questions to the major parties in the lead up to elections, ensuring they are aware of surgeons’ concerns and our proposed solutions to some of the problems besetting our public hospitals. The responses of the parties to our correspondence make for interesting reading and are publicly available on the relevant regional page of the College website.

It is likely that the next New Zealand general election will be held in the latter half of this year, and the NZ National Board will be developing an “election manifesto” and engaging with the major parties during the campaign on matters of concern to Fellows.

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**FRACS as a trademark**

Fellows may not be aware that the College has for several years protected the term ‘FRACS’ via a trademark. This ensures that the FRACS post-nominals are reserved for use by the College and Fellows of the College. It is important that Fellows are aware of what that means for them and the use of their FRACS post-nominals. Fellows are obviously permitted—and indeed encouraged—to identify their Fellowship of the College by the use of their post-nominals.

However, using the FRACS as part of a business or website name is more problematic. Here the post-nominals are being used as a marketing tool in a commercial enterprise and the College would prefer that this did not occur without its knowledge or permission. The College may grant permission to use the FRACS in this fashion, but only with adequate acknowledgement of the College and the Fellows.

To assist Fellows in appropriately identifying themselves as a FRACS, the College is in the process of developing a new logo for use by the Fellows. This will allow Fellows to use a stylised FRACS on letterhead, with compliments slips, decals on practice windows or doors and other printed or electronic material if they wish.

This new logo is to be considered by Council later this month and will, I hope, be available to Fellows in the next couple of months.

**Past President’s reflections**

The Governance and Advocacy Committee, in conjunction with the Heritage and Archives Committee, recently invited immediate past-President, Professor Ian Gough, to summarise his achievements and to highlight memorable events that occurred during his Presidency and his broader time on Council.

This summary was recorded as a DVD and is now available through the College website. Both committees believed that concept of recording the experiences of a President in his time on Council would form a valuable adjunct to the College tradition of portraiture.

Professor Gough provides a fascinating vista of the change that occurred at the College over his nine years on Council and his insight into matters such as the challenges posed by the ACCC, the introduction of SET and the general politics of healthcare, provides compelling viewing for those Fellows with an interest in the College's history.

The DVD chapters can be found on the Heritage and Archives page of the College website.

**Congratulations on your achievements**

At the final council week of 2010, Professor Richard Clayton Bennett was awarded the International Medal.

**Professor David Watters**

Chair, International Committee

The International Medal is awarded for consistent and outstanding contributions over a considerable time to the International work of this College. Professor Bennett became a Fellow of this College in 1960. He was a graduate of the University of Adelaide.

In acquiring his Fellowship, he won the Gordon Taylor prize during the Part 1 examination in 1957. Later, he was a member of the Court of Examiners from 1972 to 1986 and a member of Council from 1975 to 1987, including honorary treasurer from 1979 to 1987.

He was the founder of the College Foundation and coordinated its activities from 1979 to 1989.

As a surgeon in practice, he was based at St Vincent’s Hospital, Melbourne from 1966 to 1991, where he was appointed by the University of Melbourne as the Hugh Devine Professor of Surgery.

Since 1997, he has held the title of Emeritus Professor of Surgery at the University of Melbourne.

Here, we recognise his contributions internationally – particularly in Malaysia and Hong Kong. He convened the 1978 Annual Scientific Congress in Kuala Lumpur and again in Hong Kong in 1993.

In 1984 and 1988, he contributed to the second and third Joint International Meetings of the College of Surgeons and College of General Practitioners of Malaysia.

In 1988, he was the College Travelling Fellow to the College of Surgeons of Malaysia, a position he helped establish and which has continued annually during the 1990s, he was an external referee for senior academic appointments at the University of Malaysia and also an external examiner.

He has been involved as an examiner and senior academic in the major teaching centres were balanced by his involvement in regional East Malaysia. Dr Ranji Mathew Oommen wrote:

In 1989, he formed the Surgeons International Foundation largely using his experience and network to provide education and training opportunities for overseas surgeons and other surgical team members to make short term visits to Australia or New Zealand.

To date, 32 individuals have been awarded scholarships since 1994. The recipients have come from Malaysia, Vietnam, Nigeria, the Pacific, Indonesia, China and Papua New Guinea. Today these individuals are surgical leaders in their home countries. The funding and administration of the scholarships awarded by Surgeons International is now managed by the International Committee of the College.

Professor Richard Clayton Bennett has been a great surgeon, teacher and researcher within his own country and made notable contributions to this College for which he has been previously recognised by the Sir Hugh Devine Medal.

With this medal, we recognise his international contributions that span over a 30 year period. He personally made significant contributions to surgery in Malaysia, the Pacific, and Papua New Guinea. Senior Surgeons today speak highly of him. However, his legacy, Surgeons International, will ensure his influence will continue for many generations to come.
After many years of helping restore sight to people in Papua New Guinea, Dr Michael Scobie is reluctantly passing on the gauntlet.

“Af ter restoring the vision of thousands of cataract-blinded people in some of the most remote areas of Papua New Guinea during the past 15 years, retired NSW ophthalmologist Dr Michael Scobie has decided to stop operating,” he said.

“Most surgeons know when the time is right to retire,” he said. “If older people are no longer independent as a result of poor vision, they must rely on children and grandchildren to lead them around and help them with the requirements of daily living.

“Some to restore the sight of older people is to free up the entire family and in a country where everyone is needed to contribute to basic subsistence survival this is of major importance. How old the patients are, in fact, is often guesswork, as most don’t know their age, interestingly when first went to Wewak, patients simply said they were born before or, after, The War, when Wewak was occupied by the Japanese. It obviously left an indelible impression!”

Dr Scobie began visiting PNG in 1996 after travelling there with Dr Booth, having decided he wished to use his skills to assist the people of a developing nation who had little or no eye-care services available.

“I had worked with Aboriginal communities travelling there with Dr Booth, having decided that was what makes going there so important, as there was an overwhelming need there, the work conducted there remained enormous. It took a great deal of soul searching to come to this conclusion, but the second week proved much busier, then there was a woman who had been blind for about eight years who had a six-year-old who that she had never seen, and a 10-year-old that she hadn’t seen since babyhood and for her to suddenly be able to see her children again was very moving.

“She also operated on a woman blind who had had leprosy resulting in both legs being amputated, and when you see such suffering and stigmatisation it is impossible not to be affected by it.”

“Dr Scobie said he was very grateful to all the team members who had gone to PNG with him over the years, and acknowledged the great work still being done in PNG by Dr Booth and her team.

“It took a great deal of soul searching to draw a line under this work and I’m sure I’ll feel hollow when June arrives and there is no journey in the offing,” he said.

“Some to restore the sight of older people is to free up the entire family and in a country where everyone is needed to contribute to basic subsistence survival this is of major importance. How old the patients are, in fact, is often guesswork, as most don’t know their age, interestingly when first went to Wewak, patients simply said they were born before or, after, The War, when Wewak was occupied by the Japanese. It obviously left an indelible impression!”

Dr Scobie said that while there were eight active ophthalmologists now working in PNG, most with constant problems of access and shortage of medical supplies and equipment, the need for cataract surgery remained enormous.

“In his last visit, for example, to Popondetta, a short flight north of Port Moresby over the Owen Stanley Ranges, more than 49 people were treated over a two week period even though prior word of the team visit had not filtered out into the community.

“The first week was rather slow in comparative terms because pre-screening and ‘toksave’ had been somewhat limited,” he said.

“Although some problems, both clinical and retractive, are dealt with in the clinic, the vast majority of our work has been cataract surgery, which is well suited to short visits, needing little or no follow up, and providing almost immediate benefit, not just to the patient but to their extended family,” he said.

“Help still needed

Dr Scobie said visiting teams were mostly comprised of two ophthalmologists, an anaesthetist and a theatre nurse and conducted mostly cataract surgery with occasional eye trauma and other urgent procedures also done.

He said that throughout his 15-year involvement in PNG, great assistance had been provided by Callan Services for the Disabled, a Catholic organisation based in Wewak that provided team members with accommodation and transport while also conducting much of the patient pre-screening, and ‘toksave’- information about our service, essential for a visit to be successful.

“For some years on the same day. The look on the faces in PNG, most with constant problems of access and shortage of medical supplies and equipment, the need for cataract surgery remained enormous.

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Poison’d Chalice

How many friends do you have?

Professor U.R. Kidding

A friend is one that knows you as you are, understands where you have been, accepts what you have become, and still, gently allows you to grow.”

I thought asking me about friends was a strange question. We were scrubbing for the last case in the afternoon list. My registrar was going to do the final procedure as the principal surgeon with me as the assistant. My mind was pre-occupied with the urgent hospital executive meeting that had been arranged for tomorrow morning. Amazing what election cycles and politicians create. Positive news stories, budget control and happy patients. What else would they want?

Friends, what was the saying, “Keep your friends close, and your enemies closer”. Some say it was Sun-tzu who said it first, but certainly Machiavelli and The Godfather have your values or could it be accused of being racist, sexist or extremist?

My registrar stated that there was some real communication being used online. “I only get emails from Nigerian Viagra salesmen,” she twittered on. Something else to highlight which groups of friends you want to be with and comments. Problem with the internet, people were saying it was starting to get out of control. Over the mask there was that stare that I occasionally get at family dinners. My daughter had been encouraging me to connect to her Facebook site and communicate more.

“What’s wrong with email?” I had replied somewhat proudly as I have become quite adept at using Facebook and friends on your social media page.

There was a pause as communication between Baby Boomer and Generation Y went through a few unspoken loops. She looked at me with something resembling pity. “No,” she said, “I was referring to Facebook and friends on your social media page.”

My registrar knew that I was a Shakespeare tragic. Facebook apparently quotes Shakespeare in its definition of friends. “A friend is one that knows you as you are, understands where you have been, accepts what you have become, and still, gently allows you to grow.”

I don’t do social media and prided myself on never even checking on my profile in Google – well rarely anyway. I knew of others who worked assiduously to make themselves internet friendly. Not for me. I reflected that people were saying it was starting to get out of control. Over the mask there was that stare that I occasionally get at family dinners. My daughter had been encouraging me to connect to her Facebook site and communicate more.

“What’s wrong with email?” I had replied somewhat proudly as I have become quite adept at using Facebook and friends on your social media page. “Put it this way Dad” she replied, “I only get emails from Nigerian Viagra salesmen, the bank and from you.”

I decided to push the point with my registrar. I understand that the Medical Students Associations and Medical Associations had just launched a Social Media and the Medical Profession guide. Seems that a lot of people were starting to regret their postings and comments. Problem with the internet, it can last forever. That photo at the medical students’ ball – possibly not the most dignified image when applying for your first consultant job. Not that people would ever discriminate against you for your youthful excesses.

Shakespeare, Julius Caesar, Act 4 Scene 3, “A friend should bear a friend’s infirmities, but Brutus makes mine greater than they are” was the other quote that Facebook could emphasise a lot more. It should make you wonder about which groups of friends you want to be with and understand what they do. Does that group have your values or could it be accused of being racist, sexist or extremist?

