New College artwork, page 13

ALSO THIS MONTH:

PAGE 11: CHRISTCHURCH ASC
“The highlight of every congress is the range of outstanding international figures."

PAGE 15: COLLEGE MUSEUM
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Emergency surgery – an impending crisis or career revolution?

ACCESS IN SURGERY

is often equated to waiting lists and closure of wards and operating theatres. But internationally there is a growing concern about access to highly trained and willing emergency surgeons. With demands of consultative practice, elective surgery and private practice the emergency and on-call commitments are often fitted in at the end of the day or between other things. Surgeons all experience the delays and the frustrations of trying to provide high-quality surgical care in this environment.

The demand for emergency surgery affects all surgical specialties but in particular, orthopaedics, neurosurgery and general surgery. Some hospitals try to cover the arrangements for these specialties by allowing for and incorporating the expected emergency or trauma load. These initiatives have some anecdotal success. Fuelled by international experience and the focus on response times, some governments have committed to major trauma centres that incorporate state-wide retrieval systems. However, these do come at a significant cost and the reality is that most trauma and acute surgery will be performed in major or regional hospitals. By necessity, one must balance standards of care against maintenance of skills, infrastructure and responsiveness. Maintaining skills, maximising responsiveness and critical mass is a difficult balancing act.

From the local casualty to formal emergency department

Over the past 20 years, the recognition of the need for good quality triage, timely acute care and appropriate supporting infrastructure has lead to the development of emergency departments and the career model of Emergency medicine physicians. The involvement of Fellows of the College of Emergency Medicine is one of the strengths of our own Early Management of Severe Trauma courses. Over this period, emergency departments have transformed from an ill-equipped “front door” in most hospitals to a key area of clinical co-ordination and treatment. Issues of bed access and ongoing care are still critical to the standard of care but the professionalism has improved dramatically. In a similar way the concept of involving surgeons “full time” in the clinical environment of the emergency department now needs to be embraced.

Is it “just a roster”?  

An article in the January 2007 edition of the Bulletin from the Royal College of Surgeons of England expands on the issue of emergency surgery in some detail and highlights how having two shifts a day of senior experienced surgeons provided substantial benefits. These benefits included the improved standard of teaching and supervision of trainees. It also resulted in improved workflow through the emergency department and into the hospital itself. Surgical care can be planned and undertaken promptly rather than fitted at the end of the day or around other cases. The efficient use of the emergency theatre was maximised. In addition, there was a well developed interface with surgical units in the provision of ongoing care.

However this is not the only model, and local circumstances will often drive the most effective process. In New South Wales some surgical units with significant acute care demands have introduced “Emergency Weeks” where the surgeon is on call for a week and dedicates this time to the hospital. Private commitments and elective work are curtailed to ensure the surgeon’s ongoing availability and presence in the hospital.

The increasing recognition of the issues surrounding “safe hours” is an important consideration. This not only relates to Trainees but also to practising surgeons. If you are up in the night doing emergency work, can you provide clear decision-making and quality technical skills in your elective work a short time later? If you can, do you believe there is a point where your decision-making and your skills are compromised? The evidence affirming this is well summarised in the Australian Medical Association “Safe Hours” documents.

Is it more than incentives?

In a world where the surgical workforce will always be less available between midnight and 6 am the response of many governments in their negotiations with the surgical profession has been dollar-focused and often specialty specific. Certainly, all surgery needs to be appropriately remunerated for the training, skills and commitment required. However, acute surgery is commonly more demanding diagnostically and technically. In addition, most of us aspire to a “normal working week” so the after-hours responsibilities do go beyond reasonable professional expectations.

There do need to be significant financial incentives for surgeons to perform acute surgery, but these must be considered as part of an overall package related to “conditions of service”. This is particularly important in smaller hospitals with frequent on-call requirements and limited registrar support. Long-term solutions to this developing crisis in the delivery of acute surgical services are unlikely to occur when specialty specific “band aid” measures are applied.

Models will vary

Changes in clinical practice will vary as we evolve to more sustainable models of emergency surgery provision. This will depend on such factors as the size of the hospital, the jurisdiction, the presence of trauma centres and the sub-specialty concerned. However we have to address the issue. The College needs to be proactively leading this debate and I look forward to your comments – including the provocative ones.

SURGICAL NEWS P3 / Vol 8 No 2 March 2007
Trauma surgery – a cross-discipline discipline

Having focused the previous section of this Surgical News article on emergency surgery I wish to highlight the ongoing development of trauma surgery. All nine specialties of the College have an active involvement in trauma surgery and the Trauma Committee of the College not only reflects this, but also incorporates the views of the Regional Committees. The issues of specialisation and regionalisation are critical in the effective co-ordination of trauma surgery as is the interface with other medical colleagues and health professionals.

The Trauma Committee is progressing the development of curricula which can meaningfully integrate with all the pre-Fellowship training programs. In particular, the expertise of the Australian Orthopaedic Association Trauma Society is critical in this regard. Importantly with the advances in trauma surgery there is a growing requirement for post Fellowship training. Current positions are mainly in the trauma centres but will also be applicable to the major outer metropolitan and regional centres. The population of Australia and New Zealand will always demand a balance between the major centres and the smaller regional centres.

The post-Fellowship training programs hopefully will be available in a number of areas over time and will be able to increase the skills required by surgeons who deliver trauma care. The academic press about trauma centres emanates mainly from the American and European environments.

Issues that we need your opinion about

These issues are critical in the optimal care of surgical patients and the College is keen to have wide input from the Fellowship to address these challenges.

Elections

At the Council meeting on 22 February 2007, Andrew Sutherland was voted President-elect. This is an excellent appointment in terms of ability, but is also singular in that he will be the first Orthopaedic President and the first Father/Son appointment. His father, D’Arcy Sutherland, a cardiothoracic surgeon was President in 1978-1979. Andrew will assume the presidency at the Annual General Meeting during the Annual Scientific Congress in Christchurch in May.
It is now three years since the Relationship Portfolio was established under the then Vice President, Peter Woodruff. Its establishment was part of an overall College restructure aimed at improving the alignment between our Council Office Bearers, College activities and our senior staff. Its immediate priorities were responding to the reporting requirements of the Australian Competition and Consumer Council (ACCC) Authorisation on Surgical Training and the ACCC reviews being conducted on overseas trained doctors and accreditation of hospitals and hospital posts. That focus subsided in intensity and is now redundant except for the annual suite of reports known as the Activities Report, which is provided to the February Council, updated for June and October Council meetings, and available to Fellows and the public on the College website. The activities of the Relationships division have substantially expanded and a summary is provided for you below.

**Regional Committees**
A most significant focus within the Relationships Portfolio has been the enhancement of the regional input to Council through the Board of Regional Chairs (BRC). The members of this board, which reports to Council through the Vice President, are the Chairs of all of our Regional/State Committees and the New Zealand National Board. The regional committees/boards are a key policy development and distribution arm for the College and are the point of contact for many Fellows and Trainees within our College structure and programs.

Regional Committees focus on regional issues relating to such issues as workforce, local government policy, media relations, training structures and fellowship support. The variation of environments, events and strategies in our states and territories and two countries are what gives such value to the contributions of the BRC to the deliberations of Council.