As we walked into the operating theatre, my registrar stated that there was some real trouble brewing as some of the more junior medical staff had accepted patients as friends in their social media and there had been some chat about hospital and clinical problems between other groups. Apparently people were starting to get lawyers involved.

Oh great, I muttered under my breath as she twittered on. Something else to highlight at tomorrow morning’s meeting. I can just hear what the talk-back shows would make of this one...

To be continued
Building the strength of East Timor

After many visits to the East Timor to help develop medical care there, Dr Noel Bayley and Mr Andrew Cochrane saw the need to take a further step.

...
What's in store at the 2011 ASC

An outstanding Annual Scientific Congress is ready for all Fellows, Trainees and Associates. In keeping with the milestone of 80 years of charting surgical progress, the convenors have struck an excellent balance between scientific content, Fellowship activities and plenary sessions addressing some of the major issues confronting surgery and surgeons.

The meeting covers a wide spectrum of interests including the latest recommendations for colorectal cancer screening and surveillance, evolving strategies for the management of rectal cancer and expert advice on issues related to inflammatory bowel disease and pelvic floor disorders.

There are two sessions dedicated to scientific research and, in a new initiative, a separate session provides an opportunity for the best posters to be presented. Three separate prizes are to be awarded to the best research papers. Trainees will also be attracted to two Master classes on 'Colorectal catastrophes' and 'Laparoscopic colorectal frustrations'.

Perhaps the session with most widespread interest is a combined Mini-Symposium to address the issues of sub-specialty training and the acquisition of advanced surgical skills.

Another highlight will be 'Consultants Corner' to be moderated by Robin Phillips, quizzing a panel of experts on the management of difficult colorectal problems and cases.

The Colorectal dinner is booked at the magnificent River Café.

The colorectal program covers important topical issues addressed by international and local experts. It will appeal to the general surgeon, the specialist colorectal surgeon and the trainee.

Scientific program

General surgery

The General Surgery convenor Trevor Collinson notes that it is a mere 20 years since laparoscopic surgery took the world by storm. These developments in general surgery quickly spread to and changed every other field of surgical endeavour. In the heady early years of one of the great revolutions in Surgery, a veritable free-for-all developed. Surgical inventiveness and enthusiasm overtook meetings; industry could hardly believe what was happening to their businesses. The rapidity of innovation led to egregious failures – of teaching, credentialing and outcome monitoring. New models were developed as concepts to replace the euphoria. True pioneers emerged, three of whom are our visitors this year and internationally recognised as distinguished leaders in the field of minimally invasive surgery. From the UK, we welcome Michael Bailey, from the US, Lee Santoreneos, has scheduled a three day program from Tuesday, 3 May. He intends the program to be an update on open and endoscopic skull base surgery including neuro-oncology and cranial base surgery. There will be a multidisciplinary approach to the meeting with contributions from our ENT and craniofacial colleagues in combined sessions.

Stephen is pleased to welcome as our invited guests Professor Takeshi Kawase from Japan whose contribution to the field of open skull base surgery is well recognised and Professor Peter Wormald from Adelaide, a world leader in endoscopic approaches to the skull base. Professor David Davila will be the invited guest for the Craniofacial surgery program. We look forward to a lively debate on open compared with endoscopic techniques, but also to technical instruction on this complex area of neurosurgery by our expert colleagues. An intention of the program is to be a consensus on a more formal approach to teaching our young neurosurgeons and encouraging subspecialty interest in this field and finally look to the exciting developments of the future. The Craniofacial program (convened by Peter Anderson) will provide a critical appraisal of current and emerging procedures for simple and complex craniosynostosis, but will also include a basic science session in this emerging and exciting area of molecular genetics.

We encourage all our colleagues, particularly our young and in-training neurosurgeons to participate in and contribute to this program. The Neurosurgery Trainee Research prize will be awarded to the best presentation in the research paper session.

Please note that the Early Bird registration, which represents a substantial discount on the registration fees, closes on 15 March.

The meeting will cover core topics of general surgery, but also new developments in technology and education. News from home if you live in the General Surgical world!

Scientific program

Neurosurgery

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Leaders meet on alcohol and injury

The College Trauma Committee met with community leaders late last year to discuss the rising issue of alcohol-related trauma, and what may be done to prevent it.

Dr John Crozier, vascular surgeon and Deputy Chair of the Trauma Committee, did a magnificent job of coordinating outstanding speakers and ensuring participation from such a broad range of stakeholders.

The Royal Australasian College of Surgeons joined the push by police to change society’s binge-drinking attitude and reduce the plague of alcohol-related violence – an initiative called DrinkWise, addiction medicine researchers, surgeons, nurses, paramedics and government representatives.

Policing initiatives such as, Operation Urinal, a trans-Tasman initiative to crack down on alcohol-fuelled violence. They expressed a united determination to take forward the tragic matter of alcohol and injury and a willingness to be the agents for change.

The workshop has established national partnerships with politicians, press, police and publicans who have already generated new research, new strategies and more effective initiatives.

I feel honoured to have been involved in such an important workshop and am impressed with the work and commitment being done by so many. I wish to thank all Fellows who attended the workshop.

We felt particularly honoured to have in attendance one Fellow who attended an alcohol summit organised by the College some 20 years ago. He reported that only eight people attended that meeting 20 years ago. He was inspired to present the latest US research on the effects of blood alcohol readings at 0.05.

The College workshop received extensive media coverage, including the Daily Telegraph, on all of the Sydney prime time news programs, the 7PM Project on Channel 10 nationally, on Sky News and on Channel 7 in New Zealand (and in NZ) and on many radio networks.

It was also satisfying and interesting to observe the ‘coming of age’ of College Trauma Week as I noted reference to College Trauma Week on ABC national news radio. We welcome the raised awareness and recognition of the work done by the College Trauma Committee in the area of trauma prevention and care of injured patients.

The College paper includes strategies to reduce the problems of alcohol abuse and/or misuse throughout the community. These include:

- **Effective alcohol taxation and pricing policies;**
- **Routinely accessible early treatment and intervention programs particularly in the primary health setting and the workplace to reduce hazardous alcohol consumption;**
- **Proactive policing of licensed venues;**
- **The installation of suitable breath alcohol testing devices (hand-held, coin-in-slot machines) in hotels, restaurants and clubs;**
- **Restriction of alcohol advertising particularly restricting advertising to young people, with effective enforcement of the Alcohol Beverages Advertising Code (ABAC) Scheme.**

In all, the College position on ‘Trauma – Alcohol’ was distributed and discussed at the meeting.

The Royal Australasian College of Surgeons joined the push by police to change society’s binge-drinking attitude and reduce the plague of alcohol-related violence – an initiative called DrinkWise, addiction medicine researchers, surgeons, nurses, paramedics and government representatives.

Policing initiatives such as, Operation Urinal, a trans-Tasman initiative to crack down on alcohol-fuelled violence including the horrific injury of ‘glassing’, were examined.

The workshop attended was one of the most successful seminars the College has participated in.

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Policing initiatives such as, Operation Urinal, a trans-Tasman initiative to crack down on alcohol-fuelled violence including the horrific injury of ‘glassing’, were examined.
New guide for Fellowship services

With this month’s Surgical News you will find a copy of a new College publication Guide to College Services and Programs. Did you know the College provides an extensive online library accessible via member login at the College website? The library can also provide a literature search service, which is further described in the guide.

In the same section of the guide is a description of the ‘Find a Surgeon’ directory. You may wish to be listed in the ‘Find a Surgeon’ directory (it’s free) to boost your clinical practice.

Need a scholarship, fellowship, grant or loan? The guide provides information in this field that you hope you will access.

Would you like to save some money on your car hire, home loan or health insurance? The guide might help you save money with Member Advantage, an organisation with which the College partners.

Other sections within the guide include Being Heard as Surgeons, Making a Difference in the Community, Professional Development and Funding for Standards Leadership.

Finally as the guide says, “the College thrives on the active participation of Fellows in a host of committees, working parties and advisory capacities.” If you are looking to get involved in education or in our wide range of committees then the guide will be a great starting point.

I hope you will take the time to consider the different facilities that Fellowship of the College provides you.

Continuing good work

A seminar conducted by Specialists Without Borders in September 2010 is the continuance of medical education in war-stricken Rwanda.

Dr Paul Anderson

Specialists Without Borders (SWB) continued its medical education initiatives in Africa by conducting a seminar in surgery over three days in Kigali, Rwanda. This was followed by teaching at the medical school in Butare. Twelve Australian surgeons undertook the journey as lecturers as well as two surgical registrars, and for the first time, five medical students, who were partly sponsored by Allergan.

The Rwandan Surgical Society requested the seminar as a way to continue the postgraduate medical education and build on the successful seminar conducted in 2009. The 2010 seminar registered 130 Rwandan doctors.

Despite positive feedback from 2009, SWB were looking to improve on the type of teaching delivered. The SWB Executive decided to move to Structured Clinical Instruction Modules (SCIMs). Each of the consultants who presented on topics was requested to create a SCIM, which would reinforce material presented in morning lecture sessions. It is hoped that these modules will then be part of an evolving curriculum for SWB teaching in developing countries.

Feedback

The seminar was considered to be a great success. Initially there were concerns from the Rwandan doctors as to how SCIMs would work in seminars such as this. However, after day one there was a unanimous approval from the local doctors for this method of teaching.

Interestingly, the SWB consultants/lecturers also found the small SCIM groups challengingly interactive and therefore more rewarding than just the delivery of lecture material.

Developing education

SWB is therefore looking at evolving the Structured Clinical Instruction Module as a preferred teaching module in developing countries. In Africa this is to be undertaken with the school of medicine/national University of Rwanda.

Future developments

A follow-up seminar has been requested in Rwanda in 2011. Requests have also been initiated from Cambodia/Honduras and Burma. With the growth of SWB, it is felt that with a growing consultant database, three or four postgraduate surgical seminars per year would be possible.

Teaching database

Register with Specialists Without Borders and become part of our growing international database of specialist teachers that we can use in future teaching seminars: www.specialistswithoutborders.org

Membership/Sponsorship

If you would like to contribute a donation to Specialists Without Borders, there are several ways to do this. You can sponsor a conference in a developing country; sponsor medical students, doctors/nurses or allied health personnel in developing countries. Online facilities for donations allow specification for each of these groups.
Dr Neil Wetzig

I had the pleasure recently to lead a volunteer medical team which travelled to the Democratic Republic of Congo (DRC) to support HEAL Africa Hospital. The main aim of the team is to assist in training the Congolese doctors, but they also deal with the treatment of more complex surgical cases for which the Congolese doctors request assistance.

HEAL Africa is a Congolese not-for-profit organisation, which is making significant advances for the people of eastern Congo by addressing the root causes of disease and poverty. HEAL is an acronym for Health, Education, Action and Leadership. The mission of HEAL Africa is "to provide holistic care for the people of the DRC (around 66 million): training health professionals, strengthening social activists and providing physical, spiritual and social healing" (http://www.healsafrica.org). HEAL Africa’s aim is to train Congolese doctors to provide quality medical care in the most underserved areas of Congo.