We offer our best wishes to our colleagues in the Northern Territory as the newly convened Northern Territory Regional Committee of the College begins its important work.

With the goal of streamlining function and increasing the impact of our regional committees/boards, the BRC will be reviewing the functions of these committees/boards and the roles and functions of our regional offices. A face to face meeting of the BRC at the College ASC in May will contribute to other background work aiming for presentation of revised terms of reference for our regional boards to the October 2007 meeting of Council.

If you have suggestions about how your College regional committee/board should function for the benefit of all Fellows in your region, there is no better time than now to have your say.

**Specialty Societies**
Specialty perspectives in debates and decisions about the whole of surgery are of the highest importance. Our President has been leading us strongly in strengthening the formal and collegial relationships between our College and the specialty surgical societies and associations. Three meetings per year between the presidents of the specialty surgical society/associations and the College Council or the Executive Committee of Council are chaired by your Vice President. As the relationships and influences grow within this wider leadership group of surgery in Australia and New Zealand, it is our desire that a similar involvement will mature at the regional level where jurisdictional policy and activities have so much effect on the performance of surgery, the lives of surgeons and the training of the next generation of surgeons.

**Workforce**
Developing the College’s workforce capacity has been a strong focus within the relationships portfolio, beginning with “just getting the numbers right” in order to report accurately. Thankfully now, with the consistent use of iMIS (the College database) for both data entry and reporting, we can be justly pleased by and confident in the data provided by the College.

In 2005, a census of the Fellowship provided important data on the detail of Fellows and their surgical working lives. This information has been provided by region and specialty to the relevant committees, associations and societies to help inform their understanding of workforce. The census will be repeated in late 2007. In addition, work was undertaken on developing maps detailing the distribution of surgical services in relation to population groupings. This is particularly assisting our understanding of the issues around sustainable surgical services in outer metropolitan and rural communities.

The workforce assessment unit is currently developing surgical workforce modelling which will be informed by expert panels from each specialty, work undertaken on surgical vacancies, and the census and distribution data.

While the surgical workforce working party of Council is to steer and digest this information, the working party has been dissolved and this function is now part of the work of the Board of Regional Chairs.

**Governance**
The Governance and Articles Working Party (GAWP) brought about some important early governance reform resulting in the formal election of Specialty Elected Councillors to Council and the ability of these Councillors to vote for and stand for election to office bearer positions on Council.
All 25 elected Councillors are equal in their tasks, opportunities and accountabilities. GAWP has become the Governance and Articles Committee (GAC) of Council. It has been tasked by Council with further reviews of the Council governance structure and it will be steering these discussions through the Council meetings and through the meetings of the presidents of the specialty societies. GAC has also been tasked with making recommendations for changes to the role and function of regional committees and how these can be both effective and better aligned with the needs of the whole surgical community: GAC and BRC will work on this task together.

The Governance and Articles Committee assists the deliberations of Council on a wide range of other issues which have included the role of a co-opted expert community advisor to Council, the contributions of Councillors to Council committees, the function and performance of Council, trade-marking of the College coat of arms and the ‘FRACS’ post suffix, representation of Council to Council committees, the function and performance of Council, trade-marking of the College coat of arms and the ‘FRACS’ post nominal, protection of intellectual property of the College, and a potential name change for the College.

Publications and Media

Surgical News has consistently improved over the last year with a keen focus on making its content more relevant, immediate, and of interest. Current attention is on health advocacy and on the community of surgeons. The feedback of Fellows concerning the value of Surgical News is always appreciated. The issue of health advocacy is an interesting one which ought to be on the agenda on most of our College groups. Our regional committees / boards have a key but as yet undeveloped role in advocacy not only for high surgical training standards and for the welfare of our Fellows but also for good public policy towards the control of “surgical diseases”.

The ANZ Journal of Surgery has also been changing its focus under the careful stewardship of Professor Bob Thomas. This will be even further developed under the new Editor-in-Chief, Professor John Hall.

Our media department continually contacts journalists and works hard to ensure that balanced articles are presented on surgical issues.

Foundation for Surgery

You can expect more information about the Foundation for Surgery in the next issue of Surgical News. Many important issues around the structure and function of this new foundation have been settled and it will grow on the platform laid over the last 20 to 30 years by the College Foundation. The Foundation for Surgery will have a significant visibility in all of our regions in both of our countries, supported by an office administration in Sydney at the NSW Regional Office.

Sponsorship and Marketing

A review of sponsorship was undertaken in 2006 to determine the best mechanism for supporting sponsorship activities at the College. As a result, the Council Secretary Mrs. Margaret Rode assumed an initiating and coordinating role at a strategic level and individual Directors and National and Regional Managers are responsible for liaison and contractual arrangements connected with sponsorship for specific activities within their area.

The College, and its sponsors, are aware of increasing scrutiny of industry support for the medical profession and the need to ensure that sponsorship arrangements are compliant with best practice guidelines. Future sponsorship initiatives will therefore focus clearly on educational and research activities that provide benefit to larger numbers of Fellows and Trainees, rather than those which may be perceived to be of benefit to an individual surgeon or Trainee, or to be entertainment or hospitality focused.

Our Valuable College Staff

Our CEO is responsible for the performance and the welfare of our staff all over Australia. Human Resources support is provided within the Relationships Division. Reports relating to aspects of our staff profile can come to Council, as necessary, through the report of the CEO or through the Relationships Portfolio report of the Vice President.
Influenza – is it worth the risk?

Vaccination is the most effective preventative measure against the Flu

AROUND 1,500 AUSTRALIANS die each year from influenza-related complications. Even though vaccination is widely acknowledged as the single most effective preventative measure, only 42 per cent of those under 65 are being vaccinated.

The resistance to influenza vaccinations is evident not only amongst those in the ‘at risk’ groups but also amongst the people who care for them. NHMRC guidelines and mounting evidence support the vaccination of health care workers, but vaccination rates amongst this group sit at only 20 to 50 per cent.

Deaths due to influenza complications now equal our national road toll, so why are so many taking the risk and avoiding vaccination?

The National Institute of Clinical Studies (NICS) is Australia’s national agency for closing gaps between evidence and practice in health care. NICS researched the barriers to vaccination in both the ‘at risk’ groups and health care workers and developed the ‘Fight Flu’ campaign and www.fightflu.com.au website to help provide the facts and encourage vaccinations.

Identifying the barriers

The barriers to immunisation included uncertainty about who is at risk, confusion with the common cold and a belief amongst the individuals surveyed that they are not at risk. There is also a common belief that vaccinations can cause influenza. Many health professionals believe that because of their work they have a natural immunity that makes immunisation unnecessary.

The belief that influenza is really just a bad cold is in striking contrast to the evidence. People with a chronic disease have a 40 times increased risk of death from influenza and up to 800 times increased risk if they have combined cardiovascular and pulmonary diseases.

Despite available evidence, NICS has found the degree of knowledge about the risks of influenza is low, even amongst health care workers, many of whom were not always of how contagious influenza can be.

Understanding the risk

Influenza is highly contagious, and can survive in the open air for up to eight hours. People are generally infectious a day or two before symptoms are evident so the capacity to spread influenza is considerable, especially in environments such as hospitals, where there are lots of people moving around the facility and out into the community. It is therefore critical that medical staff, especially those in contact with at-risk patients, be immunised to protect themselves, their colleagues and their patients.