North eastern Congo has one of the highest incidences of very large goitres occurring in Africa due to iodine deficiency and dietary factors. Estimates indicate that up to 65 per cent of the population will develop a goitre in their lifetime. As a breast/endocrine surgeon, I found the surgery and teaching of goitre management in this area particularly fulfilling.

Although the team has been travelling yearly to this area, the improved security in the past year has led to a greater sense of safety. This means that other programs could be conducted, such as a general surgical outreach program with Anthony Fisher and me for one week in Bumembo, a large town several hundred kilometres north of Goma. There are no medical specialists currently working regularly in Bumembo.

Building on care

A gynaecology outreach program was also conducted for the second year to Idjwe Island situated on Lake Kivu between Rwanda and DRC. Overall 49 general surgical cases and 46 gynaecology cases were performed.

The repeated visits have allowed the team to develop relationship and trust with the Congolese surgeon and assist with surgical decision making and technical issues. However, over the past year the team has found that a more effective form of education has been small group tutorials and teaching ward rounds.

A pleasing feature this year was that a doctor who was identified by the team in 2006 as having significant surgical potential, has now returned to work at HEAL Africa after formal surgical training in Uganda. I was able to continue the mentoring relationship with the Congolese surgeon and assist with surgical decision making and technical issues. This surgeon is now more effectively and safely performing surgery on large goitres and continues this work even when the team is not in Goma.

Another highlight this year was to see a young woman who underwent a colonic replacement for a long and tight oesophageal stricture. This major surgery was performed by last year’s team in less than ideal conditions and yet the young woman has gained weight, has no significant side effects and is now employed at the hospital.

Her life would not be the same if the team had not visited HEAL Africa. The work done by the volunteer team aims to achieve significant sustainable changes and help the Congolese to develop and improve their medical care.

This was my sixth trip to Goma since 2003 and all but three of the team members have been at least once before. Other team members included: Brisbane Doctors Judith Goh and Hannah Krause (Uro-Gynaecologists); Dr Anthony Fisher (Anaesthetist, Townsville Hospital); Dr Murray Thorn (Radiologist), a Radiographer, Dentist and IT support professionals.

The hospital is located in Goma, the provincial capital of North Kivu province in eastern Congo on the border of Rwanda. Only six qualified African surgeons work in eastern Congo servicing approximately 30 million people. The hospital is mainly a surgical facility with 160 beds. It is an integral part of HEAL Africa and is now recognised by the Congolese Government as one of three tertiary referral hospitals in the DRC.

This area of DRC endured great suffering after the Rwandan genocide of 1994 and subsequent conflicts. Medical resources are limited and armed conflict was commonplace until recently. Sexual violence against women has been used as a weapon of war. Women, both old and young, are often left with fistulas, after either prolonged labour or as a result of sexual violence.

Because the Congolese doctors gain considerable knowledge from the internet, the volunteer team has concentrated on improving the IT support for the hospital as well as installing a computer based phone system.

As 2010 is the ‘International Year of the Nurse’, it was particularly pleasing to include a small group of nurses, who this year concentrated on both theory and practical training for the HEAL Africa hospital nurses. They covered areas such as critical care nursing, including recovery nursing, midwifery, dressings and infection control.

Laparoscopic surgery does not exist in the DRC. Overall 49 general surgical cases and 46 gynaecology cases were performed.

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First national report on surgical mortality

After its inception in Western Australia more than seven years ago, the Audit of Surgical Mortality (ANZASM) is now undertaken in each state and territory to provide powerful data for continuing and improving surgical excellence.

Applications are invited from eligible Post Fellowship Trainees for training in Upper GI Surgery.

ANZGOSA’s Post Fellowship Training Program is for Upper GI surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in Upper GI surgery will involve satisfaction completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit.

ANZGOSA’s/ANZASM Steering Committee

Guy Maddern
Chair, ANZGOSA Steering Committee

Guy Maddern
Chair, ANZASM Steering Committee

I give you great pleasure to announce the release of the first National Report from the Audit of Surgical Mortality (ANZASM). This report is based on the activities and outcomes during 2009. This first national report contains data from regions that were operational during 2009 and aims to provide a snapshot of the causes behind mortality associated with surgical patients. Now that all the regions are contributing, it will result in a very large and powerful dataset. One of the important challenges remaining is incorporating all private hospitals into the audit system. This has been an important part of the audit process, and one that will be necessary to continue. The audit has been able to maintain a consistent database across Australia, making it possible to provide national figures. It is anticipated that there will be comparisons of trends over time, as more information becomes available. The primary objective of the audit is peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors and trends associated with surgical mortality. It is intended as an educational rather than a punitive process. The College is rightly proud of this important initiative in collaboration with the jurisdictions. Aggregated information will be available to surgeons in order to ensure that lessons are learnt and that the highest quality care is provided into the future. Therefore ANZASM should be embraced by all surgeons and actively supported by health departments in Australia.

A limited number of printed copies of this report will be available by requesting a copy from your local regional audit office. Alternatively an online version can be downloaded from the College’s website.

Thank you for your ongoing support of this important and valuable initiative.

ANZGOSA/ANZASM

Important lessons through audit case studies

The Victorian Audit of Surgical Mortality highlight some important lessons from three case studies from the latest audit. These provide continuing education for all Fellows.

Case study: consultant not informed of patient’s refusal to have a colostomy prior to administration of anaesthesia

Informed consent has a dual purpose. Firstly, it informs the patient of probable diagnosis, the treatment options and their consequences. Secondly, the patient can be given more information on issues they don’t understand. In this case the full consequence of refusing a stoma may not have been appreciated. From a surgical perspective, the process of gaining consent provides insight into the patient’s wishes and expectations. The latter may need to be realigned with known outcomes to avoid inappropriate expectations.

For such a major case with high potential for an adverse outcome, the treating surgeon should be responsible for the consent process. Having to adopt a suboptimal treatment plan would have been an unpleasant experience for any surgeon. We must accept that in this instance the patient had the absolute right to expect their wishes to be observed. However, if the consequences had been fully outlined, the decision made might have been different. The communication breach between registrar and surgeon must surely have been a learning process for both.

Comment: The operation had been delayed to allow for further discussion with the patient. This, however, would indeed have been a difficult option considering the circumstances. The lesson here is, while consultation is ongoing, the patient can change their mind. If the patient were informed of all options, no surgeon would have proceeded.

Case study: a patient referred to a rehabilitation unit after joint replacement developed a strangulated femoral hernia

This case exemplifies the need to establish a proper diagnosis for persistent symptoms. An orthopaedic patient in a rehabilitation unit developed an acute but correctable surgical problem, which was not recognised.

This occurred as the treating doctors did not consider the possible causes of the persistent symptoms of vomiting or examining the patient with those in mind.

After the case was eventually identified and then confirmed by appropriate investigation, there seemed to have been a delay in obtaining surgical input at a senior level. Requests for cross specialty review all too often seem to go through junior medical staff and filter upwards (or not). This is inefficient and wasteful. It is hoped it would be better if such requests were made directly between appropriate senior medical staff.

Comment: This case highlights the problems with specialised and fragmented care, where clinical problems outside the comfort zone of one specialty are not considered and inappropriate diagnoses are entertained for too long. This case also demonstrates the problems of failure to recognise early clinical deterioration in a patient.

Overall recommendations

• Complex cases require clear demonstrable leadership in patient management.

• Regular team meetings involving all disciplines should inform all involved of the treatment plan.

• Patient consent is both an essential and valuable process that should not be left to chance.

• Where clinical deterioration occurs with no defined cause, it should be remembered that the cause may be related to something outside of the treating surgeons’ specialty knowledge.
Providing better support for examiners

The Court of Examiners is about to introduce an examiners’ training course as a means of providing greater support to new examiners, and to improve the reliability of the Fellowship examination.

Spencer Beasley, Chair, Court of Examiners

The Court of Examiners recognises that for such a high stakes examination, being an examiner carries with it a number of responsibilities and obligations, and increasingly requires specialised skills. It is expected that the new course will help equip examiners with the knowledge and expertise they need to perform at the level now demanded of them.

Recently three senior members of the Court travelled to Edinburgh to gain information about the UK Intercollegiate examinations, their examiners’ training course and other aspects of their assessment processes. The generosity of the UK Colleges in sharing their knowledge has facilitated the development of a RACS course, although our course is one tailored very much to our local needs.

The course will focus on a variety of topics, including:
1. Examination preparation (blueprinting content against the competencies being tested, standard setting, and maximising the reliability and validity of the exam);
2. Conduct of the examination itself; and
3. Monitoring and providing feedback on examiner performance.

Instruction of examiners commences with a distant learning component (based on an examiners’ manual) followed by a pre-course assessment and a one day course. New examiners then have one Fellowship examination at which they are primarily observers, but during which they will have other tasks, such as assessment of the taxonomy of viva, review and the performance of current examiners, and direct involvement in one viva.

The first recipients of the course will be the nine specialty senior examiners and their deputies. This will be held immediately before the May examinations. There will be two further courses held during 2011, for which priority will be given to new examiners. In due course, all examiners will be expected to complete the course.

The examiners’ training course initiative represents another step in the ongoing refinement and improvement of the SET assessment processes.

Doctors and mental health

Doctor’s health was the topic of discussion at the latest Victorian General Scientific Meeting, with Fellows teaming up with beyondblue to look at some of the key issues.

Michael Dobson
Immediate past Chair of Victorian Regional Committee

I have been the VSC representative on the Victorian Doctors’ Health Program (beyondblue) for the past two years. During which time I have become more aware of the various roles played by VDHP. Additionally, with the advent of national registration, the excellent model of the VDHP is being adopted in other states of Australia.

The Victorian Annual General Scientific Meeting held in Lorne in September, 2009, had its major theme “Lifestyle and Surgery”. Dr Kym Jenkins (Medical Director, VDHP) created a lot of interest among the delegates in the work of VDHP and the extent of its role in supporting the profession, in particular medical students and doctors in training.

There were 30 referrals for medical students, 41 for doctors in training, 7 for specialists and 25 for general practitioners. This year’s figures have not been published, but the trend of referrals is upward.

There has been a change in referral pattern with younger doctors and students self-referring before significant consequences arise. The program, of course, receives referrals from the Medical Board, however, these referrals are now not the majority of its work.

Building on this there has been a major initiative launched at the end of August, 2010, in Victoria – the beyondblue Doctors’ Mental Health Program (bobyBlueHP). The backbone of this program stems from the draft publication by beyondblue of the first comprehensive systematic world literature review concerning the mental health of doctors.

Ten topics were selected for this literature review:
• Prevalence of anxiety and depression
• Prevalence of substance misuse and self-medication
• Suicide rates
• Risk factors for anxiety and depression
• Help seeking rates for anxiety and depression
• Barriers to help seeking
• Interventions for anxiety and depression
• Attitudes of medical colleagues
• Impact on patient care
• Impact on work and family life

The findings do not suggest higher rates of depression or anxiety in doctors compared to other professionals. Self-prescription was common in medical practitioners. The suicide rate in medical practitioners was higher than the normal population with a 2.75 to 7.75 per cent higher risk in males. Barriers to help-seeking include concerns about stigma, adverse effect on career development, confidentiality and embarrassment. 

beyondblue is an Australian organisation dealing with anxiety and depression and it has an Expert Reference Group comprising psychiatrists, Deans of Health Faculties, Medical Directors etc. drawn from a wide range of practitioners throughout Australia.