Protecting yourself – protecting others

“Senior clinicians have a critical role to play in promoting workplace influenza vaccinations. We know that when someone in a specialist or mentoring position advocates vaccination, their opinion has a large impact on junior staff,” said NICS Executive Officer and Influenza Program Manager, Dr Jan Davies.

“Many of the medical professionals we interviewed hadn’t thought about protecting themselves and their colleagues from influenza. Influenza accounts for approximately 10 per cent of all workplace absenteeism due to sickness, so the impact on organizations and those left to manage the workload is considerable. On average, there are 15,000 hospitalisations due to influenza complications each year, so we need to protect both at risk patients and the people who care for them, said Dr Davies.

“A number of surgeons practice in remote areas or spend time overseas where vaccination rates are even lower than in Australia, so it is very important that they protect themselves.”

The NICS Fight Flu campaign

The NICS Fight Flu website provides a range of tools and tactics to help increase vaccinations amongst health care staff and patients. The site provides the facts about influenza, the ‘Are YOU at risk’ questionnaire in 16 community languages and the latest evidence to support vaccinations.

Around 1500 Australians die each year from influenza-related complications. Immunisation is the single most effective measure to preventing hospitalizations and death from influenza, so we really have to ask whether avoiding a vaccination is worth the risk?
Vincent Lam

The Younger Fellows Committee of the College with the assistance of Tyco Healthcare has generously provided a Traveling Fellowship to support my fellowship in hepatobiliary/pancreatic surgery at Queen Mary Hospital, Hong Kong under the supervision of Professor S.T. Fan and Professor Ronnie Poon. The Fellowship will start from February 2007 for a 12-month period.

Hepatocellular carcinoma (HCC) is among the three most common causes of cancer death worldwide, accounting for about 315,000 deaths annually. In low-incidence countries like Australia and the USA, the incidence of HCC has recently doubled and will double again in the next 20 years. Liver resection and liver transplantation are considered the only curative treatments for HCC. The recent development of loco-regional ablative therapies such as radiofrequency ablation and cryotherapy has provided new avenues for the treatment of HCCs. These techniques are also potentially curative. In addition liver resection for non-HCC liver metastasis, in particular that from colorectal cancer (CRC), has become the standard of care. Liver resection for CRC remains the only potentially curative therapy for this disease when it is accompanied by liver secondaries. Surgeons with specific training for liver cancer will thus be required to provide the best clinical care in a multi-disciplinary setting.

Queen Mary Hospital, Hong Kong is world-renowned for cancer resection surgery involving the liver. Professor S.T. Fan, the Division Chief of Hepatobiliary/Pancreatic Surgery at Queen Mary Hospital, has had remarkable achievements in the area of liver surgery. Over the years, Professor Fan’s team has been engaged in sustained high-quality clinical and laboratory research and has made major contributions in areas including liver cancer, liver transplantation and radiofrequency ablation. The 12-month fellowship in the world’s best liver cancer centre will provide me with the opportunity to train and advance my skills in the multiple treatment modalities required to effectively manage complex patients.

“I wish to express my gratitude to the Younger Fellows Committee and Tyco Healthcare for providing me with this traveling fellowship. On top of the financial assistance, it is the support and recognition from the College that is most appreciated.”

This experience will further my clinical skills and build on my research skills. The proposed research projects include:
1. A prospective analysis of radiofrequency ablation of liver tumours at Queen Mary Hospital
2. Establishment of a comprehensive liver cancer database linked to a phenotypically well-characterised patient cohort

I anticipate learning a lot about the logistics of conducting good research as well as gaining personal experience through involvement in the whole process from planning to completion.

I wish to express my gratitude to the Younger Fellows Committee and Tyco Healthcare for providing me with this traveling fellowship. On top of the financial assistance, it is the support and recognition from the College that is most appreciated.
Adam Bartlett

I would like to thank Tyco Healthcare for their generous support in assisting me in my post-Fellowship training.

During my house surgeon years I had the opportunity to undertake full-time research looking at the role of lymphocyte co-stimulation in transplantation, which fuelled an interest in abdominal transplantation.

Having completed my FRACS in general surgery, I wanted to pursue a career in hepatobiliary and transplantation surgery. I spent 12 months working as a surgical fellow at the New Zealand Liver Transplant Unit and have recently taken up the position as Surgical Fellow at the Institute of Liver Studies, Kings College Hospital, London.

The liver unit at Kings College Hospital is the largest unit in Europe, undertaking over 200 adult and paediatric liver transplants, approximately 100 Whipple’s and over 200 liver resections a year.

In addition, Kings College is involved in numerous clinical trials and as part of my role I am looking at the outcome of various surgical techniques that Kings College has popularised over the last few years – in particular, the sequence of liver allograft reperfusion and the routine use of portal-caval shunting.

I intend to stay at Kings College for two years, by which time I hope to gain exposure to some of the recent advances in hepatobiliary and liver transplantation, including laparoscopic liver resection, non-heart beating (deceased after cardiac death) donation, split liver transplantation and adult live donor liver transplantation – the latter of which is due to commence in the United Kingdom in early 2007.

Although more days are spent on call than off, the experience to date has been invaluable to anyone wishing to pursue a career in hepatobiliary and liver transplantation.
As we know, medical knowledge is expanding and changing at a rapid rate. New techniques, new drugs and new procedures are being developed. New clinical trials report regularly on advances. Doctors must, in their practice, utilise the best available medical knowledge and techniques in the care of their patients.

However, when does a new technique become accepted and expected practice? What are the obligations to explain to patients the risks of new or experimental practices – particularly when results may be exceptionally good?

A case in Western Australia highlights this dilemma. *Hall v Petros* (2004) WADC 87 (27 May 2004) involved the use of a relatively new procedure - intra vaginal sling plasty (“IVS”). Dr Petros was an advocate of IVS techniques. A small group of gynaecologists and surgeons had been pioneering IVS. However, evidence presented during the case suggests that there were no independent studies on the IVS technique and that the more common “gold standard procedure” was different. The IVS procedure was not part of the training program for RANZCOG.

The case is interesting given recent changes to the law of negligence resulting from the medical indemnity crisis. The Ipp Report recommended that, in determining negligence, reference must be made to any generally accepted practice of the medical profession. The Ipp Report recommended that a defendant doctor should not be held liable where the conduct in question is in accordance with an opinion widely held by a significant number of respective practitioners in the relevant field. This test is now enacted in civil liability legislation in most states and territories.

One of the issues in *Hall v Petros* was whether the IVS technique was supported by a body of evidence of “respected practitioners”. However, more determinative in the case was the alleged failure by the doctor to provide sufficient information and advice to the patient, particularly to warn of material risks inherent in the IVS treatment and the risks and benefits of alternative treatments. It appeared concluded that the doctor did not adequately warn the patient as to the risks of tape rejection, or infection, relevant to IVS procedures. Accordingly, the case was more inherently an “informed consent” case, than case of negligent treatment.

The case reflected on the situation where new techniques are emerging and the responsibilities of doctors involved. Cases have consistently confirmed that new techniques and new procedures should be utilised where there are proven successful results. There are even cases where it may be negligent not to adopt the new procedure or new technique, even though it is not universally common practice within the medical profession. These cases are suggested as “negligent majority” cases, where the majority of doctors are not performing an otherwise successful, albeit new, procedure.

However, inherent in a new procedure is a heightened obligation to inform the patient - both of the risks involved in the new procedure and the alternative procedures available.

The decision in *Hall v Petros* should not deter doctors from exploring new techniques and new procedures. Indeed, where there are proven successful results, there may be an obligation to stress the value of new techniques and procedures. However, there is also a greater liability for doctors to inform patients that the techniques or procedures are new or experimental, and any particular risks inherent in the new procedures or techniques. Patients must also be given the choice of alternative procedures, and full information on the benefits and risks of the alternatives.

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AstraZeneca Upper GI Research Grant Recipient - 2007

The College would like to congratulate Professor Guy Maddern, who is the 2007 recipient of the AstraZeneca Upper GI Research Grant. Professor Maddern is the R.P. Jepson Professor of Surgery at the University of Adelaide and the Director of Surgery at the Queen Elizabeth Hospital. This grant will be used by Professor Maddern to undertake a research project entitled “Modified hepatic radiofrequency ablation: Long term studies of morbidity using a large animal model.”

The College wishes to thank AstraZeneca for its continued support of medical research in the field of Upper GI/HPB Surgery.
Christchurch ASC

Fellows and Trainees are able to access the provisional program via the College website

THE 2007 CONGRESS has been expanded and revamped to increase its appeal to a broader range of surgeons and trainees. Masterclasses, plenary sessions, online electronic posters and natural science sessions, in addition to Workshops to introduce surgeons to mini-presentations from the Fellowship education program, have all been added. These Workshops include “The paperless office” from a young ENT surgeon, Sherryl Wagstaff who will discuss her own experience in this increasingly popular way of running a surgical office; Stewart Sinclair will demonstrate how to get more than a diary and a telephone list from that expensive PDA you bought! The Workshop on “Boosting PowerPoint” sold out last year so it is re-appearing this year. The Workshop includes the often difficult area of incorporating multimedia in your presentations without glitches. Please register for these and others on the Registration Form. The “Audit Workshop” from Tony Green and the Audit committee is making its biennial appearance to bring you up to date with this increasingly important tool for quality assurance. Pam Montgomery’s team will be presenting 90 minute, mini-sessions on “The surgeon as manager and leader” and “The surgeon as communicator”.

The entire Provisional Program may be accessed via the College website. Go to the home page and the link to the Congress is on the left of the screen. There you may review an electronic copy of the Provisional Programme. You can also download a copy of the Registration Form, although increasingly delegates are registering online – for this you need your user name and pass word.

A highlight of every Congress is the range of outstanding international figures who participate in the programs. Mr Stuart Gowland has designed a Plenary program that will demonstrate how technology will impact on your surgical practice over the next decade – on training, accreditation to use new equipment, professional interaction and trans-national meetings. Educational leaders participating in the plenaries and the Surgical Education program include Anthony Gallagher (Dublin), Richard Canter (Bristol), Oscar Traynor (Dublin), John Orr (Edinburgh) and Murray Brennan (New York).

Professor Brian Rowlands (Nottingham) has accepted the invitation to attend as the RACS Visitor in General Surgery. Brian is the President of the Association of Surgeons of Great Britain and Ireland and he is a senior researcher at the internationally recognised Wolfson Digestive Diseases Centre. His research interests are broad and encompass obstructive jaundice, intensive care medicine and nutritional support. During the meeting he will also address the issue of standards on surgical wards.

The Trauma Surgery program continues to expand. In Christchurch the program will expand across four days and a Masterclass (do not forget – there is no extra charge for trainees to attend Masterclasses!). The Trauma program will benefit greatly from the participation of Professor John Falides (Chair, Department of Trauma, University of Nebraska) and Professor Michael Bosse (Director of Orthopaedic Clinical Research at the Carolinas Medical Centre, North Carolina). Professor Bosse is President of the Orthopaedic Trauma Association in North America and he is participating in both the Trauma and the Military Surgery programs.

In 2006, the College appointed a Community Advisor to Council – The Honourable Geoffery Davies. Mr Davies has retired after a distinguished legal and judicial career and His Honour will bring his extensive medicolegal expertise to the Medico-legal program as the RACS Visitor. One aspect will be to review the worth of judicial enquiries into hospitals and healthcare delivery – is there long-term benefit? Also participating are Professor Alan Merry, chair of the Quality and Safety committee of the World Federation of Societies of Anaesthetists and Mr Ron Paterson, the New Zealand Health and Disability Commissioner. Their views on the delivery of high quality surgery should provide a fascinating insight into how others view us.

So, for the best in education – see you in Christchurch.
Association moves into its second year

Trainees must be aware of changing requirements as RACSTA continues its work under a new committee

THE ROYAL AUSTRALASIAN College of Surgeon Trainees Association (RACSTA) is beginning its second year representing Trainees of the College. With the changes encompassing basic Trainees and the dynamic environment with respect to the College’s role in training, Trainees need to be vigilant about any requirements that will change for their entry into their stream or continuing training. Many thanks go to the outgoing committee who have worked to establish a forum for Trainee issues. Some members from the interim committee will provide the necessary linkages between it and the new committee.

Safe working hours
The recent national focus for doctors in general have been on reducing working hours. However, given the reduced training time, and the scope of experience that we all have to accomplish, the RACSTA objective will be to ensure that the future safe working hours policy will not hinder our ability to gain experience after hours.

Relocation
RACSTA has secured an agreement for discounted prices when requiring removalists due to work relocation. This is available to all college Trainees.

Surgical Education and Training Program (SET)
It is vital that all basic Trainees are aware of the SET requirements, and of the changes to their future of advanced training applications. In addition to the information noted online at: www.surgeons.org/ are the following:

• The Basic Science Examination (BSE) and Clinical examinations will continue to run twice per year.
• The current BSE will be recognised as prior learning for those gaining entry into SET in 2009.
• In 2008 Trainees will be selected into SET 2, and SET 1.
• Eligibility criteria differs slightly between specialties, and are available for viewing at: www.surgeons.org Registration for SET 2008 is now open.
• In order to apply for selection into SET applicants who can demonstrate that they will complete all the mandatory clinical requirements of the specialty into which they will apply by December 31 2007, will be eligible.