One consultant psychiatrist from this group summarised thus: “I rather think that the main issues with doctor’s health are:
• Break down the stigma of mental illness (a major challenge)
• Encourage doctors to avoid treating themselves without any form of professional supervision.
• Emphasise that psychological therapies do work and cannot always be done as ‘self-help’
• Challenge the notion that saying ‘no’ to work is not unprofessional
• Challenge doctors to exhibit the same level of treatment adherence that they would want from their own patients.”

A requirement of mandatory registration is that of mandatory reporting. Prudent counselling of a colleague or friend whose performance is being adversely affected by substance abuse, psychological difficulties or the stresses of professional or personal life may avoid this necessity.

The Victorian State Committee has ‘Doctors’ Health’ on their agenda for 2011. If you would like to contribute or participate in this project, you can email your information to college.vic@surgeons.org or call the VR0 at 9299 1234 for further contact details.

The following resource is readily accessible on the web: The Mental Health of Doctors - A systematic literature review – www.beyondblue.org.au
Researching to help many

After his work from the Eric Bishop Scholarship in 2009/10, Dr Johnny Wong is continuing his important research into spinal cysts with the Sir Roy McCaughey Surgical Research Fellowship for 2011.

Dr Johnny Wong at work researching

W

hile surgeons have known since the 19th century of the existence of a spinal cyst that can form following spinal cord injury, it wasn't until the late 1980s that they had the chance to begin a close study of it.

Called syringomyelia, the cyst occurs in approximately 28 per cent of patients following spinal cord injury, often putting further pressure on the damaged cord which, in turn, can create further neurological deficits in patients who may already be partially paralysed.

However, there is limited understanding of the mechanisms of syrinx formation and enlargement.

Now the recipient of two College scholarships, Dr Johnny Wong, is conducting research to find the answer.

"No-one knows how they form, but we do know that a quarter of patients with spinal cord injuries go on to develop syringomyelia," Dr Wong said.

"They represent a second spinal cord injury in a way, creating further problems such as pain, weakness and numbness. For people who may already be in a wheelchair who may then lose the use of their arms, the development of a syrinx is a very big deal.

"The current thinking is that the original spinal cord injury and scarring resulting from blood around the spinal cord create the environment, which in turn, promotes the cysts to develop."

"Current treatment involves dividing the scar tissue and freeing up the spinal cord or draining the cyst and inserting a shunt. However, this is very difficult surgery and often unsuccessful with the cyst recurring and worsening symptoms over time.

"If we could find the trigger to the initial cyst formation, we hope to find a way to prevent it and if we can identify the factors that influence the flow of fluid going in and out, we may be able to interrupt it."

"The popular research involves creating the cyst in rat and sheep models and then using dye and ultra-sound technology to follow the flow of the fluid."

His work has attracted keen interest, with the College awarding him the Eric Bishop Scholarship for 2009/10 and the Sir Roy McCaughey Surgical Research Fellowship for 2011. He has also received a scholarship from the Neurosurgical Society of Australasia (NSA).

"Already, Dr Wong has made a presentation outlining his work and initial findings to the NSA and was invited to present his work to the Syringomyelia International Symposium held in Berlin in December."

"Until now, no-one has ever seen fluid flow going out of the cyst, but we thought that if fluid was only going in, the cysts would rapidly enlarge and eventually rupture," he said.

"We have found that fluid does flow out of the syrinx and it does so in a diffusion pattern into the spinal cord."

"Recently, we have been investigating the role of water channel proteins in syringomyelia on the basis that we can change their function at the molecular level we could shrink the cyst either by blocking off the flow into the cyst or promoting the outflow."

Dr Wong is a SET #4 neurosurgical Trainee with the College and undertaking his research as part of a PhD under the supervision of Professor Marcus Stoodley, Professor of Neurosurgery at the Australian School of Advanced Medicine at Macquarie University in Sydney.

Given the nature of his research, he has divided his time between the university and the Institute of Medical and Veterinary Sciences in Adelaide where the sheep experiments are performed.

"Dr Wong said that even though a year-long research component is mandatory in neurosurgery training, he had chosen a longer-term project because it had the potential to vastly improve the lives of patients already suffering this severe injury.

"I have always been interested in research not only because I enjoy the intellectual pursuit, but also that when you operate on a patient you can benefit the individual, but if you make a major advance in research you can help many people," he said.

The Eric Bishop Scholarship has been made possible due to a generous donation from the late Eric Bishop and is available to Fellows or Trainees wishing to take time away from clinical practice to concentrate on research. The Sir Roy McCaughey Surgical Research Fellowship is available to Fellows or Trainees wishing to conduct PhD research in Sydney.

Both scholarships carry a stipend of $60,000.

With Karen Murphy

When you operate on a patient you can benefit the individual, but if you make a major advance in research you can help many people."
This inspirational course contains elements of interest for medical students through to any surgeon who has ever considered involvement with publication or presentation of any academic work. Come along and find solutions to questions you have always wondered about in regard to surgical research.

In addition to highly regarded faculty from Australia and New Zealand, faculty in the 2011 DCAS course represent The University of Edinburgh, Baylor College of Medicine, The Johns Hopkins Hospital, The University of Wisconsin, Vanderbilt University, University of Texas, University of Michigan and the North Western University in Chicago.

Topics addressed include:

- Where do good ideas and research questions come from?
- Why every surgeon can and should be an academic surgeon
- How do I get started as an academic surgeon?
- Writing a successful abstract and paper
- Delivering an effective research presentation
- Finding the money for research
- Choosing a Journal for submission
- Analysing your data
- Success in surgical research - basic science and outcomes
- Designing and running successful Randomised Controlled Trials (Clinical/Translational)
- Career pathway development
- Challenges to successful research
- Development of Academic Surgery in Australia and New Zealand - a historical perspective
- How do you fit it in: work-life balance
- The future of academic surgery
- Approaches to research from rural/remote locations as well as from developing nations.

Interactive Workshops

- Challenges in any current research project. Bring your problems with you for brainstorming and discover how the experts would approach them.
- Approaches to research from rural/remote locations as well as from developing nations.

Keynote Speaker: Professor Guy Maddern FRACS

“Lessons learned in my own academic career so far”

RACS Faculty include:


AAS and International Faculty include:

- Herbert Chen, Justin Dimick, Lillian Kao, Scott LeMaire, Fiemu Nwariaku, Rowan Parks, Timothy Pawlik, Carla Pugh and Carmen Solorzano.

Dr Richard Hanney

The Faculty of Academic Surgery (AAS) and the Association for Academic Surgeons (AAS) will be running the third annual course, “Developing a Career as an Academic Surgeon (DCAS)” on the day before the RACS Annual Scientific Congress (ASC) in May in Adelaide. The President of the AAS has described an academic surgeon as “any surgeon that plays some active role in educating others or in conducting research of any type”. On this basis and in partnership with the RACS Academic Section, the DCAS course aims to inspire every surgeon and help them find ways to improve academic aspects of their own career pathway.

Challenged by “Why every surgeon can and should be an academic surgeon”, the 72 registrants in 2010 ranged from medical students to Department Heads and included all levels of surgeon and trainee in between. “Research in Private Practice” demonstrated the commitment of organisers to recognise one direction in which surgical research and training is currently progressing in Australia and New Zealand. The 2011 course will also again include an interactive workshop where experts from amongst the 77 faculty will sit down with participants to help work through any seemingly insurmountable challenge in any current research project. Participants in 2009 rated this session alone as being worth the time and $176 registration fee of the course. Bring your questions and problems with you!

Topics to be addressed in the 2011 course include: “Where do good ideas and research questions come from?”, “Designing and running successful Randomised Controlled Trials”, “Writing a successful abstract”, “How do you fit it in: work-life balance”, “Approaches to research from rural/remote locations as well as from developing nations”, “Writing a successful grant application”, “Applying for an academic position”, “Success in surgical research - basic science and outcomes”, “Designing and running successful Randomised Controlled Trials (Clinical/Translational)”, “Career pathway development”, “Challenges to successful research”, “Development of Academic Surgery in Australia and New Zealand - a historical perspective”, “How do you fit it in: work-life balance”, “The future of academic surgery”, “Approaches to research from rural/remote locations as well as from developing nations”.

CPD Points will be available for attendance at the Course with point allocation to be advised at a later date.
Defining competence through standards

Setting out degrees of competency will help in assessing Trainees and providing feedback. Your feedback on the standards set out here is welcomed.

• The process is quite time consuming and labour intensive.

A second approach, favoured by this College, is to develop global frameworks of ‘standards’, which define increasing levels of difficulty and complexity of knowledge, skills and attitudes associated with a competence, and the level of performance at which ‘competence’ is achieved.

These standards frameworks are based on extensive research of international literature and best practice, as well as consultation with the different groups within the College involved in education, training and professional development. Currently this approach is being used to identify standards:

• in medical and technical expertise that could be expected of medical graduates and PGY1 and 2 (i.e. prior to commencement in SET);
• in medical and technical expertise that could be expected of Trainees at different stages of their progression though SET; and
• in the seven non-technical or professional competencies.

The first of these is being overseen by the Skills Education Committee and the second is the responsibility of the specialty training boards. The initial definition of all the professional (non-technical) competencies is being done within the College and then promulgated through a range of different forums for consultation.

This paper, presenting the first of the professional standards is published to initiate discussion through the Fellowship and wider surgical community.

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Judgement – Clinical Decision Making

Judgement-Clinical Decision Making is a competence that is central to both diagnosis and performance of all procedures.

In his latest book, The Checklist Manifesto, Atul Gawande (2009) makes a distinction between errors of ignorance (mistakes we make because we don’t know enough) and errors of ineptitude (mistakes we make because we don’t make proper use of what we know). For surgeons, the latter kind of error, that of poor judgement, can have extreme consequences.

For the purposes of defining an acceptable standard of performance in the competence of Judgement – Clinical Decision Making for surgical Trainees, the following five components (knowledge, skills and attitudes) have been identified:

A. Perform a complete and appropriate assessment of a patient.
B. Recognise the symptoms of and accurately diagnose problems.
C. Organise diagnostic testing, imaging and consultation as appropriate.
D. Manage patients.
E. Monitor and evaluate own decision making processes.

The behavioural indicators in each of the five standards following correspond with each of the five components (A-E).