Results of new elections:

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<tr>
<th>Trainee</th>
<th>Position</th>
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<tbody>
<tr>
<td>John Corboy (SST – NZ)</td>
<td>Chair + General Surgery NZ</td>
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<tr>
<td>Damian Amato (SST – TAS)</td>
<td>Executive + Neurosurgery</td>
</tr>
<tr>
<td>Mary Theophilus (SST – WA)</td>
<td>Executive + General Surgery AU</td>
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<tr>
<td>Brandon Adams (BST – NZ)</td>
<td>Executive + BST NZ</td>
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<tr>
<td>Chien-Wen Liew (BST – SA)</td>
<td>Executive + BST SA/NT</td>
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<tr>
<td>Jacob McCormick (BST – TAS)</td>
<td>Executive + BST TAS</td>
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<tr>
<td>Nick Riobus</td>
<td>Cardiotoracics</td>
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<td>Kim Taylor</td>
<td>Plastics</td>
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<td>Eva Fong</td>
<td>Urology</td>
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<td>Mitchell Nash</td>
<td>BST NSW/ACT</td>
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<td>Simon Quinn</td>
<td>BST QLD</td>
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<tr>
<td>William Pianta</td>
<td>BST VIC</td>
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<tr>
<td>David Choy</td>
<td>BST WA</td>
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<tr>
<td>Natasha Polites</td>
<td>Otolaryngology</td>
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<td>James Wood</td>
<td>Paediatrics</td>
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<td>Rob Wallace</td>
<td>Orthopaedics AU</td>
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<td>Michael Rosenfeldt</td>
<td>Orthopaedics NZ</td>
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<td>Cathy Thoo</td>
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<td>Matthew Peters</td>
<td>General QLD</td>
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The new 2007-2008 RACSTA committee will continue the already established enthusiasm and direction to ensure that your issues are addressed and managed. Your first point of call for your training issues is to the RACSTA committee in your state. Please stay tuned to the RACSTA segment (under Trainees association) on the College website for further developments.

The next national meeting will be 24-25 March 2007.
Harmony within the Court of Examiners

A painting has been created to illustrate the specialties working together.

AN AMUSING EXERCISE drawing on artistic expression and co-operation between the surgical specialties has resulted in a new College artwork set to grace the walls of the Queensland State Committee offices.

The painting, which shows nine yachts in Morton Bay each bearing signifiers of each specialty on the sails, was the brainchild of councillor Dr Rob Black, and Chair of the Court of Examiners. Dr Black said the painting was created as part of a fun corporate-bonding exercise during last year’s Court of Examiners Dinner held in Brisbane in October.

Local artist Donna Gibb was commissioned by Dr Black to steer surgeons through the artistic process during the dinner, with needed touch-ups done later. Ms Gibb, a trained artist, runs a business that gives others the chance to paint under her guidance and over her original sketches. She has now taken her studio around the country to such glamorous events as the Spring Racing Carnival in Melbourne, the Gold Coast Indy and the 2003 Queensland and NSW Super 12 Rugby corporate lunch.

“Before the dinner I sat down with Donna Gibb and came up with an idea that would illustrate all nine specialties, working in harmony with no winners or losers,” said Dr Black. At the dinner, surgeons representing each specialty were called up and asked to paint a particular boat under her supervision with the buoy at the front representing the College crest. Then she took the painting away and worked on it, adding the lighthouse, the mangroves, the lights in the sea and the sky, “.

Dr Black said surgeons at the function had fun deciding on the symbolism for each sail. They are, from left to right: the undescended testes of Paediatrics; the blood and white bandages of Orthopaedics; the black blob of the gall bladder with squiggly bile ducts of General Surgery; the pink tongue and tonsils of Otolaryngology, Head and Neck; the Phoenix Rising of Plastic and Reconstructive surgery; the bleeding heart of Cardiothoracic; the purple, red and blue of the aorta and blood vessels of Vascular; the green with red nerve cells and grey matter of Neurosurgery; and the urine-yellow background to the endoscopic view of the prostatic urethra of Urology.

“I took great care in my instructions to the artist that no yacht – specialty – should be a winner but be tacking and working together,” Dr Black laughed.

“Though I am worried about that Phoenix Rising in the middle. The tongue and tonsils are putting up a good show back there with the bleeding hearts, but watch that undescended testes coming in on the left. The bandaged mast of the Orthopods looks as if it is going to take us all head-on but that would be most uncharacteristic.”

Dr Black said the exercise was enjoyed and had added to the on-going harmony within the Court of Examiners. “These dinners are an important way for us all to stay in touch, as well as offering an opportunity to recognize the tremendous amount of pro-bono work done by surgeons of each specialty within the Court,” he said.

“Court business is core business for the College. It is an extremely serious responsibility to act as examiners to those going for their Fellowship and that responsibility is taken very seriously. This painting exercise, was a way to work together in a light-hearted way under the supervision of someone who knew what they were doing.”
The cost of trauma

The findings of a new research project to lead national debate on funding for dedicated, improved services for trauma patients.

A RESEARCH PROJECT that calculates the cost of trauma to a particular group of Queensland patients is expected to be released within months and lead a national debate about the quality and funding of Australian trauma systems. The work is being headed by Professor David E Theile, the Clinical CEO of Princess Alexandra Hospital in Brisbane and the 2006 recipient of the $50,000 CONROD-RACS Trauma Fellowship.

Professor Theile is collaborating with Associate Professor Luke Connelly, the Director of the Australian Centre for Economic Research for Health, and Professor Michael Schuetz, Professor of Traumatology at Princess Alexandra Hospital. He said the Fellowship funding allowed for the employment of a dedicated research officer to help collate the entire breadth of costs associated with trauma for multiple-injury trauma patients brought into the Princess Alexandra Hospital in 2004.

The costs calculated include pre-hospital, ambulance, and inpatient costs as well as post-hospital costs such as rehabilitation, loss of earnings and work-time productivity and costs associated with on-going disability.

Professor Theile said the work was done to allow for a more knowledgeable debate about the need to develop comprehensive trauma services across Australia.

“Ten years ago, the National Health and Medical Research Council put the national cost of trauma at $13 billion per year,” he said.

“Now with ancillary costs that would be up to $17 billion. But still it has been very difficult for those in the medical profession to argue for greater funding to develop comprehensive, sophisticated trauma services.

“One of the problems with this is the high costs associated with establishing such a service in that you need highly experienced people available to treat all the different injuries of the multiply-injured patient when they come in. That means you have to build in a relative excess of capacity simply to meet with the peaks of demand.

“That is an economically hard argument to win with hospital administrators and those that control health spending.”

Professor Theile said that while mortality rates versus the degree of trauma injury were now “pretty good”, not enough attention had been paid to devise trauma systems designed to limit on-going disability and impairment.

“We are not just talking here about mortality but more about the young lives that can be comprehensively changed by trauma, particularly when there is no system to treat all of their injuries at the time of hospital arrival,” he said.

“We know that if people get top trauma care when they first come in not only is the mortality rate reduced but you then see, in its coarsest form, the difference in being able to save a limb or not save a limb, save function or lose function.”

“So we are talking of broken bones, for example, that may have healed but that cause on-going disability, or chronic pain or impairment. We know that if people get top trauma care when they first come in not only is the mortality rate reduced but you then see, in its coarsest form, the difference in being able to save a limb or not save a limb, save function or lose function.

“Clearly if we have a system that is focused on trauma rather than just dealing with such patients as part of all that comes into the emergency department we will do much better.”

Professor Theile said the research project looked at those patients defined as multiple-site injured with an injury severity score as used in most hospitals greater than 15. He said the research officer contacted each individual who entered the Princess Alexandra Hospital as a trauma patient in 2004.

Those people were then asked to fill out an extensive questionnaire and participate in face-to-face interviews to determine any on-going disability or loss of earnings. He said in-hospital costs had been investigated using two methods — the Diagnostic Related Groupings, which allowed him to calculate known costs compared with a bottom-up analysis which looked at every blood test, every x-ray, every treatment measure taken.