RACS – Five Stage Framework showing the Development of Judgement – Clinical Decision Making

Stage 1

Base level

A. Identifies patterns in a list of evidence
B. Rigid adherence to taught rules or plans
C. No discretion in judgement
D. Situations are managed on a rote basis
E. Deal with exceptions to the general rule

Stage 2

Novice

A. Takes a history, perform an examination, and arrive at a well-reasoned diagnosis
B. Explains relationships and rules applied among patterns
C. Hypothesises explanations for patterns, tests generalised explanations and eliminates alternatives
D. Manages all patients (including the critically ill) in a way that demonstrates sensitivity to their physical, social, cultural, and psychological needs
E. Recognises own errors and adapts to patient needs or changed circumstances

Stage 3

Advanced Beginner

A. Conduct an effective, efficient and focused examination of patients with common conditions
B. Recognise the most common disorders and differentiate those amenable to surgical treatment
C. Understand the symptoms of and accurately diagnose problems
D. Effectively interpret radiographic investigations
E. Recognises own errors

Stage 4

Competent

A. Conduct an effective, efficient and focused examination of patients with complex conditions
B. Identifies when there is most important in a situation
C. Sees situations holistically rather than in terms of single components
D. Deals with deviations according to the situation
E. Capable of conjecture and hypothesis testing to deal with exceptions to the general rule
F. Selects medically appropriate investigative tools and monitoring techniques in a cost-effective, and useful manner
G. Considers all possible alternatives
H. Manages all patients (including the critically ill) in a way that demonstrates sensitivity to their physical, social, cultural, and psychological needs
I. Recognises own errors and adapts to patient needs or changed circumstances
J. Recognises own errors and adapts to patient needs or changed circumstances

Stage 5

Proficient

A. Takes a history, perform an examination, and arrive at a well-reasoned diagnosis
B. Explains relationships and rules applied among patterns
C. Hypothesises explanations for patterns, tests generalised explanations and eliminates alternatives
D. Manages all patients (including the critically ill) in a way that demonstrates sensitivity to their physical, social, cultural, and psychological needs
E. Recognises own errors and adapts to patient needs or changed circumstances
F. Recognises own errors and adapts to patient needs or changed circumstances
G. Recognises own errors and adapts to patient needs or changed circumstances
H. Recognises own errors and adapts to patient needs or changed circumstances
I. Recognises own errors and adapts to patient needs or changed circumstances
J. Recognises own errors and adapts to patient needs or changed circumstances

Rigorous adherence to taught rules or plans

Stage 6

Expert

A. Takes a history, perform an examination, and arrive at a well-reasoned diagnosis
B. Explains relationships and rules applied among patterns
C. Hypothesises explanations for patterns, tests generalised explanations and eliminates alternatives
D. Manages all patients (including the critically ill) in a way that demonstrates sensitivity to their physical, social, cultural, and psychological needs
E. Recognises own errors and adapts to patient needs or changed circumstances
F. Recognises own errors and adapts to patient needs or changed circumstances
G. Recognises own errors and adapts to patient needs or changed circumstances
H. Recognises own errors and adapts to patient needs or changed circumstances
I. Recognises own errors and adapts to patient needs or changed circumstances
J. Recognises own errors and adapts to patient needs or changed circumstances

Rigorous adherence to taught rules or plans

Stage 7

Master

A. Takes a history, perform an examination, and arrive at a well-reasoned diagnosis
B. Explains relationships and rules applied among patterns
C. Hypothesises explanations for patterns, tests generalised explanations and eliminates alternatives
D. Manages all patients (including the critically ill) in a way that demonstrates sensitivity to their physical, social, cultural, and psychological needs
E. Recognises own errors and adapts to patient needs or changed circumstances
F. Recognises own errors and adapts to patient needs or changed circumstances
G. Recognises own errors and adapts to patient needs or changed circumstances
H. Recognises own errors and adapts to patient needs or changed circumstances
I. Recognises own errors and adapts to patient needs or changed circumstances
J. Recognises own errors and adapts to patient needs or changed circumstances

Rigorous adherence to taught rules or plans

Stage 8

Mentor

A. Takes a history, perform an examination, and arrive at a well-reasoned diagnosis
B. Explains relationships and rules applied among patterns
C. Hypothesises explanations for patterns, tests generalised explanations and eliminates alternatives
D. Manages all patients (including the critically ill) in a way that demonstrates sensitivity to their physical, social, cultural, and psychological needs
E. Recognises own errors and adapts to patient needs or changed circumstances
F. Recognises own errors and adapts to patient needs or changed circumstances
G. Recognises own errors and adapts to patient needs or changed circumstances
H. Recognises own errors and adapts to patient needs or changed circumstances
I. Recognises own errors and adapts to patient needs or changed circumstances
J. Recognises own errors and adapts to patient needs or changed circumstances

Rigorous adherence to taught rules or plans

Stage 9

Leader

A. Takes a history, perform an examination, and arrive at a well-reasoned diagnosis
B. Explains relationships and rules applied among patterns
C. Hypothesises explanations for patterns, tests generalised explanations and eliminates alternatives
D. Manages all patients (including the critically ill) in a way that demonstrates sensitivity to their physical, social, cultural, and psychological needs
E. Recognises own errors and adapts to patient needs or changed circumstances
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H. Recognises own errors and adapts to patient needs or changed circumstances
I. Recognises own errors and adapts to patient needs or changed circumstances
J. Recognises own errors and adapts to patient needs or changed circumstances

Rigorous adherence to taught rules or plans
Cowlishaw Symposium

The eighth biennial Cowlishaw Symposium was held on Saturday 6 November, 2010, in the Hughes Room at the College’s Melbourne office.

The Symposium began with the 10th Kenneth Fitzpatrick Russell Memorial Lecture, delivered by Philip Sharp, whose topic was Herman Boerhaave: the “Dutch Hippocrates”.

After lunch Felix Behan gave an enthusiastic presentation on the restoration of one of the Cowlishaw books, Anatomia deudsch, the first German edition of Vesalius (1551), currently being undertaken by Nick Doslov of Renaissance Bookbinding.

The last paper before lunch was given by Hon Professor Sam McPhee, whose subject was Sir Kenelm Digby, the 17th century diplomat, scientist, entrepreneur, poet, philosopher, privateer, duellist and general eccentric.

After the tea break, the second session began with Emeritus Professor Donald Simpson discussing the exploits of Bartolommeo Eustachi, the papal anatomist, in Renaissance Rome.

The College’s thanks go to the presenters, who also chaired the first session and presented Philip Sharp with the Kenneth Fitzpatrick Russell Medal.

Dr Jeremy Rosenbaum, jeremy@rosenbaum.net

CV and some images of your previous work, to Jeremy Kibel, info@blockprojects.com.au

Dr Jeremy Rosenbaum on 0412 313 411.

by 30 April 2011. For further information, please call

CV and some images of your previous work, to:

Dr Jeremy Rosenbaum, jeremy@rosenbaum.net

CV and some images of your previous work, to:

Turn the exhibitions:

1. Turning It Outwards
2. Despair & Delight: An Exhibition of Doctors’ Artworks

The Turning It Outwards exhibition aims to challenge doctors to respond creatively to conflicting and difficult emotions in their day-to-day work, through media such as painting, sculpture and photography. The exhibition hopes to lift the veil on the medical profession, to provide a window into the private and intimate emotional landscape of doctors.

It is not always possible for doctors to express themselves amongst peers or patients, and this inability or unwillingness can (and does) contribute to burnout, suicide, mental breakdown and mental health issues. Without an effective outlet, emotions bottle up, percolate and may ultimately explode. Some doctors have found that laying bare their humanity through creative outlets can bring perspective to such issues and enrich their lives.

For more information, please call

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Specialist Consultants in permanent and temporary medical staff placements.

Contact Carol Sheehan

Established since 1977

Surgical News PAGE 32 Vol: 12 No:1, 2011

Surgical News PAGE 33 January/February 2011
The restoration of the 1551 Vesalius textbook
From a presentation at the Cowlishaw Symposium at the Royal Australasian College of Surgeons meeting in November, 2010

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**“De Humani Corporis Fabrica”**

Felix Behan, Victorian Fellow

I have used Helen Keller’s quote “Yesterday’s heroism is tomorrow’s orthodoxy” as an introduction to this story of Vesalius, because his contemporaries scorned him for daring to question Galen of Pergamon, Tübingen (127 – 199 AD) and his edicts on anatomy. Galen’s presence was so prestigious in Rome that even the Emperor Marcus Aurelius appointed him as surgical practitioner for the Roman legions.

Recently I saw again the film The Gladiator with Maximus in charge of the Roman forum under Marcus Aurelius and in this historical/fictional account, Galen was featured attending to the mutilating injuries in the Germanic campaign.

This story of the Vesalius textbook restoration takes me into the back streets of Fitzroy in Melbourne, where I met Nick Doslo, an antique book restorer at Renaissance Bookbinders. He was doing some leatherwork on the leather casing of my set of antique silver goblets (for drinking malt on the moors in times past, no doubt) when he showed me, with reverent homage, this 1551 Vesalius textbook he was restoring for the Royal Australasian College of Surgeons under the curatorial supervision of Geoff Down.

The book was in a state of severe deterioration including boor damage to the leatherwork and water stains to the end-plate pages. The silk ribbon page markers had been eaten back to the binding reflecting its 450+ years.

This textbook has been part of the College heritae since the Cowlishaw collection was purchased in 1943 – it had been offered unsuccessfully for sale in Sydney to the Royal Australasian College of Physicians.

Luckily the RACS purchased this and Sir Alan Newton (for something in the order of £2,500). What is its worth today? When I was in Paris recently at Alain Bireux, the antiquarian book retailer on the Left Bank, I was shown an original Talagaciou in his sale catalogue for £50,000! Relatively, this puts the value of the Vesalius textbook in the six figure range.

What important anatomical and surgical minds would have looked through these pages (gloved, one hopes!) over the 450 years? I went to Nick's studio on a fortuitous basis to record the details of his craft, and the value of the restoration alone may have approached £4000 to £5000.

The work included removing glue detachments (Ex Libris) of previous owners, pencil marks using a rubber eraser, fumigation to eliminate any remaining insects, restoring damaged pages and reconstituting them with fresh Bushells Tea to add to authenticity to match the original.

I warned Nick about the dangers of tuberculosis organisms that might be lying dormant and I repeated the World War II stories about spores re-emerging following surgical mummification and cold war wounds.

This led me to review the history of Vesalius. He was born on New Year’s Eve in 1514 and died as a shipwrecked sailor in Zakynthos in 1564. His text De Humani Corporis Fabrica was one of the most influential textbook of anatomy ever written. Perhaps we should also thus say he was a founder of modern surgery.

It may be similar to my colleague Bob Marshall’s 2004 textbook Living Anatomy: Structured as the mirror of function, which reflected his comprehensive surgical career based on the love of anatomy. It is a landmark publication of the 21st century and will be seen as the same light as Vesalius in time I suspect.

Vesalius was born in Brussels (Bruges) and his father was an apothecary to Emperor Maximilian and Charles V. He studied Galen under Jacques Dubois in Paris in 1533, doing the anatomical dissections himself without an attendant, as was the habit of the time and supported by his findings with meticulous drawings.

His updated version of Institutiones Anatomicae led to criticism from his detractors. Yet any new emerging principle always creates controversy, and it brings to my mind the Brendan Behan quote about such types: “Critics remind me of eunuchs in a harem – they know how to do it, they see how to do it, but...”

Vesalius was forced to leave Paris in 1536 following the outbreak of hostilities between the Holy Roman Empire and France. Vesalius went on to Venice, the origin of this publication, before going to Padua where he held the chair in surgery.

In 1538, a Paduan judge made available the body of an executed criminal for dissection purposes, which broke the long standing tradition prohibiting human anatomical dissection, established since the time of the Roman era and adopted subsequently by the Church.

This became the first accurate anatomical dissection drawing by a commissioned artist with copper engravings by Calcar, a pupil of Titian. In 1541, he found Galen’s anatomical findings were based on animal studies thought to be Barbary apes. Actually, they were Macaque monkeys indigenous to Gibraltar, an outpost of the Roman Empire.

In 1541, he published a correction of Galen’s Opera Omnia with some corrections which included: the heart was the mechanical unit for circulation and not the liver as declared by Galen’s canons; the sternum consisted of three major portions (Galen said there were seven); and the jawbone was a single unit and not double as Galen stated. The trunk, abdomen and limbs were re-evaluated.

He also named various bones of the skull including the sphenoid and stated that the brain and nervous system was the centre of the mind, discounting another faulty Aristotelian claim who said it was the heart.

He then proposed the striking hypothesis that anatomical dissection might be used to test physiological findings to establish functional principles – the beginnings of evidence-based medicine.

In 1543, his public dissection in Basel in Switzerland became known as the Basel skeleton, still preserved to this day – the world’s oldest anatomical preparation.

In the seven volumes of the 1544 publication, Calcar did the copper engravings. It was a major success, like Gray’s Anatomy, with Vesalius only 30 years of age at the time. Gray was 38 when he produced his 1858 publication with the help of Van Dyke Carter, the illustrator.

He went into the court of Charles V, Holy Roman Emperor and King of Italy with an extensive Empire. Over 11 years there, he was the subject of scorn while travelling with the court to various battlefields, since more bringing to light the inseparable link between surgical development and the traumas of war.

The other courtiers misused this barber surgeon as lacking ‘prestige and status’. Some physicians still think this way, like the Navy, the senior service. We are trying our utmost to erode this entrenched perspective.

He was even sent on pilgrimage to the Holy Land as punishment following an Inquisitional type inquiry by the court of Charles V Why? He conducted a post mortem on someone whose heart was, unknowingly, still beating with the person presumably brain dead.

Vesalius died at 50 years of age on the Ionian sea, shipwrecked near Zakynthos. He was about to be given a pauper’s grave there (where usually the bodies were fed to the dogs) but a benefactor stepped in, at the 11th hour, to pay for the funeral.

This story of anatomical dissections reminded me of my own experiences in London in the 1970s when I was engaged in research at the Royal College of Surgeons as a Bernard Snowley Research Fellow into the vascularity of flaps.

The homeless who died under Waterloo Bridge were taken across to Charing Cross.

I harvested flaps from the forehead and chest wall and scalp from the bodies of these unfortunate individuals to come upon my concept of the Angiotome. The procedure of draping the post mortem scalp over a bowl after hair removal helped identify superficial temporal and occipital vessels. This technique was used in preparation in the first published microsurgical scalp replacement at the Alfred with Graham Miller, John Anstee and John Snell in 1974.

This clinical application must reflect our indebtedness to such deceased individuals. We still rely today on the geniocy of those who are willing to bequest their remains for the purposes of medical research and education, an altruistic principle as medical science has benefited from this in our ongoing educational development.

Felix Behan, Victorian Fellow

Hospital in the Strand for final post mortem assessments. The mortician at Charing Cross allowed me access to the cadaver before they were buried in a pauper’s grave (as what almost happened to Vesalius himself).

Nick Doslova from Renaissance Bookbinders with the antique text, the burnt-damaged book before restoration.
Professional Development Activities 2011

The College continues to provide a range of courses to help you through your working life.

>Communication Skills for Cancer Clinicians
12 March 2011, Melbourne
In partnership with The Cancer Council Victoria, this four-hour workshop focuses on teaching you evidence-based, step-by-step communication skills that break down the challenge of delivering bad news to patients and their families. A clinical psychologist will demonstrate the communication strategies and a role play exercise with an experienced actor enables you to practice your new skills.

>Providing Strategic Direction
18 – 20 March 2011, Sydney
Want a solid understanding of a strategic planning process? Over 2½ days you can gain the skills and knowledge to produce and implement an organisational strategy. Focus will be on how to establish a strategic direction through an effective planning process. You will also learn more about conducting an organisational/sector analysis, sustaining a competitive advantage and developing strategic measurement systems.

>Supervisors and Trainers for SET (SAT SET)
23 March 2011, Perth. 5 April 2011, Melbourne
This course assists supervisors and trainers to effectively fulfill the responsibilities of their very important roles. Participants will learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEN) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. The workshop offers an opportunity to explore strategies to improve the management of trainees, especially those that are underperforming, with focus on how to prepare, conduct and review a mid-term meeting. It is also an excellent opportunity to gain insight into the College’s policies and processes; including legal requirements and the appeals process.

>Surgical Teachers Course
31 March – 2 April 2011, Sea World Gold Coast
The Surgical Teachers Course builds upon the concepts and skills introduced in the Supervisors and Trainers (SAT SET) course. An educational framework provides an effective guide to planning teaching episodes; from needs assessment and goal setting to the instructional methodology. The comprehensive curriculum is delivered over two and a half days and aims to enhance the educational skills of those with a keen interest in the teaching and assessment of surgical trainees. Participants are also encouraged attend a Supervisors and Trainers Course (SAT SET), a forerunner to the Surgical Teachers Course.

>Occupational Medicine: Getting patients back to work
Friday 8 April 2011, Melbourne
Doctors are increasingly expected to participate in the helping patients return to work. Understanding a patient’s working environment, job restrictions and work role alternatives can improve communication between stakeholders and assist doctors to provide better advice to patients. The next Occupational Medicine course will visit two industries after; the Mushroom Exchange, Australia’s largest mushroom growing and packing complex plus the QANTAS aircraft maintenance facility. Participants may choose to attend one or both sites.

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

The professional development activities that the College is offering in 2011 are tailored to the specific needs of surgeons. By providing these workshops, the College supports the maintenance of your skills and knowledge in today’s dynamic world.

11 March 2011, Melbourne
In partnership with The Cancer Council Victoria, this four-hour workshop focuses on teaching you evidence-based, step-by-step communication skills that break down the challenge of delivering bad news to patients and their families. A clinical psychologist will demonstrate the communication strategies and a role play exercise with an experienced actor enables you to practice your new skills.

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Early Management of Severe Trauma in Samoa

Disaster can be a painful time though also a time to recognise opportunities. An Early Management of Severe Trauma Course (EMST) was conducted in Samoa in September 2010. It was a time for faculty to see the proposed venue and to set up and plan the course to ensure it ran smoothly and also to head off around the island where faculty were able to see some of the worst hit areas for themselves.

In Samoa, there was high media interest in the course with articles and pictures appearing in the local press. The course was arranged to take place around the anniversary of the tsunami itself and was held at the Oceania University of Medicine (OUM) which had kindly cut lectures for three days to allow us to utilise the lecture room, lab and various other areas for the course.

Nearly all of the 16 participants had been involved in the aftermath of the tsunami and their stories were fascinating. They ranged in speciality from General and Orthopaedic surgery through to Gynaecology and Paediatrics and out to Private General Practitioners.

We ran the course in its standard two and a half day format with a combination of interactive lectures and practical skill stations with some slight modifications to the program to take into account the local environment and available resources. For example, Samoa doesn’t have a blood bank or a fully equipped Intensive Care Unit. Their splints tend to be bamboo sticks rather than full traction splints and things like FAST scanning and embolisation are just not available.

The most relevant final day scenarios for the local environment were selected; the hypothermia case was modified for example! Medical student volunteers acted as patient models for the cases and the faculty applied the moulage make up themselves – it was worryingly good in some cases!

Several volunteers that had put their names forward to instruct on the course headed out a few days early. This provided the opportunity for faculty to see the proposed venue and to set up and plan the course to ensure it ran smoothly and also to head off around the island where faculty were able to see some of the worst hit areas for themselves.

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The most relevant final day scenarios for the local environment were selected; the hypothermia case was modified for example! Medical student volunteers acted as patient models for the cases and the faculty applied the moulage make up themselves – it was worryingly good in some cases!

The participants genuinely enjoyed the course and they all seemed to get a tremendous amount out of it. The course and faculty dinners were well attended and we were privileged to hear some of the harrowing stories in which the Samoans are renowned. The course catering was some of the most impressive I have seen as was the amount that the participants managed to get through.

In a single course, a good proportion of the local medical community who had shown interest in EMST after a number of Samoan doctors had attended the course in Fiji

As the EMST course is designed to teach lifesaving skills with minimal resources, particularly in the first few hours after trauma, it was seen to be highly beneficial in providing medical practitioners with additional trauma management skills. With this in mind, a request was made to the Pacific Development Unit (PDU) in New Zealand to see if an EMST course could be run in Apia.

Funding became available as a consequence of the relief effort and particularly by a charitable donation from BUPA Healthcare, providing the means to make the course a reality.

Several volunteers that had put their names forward to instruct on the course had helped in Apia, correspondingly medical and other resources were not readily available. Many of the islands’ 40 or so registered medical practitioners were pressed into service that day to help with the recovery and treatment of victims, often with minimal resources at their disposal. The tsunami experience galvanised the need for an Early Management of Severe Trauma (EMST) course to be provided for the local medical community.

The tsunami experience galvanised the need for an (EMST) course to be provided for the local medical community.”

― Mark Sanders, EMST Course Director
Getting patients back to work

The Medico Legal Section is continuing with industry visits on return to work practises after a successful 2009 program.

Industry visits are a part of the CPD program convened by the Medico Legal Section. Each workshop held to date has been an amazing adventure. They provide a unique opportunity for participants to gain valuable insights into industry as well as CPD points through this hands-on course.

As surgeons, we treat and advise patients from our specialised knowledge base. Through the workshops, you can gain industry knowledge and learn what will make the most difference in assisting your patients and their employers in the return-to-work process.

The next site visits are to Mushroom Exchange, Qantas, Melbourne in March, 2011 and to GM Holden in Adelaide, as a pre-ASC workshop on Monday, 2 May, 2011. At both workshops participants will see factories, workers and management in action and be able to consider their skills and needs from a new perspective.

Earlier articles have been half day visits to the Ford motor company in Broadmeadows, Victoria and the Coal Mine Training Facility in NSW. Feedback indicated that a whole day format would be preferable for future workshops. Consequently, the next workshop was a full day.

On 12 November 2010, in Victoria we visited In2Store, which is the largest undercover warehouse distribution centre in Australia; and Sutton Tools, a fourth generation precision engineering company exporting worldwide.

At In2Store, we were able to observe the complete process from goods arriving through warehousing, picking and packing to dispatch. We saw first-hand the range of activities performed, much of which was machine related, but with some manual handling. We saw how the warehouse accommodates workers in returning to work. This store has a relatively young workforce with a strong desire to return to work.