“Ultimately, we want to extrapolate these figures of our experience in Queensland to say this is what trauma costs to the community each year in this country. The multiply-injured patient in Queensland is no different to the multiply-injured patient in Victoria except perhaps for travel distance to the hospital,” he said.

“So we are talking of broken bones, for example, that may have healed but that cause on-going disability, or chronic pain or impairment. We know that if people get top trauma care when they first come in not only is the mortality rate reduced but you then see, in its coarsest form, the difference in being able to save a limb or not save a limb, save function or lose function.

“Clearly if we have a system that is focused on trauma rather than just dealing with such patients as part of all that comes into the emergency department we will do much better.”

Professor Theile said he hoped to release his findings within three months.

The CONRAD-RACS Trauma Fellowship is jointly funded by the Motor Accident Insurance Commission and the Foundation for Surgery. The Fellowship is available to Fellows or registered Specialist Surgical Trainees for research into areas such as epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma.
THE COLLEGE MUSEUM was officially opened by the President, Russell Stitz, on 21 February, in a ceremony attended by Councilors, Presidents of Specialist Societies, and a number of distinguished guests. This event was held to mark the 80th anniversary of the founding of the College, in February 1927.

For many years most of the collection has been in store, without a proper place to display the large numbers of historic, interesting and significant artefacts of surgery which the College now holds. The establishment of a Museum in its own space now affords the opportunity to show more of the heritage collections than ever before.

The Museum will act as a hub for collection management, from which a program of displays for the Regional Offices can be administered. The College will be working towards recognition from the Australian Taxation Office in order to participate in the Cultural Gifts Program, a Federal Government initiative aimed at encouraging philanthropic donation by offering attractive tax concessions. The Museum will also be registering for accreditation under the Museum Accreditation Program (MAP), a quality assurance program managed by Museums Australia.

The Museum is located on the lower ground floor of the Melbourne building, and is reached by going down the main stair from the foyer. The Museum is accessible to Fellows and Trainees during normal business hours, Monday to Friday and will soon be open to the public.

Ivan Thompson, Michael Sexton & John Royle
Fellows looking at the museum of surgery
John Collins & Cass McInnes
Russell Stitz, Bruce Waxman & Wally Thompson
Rob Black, Peter Woodruff & Ross Blair
The opening speech outside in the courtyard
Andrew Sutherland, Cass McInnes & Russell Stitz after the unveiling of the plaque.
Talk to us first!

Contact the Conferences and Events Management Team at the College for a competitive quote.

We can manage all aspects of your next event with the benefit of truly understanding your requirements.

Contact: Lindy Moffat, Manager, Conferences and Events Department,
E: lindy.moffat@surgeons.org / P: +61 3 9249 1224

INTERNATIONAL CONFERENCE ON EDUCATING AND TRAINING SURGEONS

5 MARCH 2008
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
MELBOURNE, VICTORIA, AUSTRALIA

Convener: John P Collins, Dean of Education

This One-day Conference will take place immediately prior to the 13th Ottawa International Conference on Clinical Competence to be held in Melbourne that week and will focus on the following major challenges in Surgical Education and Practice:

- Selection of Surgical Trainees or Residents
- Integrated (Seamless) Surgical Education and Training
- Ongoing Assessment of Trainees
- Optimising Learning in a Changing Environment
- Managing the Underperforming Surgeon

Join a panel of International and Local Experts to discuss these important issues and contribute to the outcome, a summary of which will be published in the Australian and New Zealand Journal of Surgery.

Further information contact:
Kymberley Walta, RACS Conferences & Events Department
+61 3 9276 7406
kymberley.walta@surgeons.org
From an Australasian Trainee to an American Trainer

RELAXING IN MY backyard and gazing at the slow-moving water in the lake on a pleasant sunny weekend in Florida, I distinctly remember the phone call from Mr Pat Bary, NZ Chair of TA&E committee. Three simple words from him, “You are in”, heralded my formal advanced Urologic training in 1999.

With a mixed feeling of excitement and relief, I joined the Auckland hospital for the first year of training. However, it was rather a difficult and disappointing year for me. The consolation was the moral support from Mr Michael Rice, a skilled surgeon who made the most difficult surgeries look easy. With anxiety and despair, I arrived at Hamilton for my second year. Mr Bary, a wise man, was there to restore my confidence and said “The only person you need to respect is the person you see in the mirror and all others need to gain respect from you”. This changed my life forever. Here I learnt how to perform endoscopic procedures such as TURP and PCNL. Dr Jessica Yin from Perth was a fellow at that time, and I owe her a lot for the teaching and encouragement.

Then I moved to the NZ capital, “the Windy Wellington”. This was where, under the supervision of a wonderful teacher and a human being, Mr Richard Robinson, I was able to master the major oncological procedures like cystectomy. Then came the dreaded fellowship examinations. I was so scared and sure that I would fail the exams. However, by the grace of God, I was able to pass in the first attempt. Two surgeons from Dunedin, Mr Sampangi and Mr Samalia, were so generous to take time off to formally prepare me for the examinations. Both are wonderful teachers and surgeons providing world-class clinical care to people of Dunedin.

I have sat for several examinations in different countries and I have no doubt in my mind that the FRACS examination is the most structured and fair of all. My training culminated in Christchurch, where I met Mr Stephen Mark, who represents the core of all Australasian trainers. He is an ideal teacher and surgeon. He is down to earth and always approachable.

In July 2002, I arrived at Miami, to start my urologic oncology fellowship. My mentor was Professor Mark Soloway, a world leader in the field of urologic oncology. He is tall and majestic looking, making youngsters jealous of his fitness. He changed my career and life forever by appointing me as Urologist and Assistant Professor at the University of Miami School of Medicine. He entrusted me with the clinical care of cancer patients and placed me in charge of clinical research in this field.

The clinical practice in the US is absolutely different from my experiences in New Zealand and Australia. The clinical volume is enormous and most patients have private insurance. We also provide care to the Jackson Memorial public hospital, which is the largest in the region and we see about 200 patients in the clinic in a day! As the days passed by, my practice started growing rapidly. I recall performing about six cystectomies a year in a NZ center and now I perform about 100 cystectomies a year in Miami, providing me with amazing operative experience and challenges.

My job comes with the enormous responsibility of teaching young trainees, which is my passion. We have 15 residents and four fellows in our program, and it is always a pleasure to see them mature into well-rounded surgeons. I won “the best teacher of the year” award in 2004. Australasian trainees are well respected here for their technical skills and knowledge and we regularly take trainees from ANZ for oncology fellowships. I actively communicate with ANZ Trainees who may need help and information regarding US fellowships.

Before I arrived in Miami, I had limited exposure to research and academic activities. However, I was able to achieve a lot due to the support from our chairman. Apart from enormous clinical material, the support from research assistants, fellows and basic science laboratories helped me with my research which resulted in several publications and textbook chapters. My academic and clinical activities helped with my promotion as an Associate Professor in Urology and invitations to speak at scientific meetings. I was also invited to be a vice chairman for the international committee on bladder cancer diagnosis.

“America is so vast that almost everything said about it is likely to be true, and the opposite is probably equally true” (James T. Farrell)

Lastly, working in the United States provides me with satisfactory financial rewards and stability that I am able to concentrate on my patient care and research without worrying about my family and future. We enjoy enormous support from the trainees and allied staff, which allows us to handle a large clinical volume and complex operative cases while maintaining a good quality of life.