At Sutton Tools, we heard and saw that production has changed from manual handling to precision engineering, where workers now mostly control machinery. However, some manual handling areas remain. We also noted multi-skilling. In this factory there is a very low turnover of staff and a very high rate of return to work, whether the reason for being off work was work-related or not. This factory has a relatively older workforce: the workers want to return to work as soon as possible and the older workers do not wish to retire.

In November 2010, we toured the BlueScope Steel blast furnace and hot rolling steel mill site at Pt Kembla NSW, which is the largest single-industry site in Australia which was simply incredible and an amazing experience. We were treated to an in-depth look at the steel production process. Being heavy industry, most processes are machine and computer-controlled. During our visit some maintenance was also being performed, so we were able to observe crane assisted manual handling.

Each site visit includes in-depth presentations concerning the industry and, of particular interest to surgeons, return-to-work in action. Case presentations are included where possible. The discussion focuses on shortened treatment times and proactive communication through written reports and certificates detailing recovery and return-to-work advice. The industry knowledge gained improves our ability to proactively manage cases back to work, which is a great assistance to workers and management.

The Occupational Medicine Course and all CPD programs convened by the Medico Legal Section are open to all surgeons. Other 2011 programs include Writing Medico-legal cases back to work, which is a great assistance to workers and management. The Occupational Medicine Course and all CPD programs convened by the Medico Legal Section are open to all surgeons. Other CPD programs include Writing Medico-legal cases back to work, which is a great assistance to workers and management.


the 2002 Adelaide ASC.

Do you have an artistic hobby?

Like painting, photography, glass blowing, sculpture, woodwork, ceramics or jewellery making. If so and you’d like to take advantage of this opportunity please contact Lindy Moffat.

We expect to repeat the very successful art exhibition held at the 2002 Adelaide ASC.

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CALLING CREATIVE SURGEONS...

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lindy.moffat@surgeons.org

CALLING CREATIVE SURGEONS...

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A/Professor Marianne Vonau
Chair, Professional Development Committee
Written by Edward (Ted) Schutz Convener

Professional development

Reports and AMA5 Difficult Cases courses.

A/Professor Marianne Vonau
Chair, Professional Development Committee
Written by Edward (Ted) Schutz Convener

Professional development

Reports and AMA5 Difficult Cases courses.
Society have created a joint award to honour Professor Chris O’Brien in order to
The American Head Neck Society and the Australian and New Zealand Head Neck
Scholarships
of Otolaryngology, University of Toronto on
grand rounds to the Faculty of the Department
the Fellows.
up with colleagues, nurses and chat with
I consider my second home having spent a
significant time there during my fellowship in
I have never seen a larger and more
connected by enormous above ground walkways.
organised by Dr Randal Weber.
hospitality when I was picked up from the
It was a wonderful opportunity to catch
an ice hockey match between the New York
Rangers and the Boston Bruins at Madison
Square Gardens.
I then left New York for Toronto, which
I considered my second home having spent a
significant time there during my fellowship in
It was a wonderful opportunity to catch
up with colleagues, nurses and chat with
the fellows.
I led a teaching session and presented
grand rounds to the Faculty of the Department
of Otolaryngology, University of Toronto on
my experience with transoral laser surgery of
early vocal cord cancer.
I also spent time with my mentor and friend
Dr Ralph Gilbert. An integral part of my career in head and neck surgery.
Dr Gilbert is a great teacher, outstanding clinician, researcher and innovator.
I naturally caught up with Dr Patrick Guillaume, who is one of the greats in head and
neck surgery Dr Guillaume has passed a wealth of knowledge and vast experience to an entire
generation of young head neck surgeons like me all over the world.
He has recently had the great honour of being awarded the Order of Canada.
After Toronto, I flew to Houston, Texas, my last stop I had heard a lot about MD Anderson. I was slightly anxious given the
great reputation of this institution.
I was pleased that it was warmer in Houston. I was greeted by great Texan hospitality when I was picked up from the
airport by Shelly’s Towncar, generously organised by Dr Randal Weber.
I have never seen a larger and more
concentrated medical precinct. MD Anderson is made up of many high rise buildings all
connected by enormous above ground walkways.
Dr Weber explained that the budget for MD Anderson per annum alone exceeds US
$3 billion. Many other hospitals are located
within the vicinity.
I attended the outpatient department operating suite and presented grand rounds on
metastatic cutaneous scc of the head neck and laser surgery for early vocal cord cancer.
This was at first slightly daunting and overwhelming. But having survived this experience it has made me more determined to continue our work, par-
ticularly in head and neck oncology.
It is easy to be disappointed by the lack of resources and infrastructure in our health
system when you travel abroad, but I feel that the true edge all the people that have trained me and
our clinicians themselves and their dedication.
The challenge remains to how we are to improve our approach. The first step is to
encourage this association with North America and fully support the “Chris O’Brien Travelling Scholar” award.
I would like to give thanks to both the
Australian and New Zealand Head and Neck Society and the American Head and Neck Society for bestowing this great honour on me.
A great thank you goes to all the members of the head and neck faculty at Memorial Sloan Kettering, University of Toronto and MD Anderson. I would also like to acknowledge all the people that have trained me and
influenced me in my career. This foremost includes all my colleagues at Westmead Hos-
pital, and significantly Professor Patrick Guillaume and his faculty.
Most importantly, I would like to thank Professor Chris O’Brien, who gave me the
opportunity to embark on a career in head and neck oncology.
Dr O’Brien was an integral involvement, support and belief in me I would have never had the
great opportunities and experiences that I had and continue to enjoy today.

Dr Carsten E. Palme FRACS
I was presented with the “Chris O’Brien Travelling Scholar” award at the annual
meeting of the American Head Neck Society in Phoenix in 2009. My itinerary
includes all my colleagues at Westmead Hospital.

Dr John Buckingham
President, ANZ Chapter of ACS

AUSTRALIAN HEAD AND NECK SURGEONS

The American and New Zealand Chapter of the American
College of Surgeons was established 25 years ago by fellows
including Tom Reeves, Doug Tracy, Murray Phelps, Ken Cox,
and John Ham. Membership is open to all fellows of the ACS
residing in Australia or New Zealand. Tom obtained fellowship due to
his training in the US, but all RACS Fellows in practice for three
years can apply for fellowship of the ACS.
The major benefit of the ACS Fellowship is that it opens up many educational opportunities
offered by the ACS both in the US and worldwide.
One of the major benefits is the Annual Clinical Congress held every
October. The Congress Registration Fee for Fellows of the ACS is
negligible. The cities it rotates through include Chicago, San Francisco
and Washington. Apart from the obvious benefits of visits to these
interesting cites, the Congress has many panel discussions and
educational courses on current topics of surgical interest as well as
state of the art lectures. The trade displays are amazing to behold.
There are 36 international chapters of the ACS. The ANZ Chapter
celebrated its 25th birthday in 2010. It was the first international
chapter to establish a Traveling Scholarship. Twenty five years ago this
was initiated and a young American surgeon under the age of 45 has
attended our Annual Scientific meeting and visited several other
chapters in Australia and New Zealand every year since. This is a highly sought-
after benefit both of our American and Australian fellows.
Presenting our own data and some of the
work that I have been involved with to some of the
most renowned and well respected clinicians
was at first slightly daunting and overwhelming. But having survived this experience it has made me more determined to continue our work, particularly in head and neck oncology.
It is easy to be disappointed by the lack of resources and infrastructure in our health
system when you travel abroad, but I feel that the true edge all the people that have trained me and
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ANZ Chapter of the ACS
Chapter celebrated 25 years in 2010

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chapters in Australia and New Zealand every year since. This is a highly sought-
after benefit both of our American and Australian fellows.

An enhanced recovery program will improve recovery and reduce complications in surgery.
Surgical, anaesthetic and nursing perspectives will be covered by a multidisciplinary faculty.
Special topic for the 2011 course: Role of Laceroposcopy in ERAS.
Your chance to get involved
Building the Academy of Surgical Educators means asking for the involvement of both Fellows and Trainees

The Academy of Surgical Educators (ASE) was established by the College in 2009 in recognition of the increasing complexity of delivering a comprehensive surgical training program and the need to further embrace modern educational theory and practice, including the use of new technology.

Fellows of the College are responsible for the design, delivery and assessment of all surgical training across all surgical specialties and the Academy will enable the College to better support and further develop those activities at the highest level.

The College’s President and Dean of Education at the time stated that the Academy “will promote high quality patient care by providing expert educational leadership, guidance and advice and through the advancement and application of educational scholarship.”

The Academy is administered by the Dean of Education, Prof. Bruce Barradlough, with the assistance of a part-time Research Officer and secretarial support. It is governed by a board made up of senior internal and external office bearers and individuals who have an active interest in surgical education. The board reports to Council via the Board of Professional Development and Standards.

An Advisory Committee supports the board and is chaired by the Dean. It is made up of representatives of the 13 Surgical Societies and Associations, other senior surgeons with active surgical academic and educational roles and a trainer representative.

The Academy will work in collaboration with all other educational groups in the College and medical educational institutions to foster and promote the pursuit of excellence in surgical education and to sustain a strong culture of professional development. It is charged with assessing current practice and in providing support and innovation to improve content and delivery of educational programs for Trainees and Fellows.

The Academy staff have already done a lot of work related to the alignment of all specialty SET programs with the College competencies. The Dean is in the process of meeting with all nine Surgical Boards, seeking to understand where advice and support from the Academy may be helpful in the delivery of education and training activities. He has also begun to develop cooperative partnerships with universities and other bodies to provide further training and qualification in education and non-surgical disciplines such as leadership and management for Trainees and Fellows.

Membership
Membership of the Academy will be open to Fellows, Trainees and others who contribute to the surgical education and surgical training programs and who have an interest in increasing their personal capacity and capability to deliver surgical education.

Non surgeons such as members of University medical education departments who are actively involved in College programs may also be eligible for membership.

Faculty Membership of the Academy will be those Fellows and others who are essential to the delivery of the educational mission of the College. The Academy of Surgical Educators aims to maximise educational leadership, innovation and research, and the academic standing of the College.

Faculty Members will have active roles in these areas. They will act as key links between the College, universities and other educational institutions to expand the educational opportunities for Trainees and Fellows.

It is anticipated that some Members will become Faculty Members either through commitment to surgical education over time, or by self-improvement in their ability to deliver teaching, through the achievement of a recognised tertiary educational qualification or appointment.

Membership will be gained by application to the Membership Subcommittee of the ASE Board. Application will be a relatively straightforward process in paper or electronic form. Details of the policies relating to the Academy criteria for membership and application are available on the College website.

Turenne of membership will be for three years initially with the option of continuing following review at three year intervals.

I encourage all Fellows who are actively involved in surgical teaching and training to become part of the Academy and apply for membership. The educational opportunities and academic support will be valuable to you personally and invaluable in your training the next generation of surgeons. Interested Trainees should also consider applying for membership.

For more information, email Rachel. Lennon@surgeons.org or call +61 3 9249 1237

Reference

Preventing heel pressure ulcers
Recognition of the need to improve a patient’s theatre and hospital visit was behind a new product to relieve pressure ulcers.

Dr David Huber
NSW Fellow

I am a vascular surgeon at Wollongong Hospital and have heel and ankle pressure ulcers referred to me for treatment. Many develop in surgical patients. I felt that they were preventable and decided to develop a device to decrease their incidence.

Approximately 25 per cent of pressure ulcers begin in the operating theatre and cost the Australian health system $89m and $1590m in the US, not to mention the suffering endured by patient and family. Craig Andrews from Design Momentum was approached to develop an operating theatre device. The brief was to elevate the heel (offload), prevent lateral malleolus, flex the knee slightly while allowing the use of calf compressors.

Hyperextension of the knee (seen when the heel is off-loaded without knee support) causes popliteal vein compression (PVC) in 19 per cent of people. We studied supine anesthetised patients and found significant PVC in 64 per cent.

I believe that off-loading the heels without flexing the knee, places patients at increased risk of DVT. Theatre acquired Venous Thrombo-Embolism cost the Australian health system $364m and the US system $136bn.

We tried a pillow behind the knee, but MRIs showed that the weight of the leg was not enough to close the popliteal vein. The knee needs to be flexed without placing pressure in the popliteal fossa. PVC also decreases the chances of calf compression.

After approximately 16 prototypes, we have a device that offloads the heel, protects the lateral malleolus, protects the skin over the Achilles tendon and flexes the knee. It consists of a polypropylene body (orthosis) supporting the calf.

That created a new problem – how best to attach the disposable component. The obvious solution is double sided tape, but this is expensive, adds work for the nurses and leaves a residue. The solution was to create a tongue in the foam that engages a hole in the orthosis. It must be disposable to satisfy infection control guidelines.

We have developed a VEG form of the distal component to decrease the ongoing cost of disposables. It can be used for short cases or where the risk of developing a pressure ulcer is considered low. Foam should be used if there is a risk of infection and for long cases.

We have performed interface pressure tests comparing pressure on the heel, lateral malleolus, Achilles tendon and the calf, and showed that the new device is a significant improvement compared with two different gel blocks, gel pads, and operating theatre mattresses?

In October, 2009, the consensus document of the European and National Pressure Ulcer Advisory Panels (peak bodies in Europe and North America) was published. The section dedicated to the operating theatre recommends:

offloading the heels, 
- distributing the weight of the leg along the calf 
- flexing the knee slightly

L essential (VEG), reduces moisture, prevents rising skin temperature and decreases shearing, all of which increase the risk of pressure ulcers. That created a new problem – how best to attach the disposable component.

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References


Therapeutic use of self and the relief of suffering

This is the first half of an article that originally appeared in the July issue 2010 of Cancer Forum, and has been reproduced with permission from the Cancer Forum Australia and Prof Keersley.

The next half will follow in March of issue 2011

Professor John H. Keersley

Suffering is a universal human experience, which may be engendered by the onset of illness, especially if illness is perceived to be chronic. This paper examines the exis-
tence of suffering and the common sources of suffering in the setting of illness and the health system. It is proposed that many health care professionals, despite mastering the diagnosis and treatment of physiologic dysfunction, may be at a loss when it comes to helping to relieve patients suffering during a stressful, terminal illness, suffering arises from the meaning ascribed by patients to events of illness, and is commonly expressed as a personal narrative. In order to help alleviate suffering and its consequences, doctors are encouraged to recognise themselves as therapeutic tools in understanding the nature of suffering, listening proactively to the narratives that these patients share, and from these new meanings can be created.

Nature of suffering

Suffering is an abstract experience whose boundaries extend beyond the horizon of our understand-
ing and its depth may be unfathomable to us. Accordingly, to Cassell, suffering “arises from the experience of incurable suffering” in individuals personhood and continues until the threat of disintegration has passed or the in-
tegrity of the person is restored” . Life threatening illness and its depth may be unfathomable to us. Concomitant with all illness represents an assault on the whole person, disconnection is common. Others refer to the disintegra-
tion of interpersonal and community connection as common. Others refer to the condition as ‘spiritual pain’ .

Sources of suffering in the context of illness

Of the many sources of suffering, the distressing effect of physical pain and other somatic symp-
toms cannot be over-emphasised. However, suf-
ferring is more than physical and emotional physi-
sic suffering and may even continue despite careful attention to physical distress. The suffering which may result from suffering after cure of cancer has been minimally hardhit,14 and has been reported the significance of patients with advanced cancer do not consider suffering to be suffering. Un-
ring of personhood, isolating the patient and engendering suffering; suffering, alienating the sufferer from self and society and may engender a ‘crisis of meaning’ . As stated by Neimeyer, “profound loss perturbs these taken-for-granted conceptions about suffering, suffering may be defined as emotional distress that is often accompanied by an existential, somatic, or physical symptom or event, threatening the individual or community” 15 .

Problem of suffering for clinicians

Despite the universal expectation that health-
care professionals are expected to engage in relieving suffering, it is acknowledged that healthcare professionals are poorly trained and unprepared to respond. It is common for many health profes-
sionals to experience emotional distress from the death of a patient, and this distress is sometimes covered.15 Since suffering frequently continues as the “demoralisation syndrome”, in patients,21,22 and many commentators stress the importance of connecting with patients,23,24 Mindful-
tness be introduced early in medical training, “the most powerful therapeutic tool you’ll ever have is your own personality” . As observed by Sackter, wide-

References

Welcome to the Surgeons’ Bookclub

Highlighted in this month’s issue are recent and new titles from across the spectrum of books available from John Wiley & Sons.

Manual of Perioperative Care in Adult Cardiac Surgery
Robert M. Bojar
9781444383439 | Pbk | 832 pages | Dec 2010
AUS$49.95 / AUS$67.96

The fifth edition of Bojar’s Manual of Perioperative Care in Adult Cardiac Surgery remains the gold standard for management of adult patients undergoing cardiac surgery. The easily referenced, outline format allows health practitioners of all levels to understand and apply basic concepts to patient care. This comprehensive guide features:
• Detailed presentation addressing all aspects of perioperative care for adult cardiac surgery patients
• Outline format allowing quick access to information
• Chronological approach to patient care starting with diagnostic tests then covering preoperative, intraoperative, and postoperative care issues
• Additional chapters discuss bleeding, the respiratory, cardiac, and renal subsystems as well as aspects of care specific to recovery on the postoperative floor
• Updated references, training on new drug indications and new evidence to support various treatment management options.

Rationality and the Pursuit of Happiness: The Legacy of Albert Ellis
Michael E. Bernard
9781444368319 | Pbk | 244 pages | Dec 2010
AUS$38.86 / AUS$33.96

Albert Ellis was writing about personal happiness long before the formal discipline of positive psychology was founded. This book describes his work in helping people to eliminate misery and obtain happiness. Many professionals have a well-developed understanding of his therapeutic approach, but few appreciate his distinctive way of helping people actively pursue happiness or know how Ellis himself conducted therapy sessions. Based on transcripts of more than 100 public demonstration and therapy tapes that Ellis personally provided to the author, this book offers Ellis at his best—a dispensable no-nonsense advice in his inimitable charismatic style, including his 11 principles of rational living. Professor Michael E. Bernard is an international consultant to universities, educational authorities, organisations, and government as well as a Professor at the University of Melbourne, Melbourne Graduate School of Education and is a co-founder of the Australian Institute for Rational Emotive Behaviour Therapy.

In Memoriam

Our condolences to the family, friends and colleagues of the following Fellows whose death has been notified over the past month:
• Vilen Kertsmans, VIC General surgeon
• John Joseph Toohey, NSW General surgeon
• Brian Gilbert Storey, NSW Urology surgeon
• Alastair Robinson, NSW Orthopaedic surgeon
• Jeffrey George Watson, QLD Urology surgeon
• Simon Bernard, VIC Plastic surgeon
• Gordon Baron-Hay, WA Paediatric surgeon
• James Sturrock Peters, VIC Urology surgeon

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

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Also available at 15% off in our best selling How To series at this special price:

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How to Survive a Peer Review 9780470378660
How to Survive in Medicine 9781118097232
How to Teach Continuing Medical Education 9780470319961
How to Write a Grant Application 9780470309357

To the Editor...

Dear Editors,

I refer to Mr Gorton’s response to my letter (Surgical News, Vol 11, No 9, 2010, page 14) in relation to statutory protection and fear that he has rather missed the point of my letter, which was not to assert that Fellows need to be unduly concerned about being found liable for any action for undertaking reporting, mandatory or voluntary.

The point I was trying to make was that nothing can prevent an aggrieved individual about whom a notification has been made from commencing civil proceedings. It is not until that happens that issues as to whether the notification has formed a ‘reasonable belief’ in relation to the matter complained of or whether the notification has been made in good faith, can be adjudicated upon.

With that in mind, I sincerely reiterate what I said in the final paragraph of my original letter, which was that a Fellow when making a notification may have a reasonable belief or may, in good faith, have formed a reasonable belief of the alleged misconduct.

Richard L. Turner, FRCS FRACS FAOA Chair

Dear Editors,

A tour de force – for that time – greatly aided from a shirt, to match the measurements of early aortic surgery by Professor Jepson (Surgical News Vol II, No 9, 2010, page 96) contrasting with the research oriented approach developing in academic departments.

In 1965, I was a Senior House Officer at the Eastern Suburbs Hospital, a newly opened small suburban hospital in Bondi Junction, Sydney, and desperate to pursue a career in surgery. Hence, I was delighted at the wide range of experience provided by the three general surgeons just joining the staff.

Alan Sharp, also a visiting surgeon to Sydney Hospital, was one of these. Having just returned to Sydney from training in vascular surgery in the UK, he was keen to advance as a special interest alongside his general surgical practice.

A male patient was admitted with a painful abdominopelvic symptom, and Alan Sharpe decided to attempt resection at Eastern Suburbs. Preparations included making the pathology department for blood, and his wife with her sewing machine and a Marks and Spencer nylon shirt.

The operation was a long and tedious process, since it was still standard practice to dissect the aortic aneurysm from the vena cava. While this was proceeding, his wife tailored (in the anaesthetic room) a tourniquet from the shirt, to match the measurements sent out to her.

The graft was inserted, total operating time about 3 hours from memory, with an initial satisfactory result; I do not know the long term outcome.

The following anecdote may add a little more to the interesting account of this tour de force – for that time – greatly aided from a shirt, to match the measurements of early aortic surgery by Professor Jepson (Surgical News Vol II, No 9, 2010, page 96) contrasting with the research oriented approach developing in academic departments.

Dear Sir,

This tour de force – for that time – greatly aided.

I refer to Mr Gorton’s response to my letter (Surgical News, Vol 11, No 9, 2010, page 14) in relation to statutory protection and fear that he has rather missed the point of my letter, which was not to assert that Fellows need to be unduly concerned about being found liable for any action for undertaking reporting, mandatory or voluntary.

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Richard L. Turner, FRCS FRACS FAOA Chair
New antimicrobial technology for surgical gloves.

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