Do I regret leaving New Zealand? I am not sure. Perhaps, I miss the beautiful countryside, good friends and quiet lifestyle. On the other hand, I enjoy being in the US where I have tremendous job satisfaction and stability.

I guess with time my views might change and I might head back to Australasia. Until then I would like to be a conduit between the two different systems, helping as many Australasian Trainees as possible and participate in the educational activities conducted by the Royal Australasian College of Surgeons.
**Invitation to apply - Scholarships, Fellowships and Grant opportunities for 2008**

The Board of Surgical Research invites Fellows and Trainees to apply for the following Scholarships, Fellowships and Grants for 2008.

## RESEARCH SCHOLARSHIPS, FELLOWSHIPS AND GRANTS

**Foundation for Surgery funded Research Scholarships and Fellowships**

Please note: *Research departments will be expected to provide 25 per cent of the funding for the following awards.

<table>
<thead>
<tr>
<th>AWARD</th>
<th>ELIGIBILITY CRITERIA</th>
<th>VALUE</th>
<th>TENURE</th>
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<tr>
<td><em>Surgeon Scientist Scholarship</em></td>
<td>Open to Specialist Surgical Trainees or recent Fellows enrolled in, or intending to enrol in, a PhD.</td>
<td>$67,500; $57,500 stipend plus $10,000 departmental maintenance.</td>
<td>Up to three years</td>
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<tr>
<td><em>RACS John Loewenthal Research Fellowship</em></td>
<td>Open to Specialist Surgical Trainees or recent Fellows enrolled in, or intending to enrol in, a higher degree.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
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<tr>
<td><em>RACS Foundation New Zealand Research Fellowship</em></td>
<td>Open to Trainees and Fellows enrolled in, or intending to enrol in, a higher degree. Applicants must be New Zealand residents.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
</tr>
<tr>
<td><em>RACS Foundation Research Scholarship</em></td>
<td>Open to Trainees and Fellows enrolled in, or intending to enrol in, a higher degree.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
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<tr>
<td><em>RACS Foundation Catherine Marie Enright Kelly Scholarship</em></td>
<td>Open to Trainees and Fellows enrolled in, or intending to enrol in, a higher degree.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
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<td><em>RACS Foundation Reg Worcester Scholarship</em></td>
<td>Open to Trainees and Fellows enrolled in, or intending to enrol in, a higher degree.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
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<tr>
<td><em>RACS Foundation Peter King Scholarship</em></td>
<td>Open to Trainees and Fellows enrolled in, or intending to enrol in, a higher degree with the topic relevant to the practice of surgery outside metropolitan areas.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
</tr>
<tr>
<td><em>RACS Foundation ANZ Journal of Surgery Scholarship</em></td>
<td>Open to Trainees and Fellows enrolled in, or intending to enrol in, a higher degree.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
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<tr>
<td><em>RACS Foundation WG Norman Research Fellowship</em></td>
<td>Open to Trainees and Fellows, resident in South Australia and enrolled in, or intending to enrol in, a higher degree. The research topic should have a trauma focus.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
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<tr>
<td><em>RACS Foundation Scholarship in Surgical Ethics</em></td>
<td>Open to Specialist Surgical Trainees and Fellows, or members of the public with a special interest in ethical issues in modern surgery who are sponsored by a Fellow of RACS. Applicants must be enrolled in or intending to enrol in a higher degree with a topic relevant to ethical problems confronting surgery.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>12 months</td>
</tr>
<tr>
<td><em>RACS Louis Waller Medico Legal Scholarship</em></td>
<td>Open to Trainees and Fellows, or law graduates. Applicants must be undertaking, or intending to undertake, doctoral research on the topic of medico-legal risks and the law in this area.</td>
<td>$57,500; $52,500 stipend plus $5,000 departmental maintenance.</td>
<td>Up to three years</td>
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The Raelene Boyle Scholarship, sponsored by the Sporting Chance Cancer Foundation, is offered for the value of $57,500 comprising $52,500 in stipend and $5,000 in departmental maintenance.

The scholarship is expected to draw interest from Fellows or trainees working within either a university or hospital research unit, involved in cancer research that is expected to make a notable impact. Basic Trainees must, as a minimum, have passed BST Part 1 exams by 31 December in the year of application, or anticipate such. Applicants must be enrolled in, or be intending to enroll in, a higher degree for the duration of the award. The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department.

A grant from the Motor Accident Insurance Commission matched by Foundation for Surgery funds has enabled the College to offer annual research funding for research into trauma to the amount of $50,000.

The Fellowship is available to Fellows or registered Specialist Surgical Trainees. Proposed research may be in any of the following areas: epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma. A single Fellowship of up to $50,000 will normally be awarded but more than one Fellowship may be made to a total of $50,000 in any one year. The Fellowship may be used for either or both salaries and expenses. It is not a requirement of this Fellowship that the research be conducted in Queensland but it must be shown that the potential benefits flowing from the research will assist the people of Queensland.

The John Mitchell Crouch Fellowship of $70,000 is awarded to an individual, who in the opinion of the Council, is making an outstanding contribution to the advancement of surgery, anaesthesiology or to fundamental scientific research in the field. The grantee must be working actively in his/her field and the award must be used to assist continuation of this work.

The Fellowship commemorates the memory of John Mitchell Crouch, a Fellow of the College who died in 1977 at the age of 36. The Council of the Royal Australasian College of Surgeons invites applications or nominations for the above Fellowship.

Criteria:
• The grantee must be working actively in his/her field.
• The award must be used to assist continuation of this work.
• The grantee must be a Fellow of the Royal Australasian College of Surgeons who is a resident of Australia or New Zealand.
• Applicants must be less than 50 years of age in the year of application.

Applications:
• Applicants must provide a brief statement about current research work and future plans.
• A detailed curriculum vitae, including a list of publications, must accompany the application. Applicants must provide a list of what they consider to be their five most important publications as well as the most important national or international lectures they have been invited to deliver, numbering no more than five in total. Applications must also include impact factors and the impact range for their subspecialty.

Please note that no formal application form is required for this Fellowship but a new application must be made for each year of application. The successful applicant is expected to attend the convocation ceremony at the next Annual Scientific Congress of the College for a formal presentation. The Fellowship recipient must also be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.

This fellowship was established following a bequest to the College from Sir Roy McCaughey. The Fellowship is open to Fellows and trainees (who as a minimum have passed BST Part 1 exams by 31 December in the year of application, or anticipate such). The applicant must be enrolled in, or intending to enrol in, a PhD and the research must be conducted in NSW. The value of this Fellowship is $57,500, comprising $52,500 in stipend and $5,000 in departmental maintenance. This fellowship is available for up to three years. The successful applicant will be required to procure 25% of the value of the Fellowship from his/her research department.

This Scholarship was established following a generous bequest to the Francis and Phyliss Thornell Shore Memorial Trust for Medical Research. The scholarship is open to Fellows and trainees (who as a minimum have passed BST Part 1 exams by 31 December in the year of application, or anticipate such) enrolled in, or intending to enrol in, a higher degree. The value of this scholarship is $57,500 comprising $52,500 in stipend and $5,000 in departmental maintenance. This Scholarship is available for 12 months. The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department.
The Eric Bishop Scholarship has been made possible due to a generous donation from the late Eric Bishop. The Scholarship is intended to support applicants who wish to take time away from clinical positions to undertake a full-time research project. This research should be conducted under the supervision of an experienced investigator, as part of a higher university degree in Australia or New Zealand. Applicants must be enrolled in, or be intending to enrol in, this degree for the duration of the award. The Scholarship will be open to Fellows and trainees (who as a minimum must have passed BST Part 1 exams by 31 December in the year of application, or anticipate such). The value of this Scholarship is $57,500, comprising $52,500 in stipend and $5,000 in departmental maintenance. The tenure of the Scholarship is 12 months. The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department.

The Paul Mackay Bolton Scholarship for Cancer Research was established by Harry Bolton in memory of his late son, Paul. The Scholarship is intended to support applicants who wish to take time away from clinical positions to undertake a full-time research project under the supervision of an experienced investigator in the prevention, causes, effects, treatment and/or care of cancer. Applicants must be enrolled in, or be intending to enrol in, a higher degree in Australia or New Zealand for the duration of the award. The Scholarship is open to Fellows and trainees (who as a minimum must have passed the BST Part 1 exams by 31 December in the year of application, or anticipate such) who are currently working either in Queensland or Tasmania. The duration of this Scholarship is 12 months. The value of this scholarship is $57,500 comprising $52,500 in stipend and $5,000 in departmental maintenance. The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department.

Applications are invited for the Plastic and Reconstructive Surgery Research Award. This Award is funded by Plastic and Reconstructive Surgeons to promote and support plastic surgical research and to encourage Specialist Surgical Trainees and recent Fellows to undertake postgraduate research studies. It recognises the link between research and clinical advances and demonstrates the Australian Society of Plastic Surgeons (ASPS) and The New Zealand Association of Plastic Surgeons (NZAPS) commitment to academic excellence within their specialty. This Award of $25,000 is designed to encourage a one year period of supervised research, preferably leading to a research degree. There is no formal application form for this award. Please refer to the College website for eligibility criteria and application details, or contact Ms Nicola Robinson, Scholarship Program Manager.

The Royal Australasian College of Surgeons and the Department of Surgery at the University of Toronto are offering a joint Fellowship to fund Fellows or Specialist Surgical Trainees wishing to undertake a Masters in Surgical Education at the Centre for Research in Education at the University of Toronto, Canada. The successful applicant will only pursue educational activities as part of the Masters program – no clinical work will be involved. The Fellowship is available for a period of up to two years subject to satisfactory performance. It is valued at $AU 50,000 stipend per annum with the University of Toronto providing a similar contribution comprising tuition and ancillary expenses.

The Murray and Unity Pheils Travel Fellowship was established following a generous donation made by Professor Murray Pheils. The Murray and Unity Pheils Travel Fellowship has a value of $10,000 and is awarded to a Trainee or recent Fellow of the College to assist him/her to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates wishing to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply. Applicants must not have commenced their travels prior to the closing date for applications. The duration of the Fellowship is 12 months.

The Paul Mackay Bolton Scholarship for Cancer Research was established by Harry Bolton in memory of his late son, Paul. The Scholarship is intended to support applicants who wish to take time away from clinical positions to undertake a full-time research project under the supervision of an experienced investigator in the prevention, causes, effects, treatment and/or care of cancer. Applicants must be enrolled in, or be intending to enrol in, a higher degree in Australia or New Zealand for the duration of the award. The Scholarship is open to Fellows and trainees (who as a minimum must have passed the BST Part 1 exams by 31 December in the year of application, or anticipate such) who are currently working either in Queensland or Tasmania. The duration of this Scholarship is 12 months. The value of this scholarship is $57,500 comprising $52,500 in stipend and $5,000 in departmental maintenance. The successful applicant will be required to procure 25 per cent of the value of the scholarship from his/her research department.

The Stuart Morson Scholarship in Neurosurgery has been established following a generous donation by Mrs Elisabeth Morson in memory of her late husband. The Scholarship is designed to assist young neurosurgeons within five years of obtaining their Fellowship of the Royal Australasian College of Surgeons or neurosurgical trainees to spend time overseas furthering their neurosurgical studies by undertaking research or further training. The Scholarship will also be open to exceptional young surgeons who are registered to practice neurosurgery in Australia or New Zealand but are not Fellows of the College. From time to time, the Scholarship may also be applied to assist overseas surgeons to spend time in Australia or New Zealand to further their training and/or research in neurosurgery. The value of the Scholarship is $20,000 and is designed to assist the recipient to meet the costs of undertaking further training and/or research work in neurosurgery. This scholarship is for 12 months.

The Hugh Johnston Travel Grants arise from a bequest of the late Eugenie Johnston. These Grants for $3,500 are designed to assist needy and deserving Fellows and trainees of the College to gain specialist training overseas. Applicants must not have commenced their travels prior to the closing date for applications.
**Margorie Hooper Scholarship**

The Margorie Hooper Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is for Specialist Surgical Trainees or Fellows of the Royal Australasian College of Surgeons who reside in South Australia. The Scholarship is designed to enable the recipient to undertake postgraduate studies outside the State of South Australia, either elsewhere in Australia or overseas. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the surgical community of South Australia. Preference will be given to the latter. This scholarship is for 12 months. The stipend is $65,000 and there is provision for accommodation and travel expenses upon application.

**Morgan Travelling Scholarship**

The Morgan Travelling Scholarship was established to fund a Fellow of the College to travel overseas to gain clinical experience or to conduct research for a period of approximately one year. To be eligible, the surgeon must have gained his/her Fellowship in the past 5 years. The scholarship is open to a Fellow from any specialty. The scholarship must be the only College funding secured by the Fellow but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The duration of the scholarship is 12 months. The value of the scholarship is $10,000.

**Research Scholarship in Military Surgery**

Applications are sought for a 12 month Research Scholarship in Military Surgery commencing in January 2008. The position available is Research Instructor at the Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA. The successful applicant will examine “Resuscitation Research for the Combat Mission” under the supervision of COL David G. Burris USMC. The position carries an initial stipend of USD$40,000.

To be eligible, applicants must hold Australian or New Zealand citizenship. Minimum requirements are to have fulfilled all the requirements of Basic Surgical Training Level 3, however, preference will be given to Specialist Surgical Trainees or Fellows.

**Ramsey Fellowship - Provincial Surgeons - 2007**

The Ramsey Fellowship was established through a bequest following donations made in 1986 and 1993 by Mr James Ramsay, AO, and subsequently through the generosity of Mrs Diana Ramsay, AO. This Fellowship is only available to provincial surgeons in Australia or New Zealand and is designed to enable such surgeons to spend time developing their existing skills or acquiring new skills away from their provincial practice.

The Fellowships can be taken for a period of eight weeks (one Fellowship of $20,000), a period of four weeks (two Fellowships each of $10,000), a period of two weeks (four Fellowships each of $5,000), a period of one week (eight Fellowships each of $2,500), or a combination of the above.

The Fellowship grant is intended to contribute substantially to:

- Return airfare to city (cities) of choice;
- Daily living allowance (travel, meals, accommodation, ongoing practice costs);
- No additional amounts are payable for travel or accommodation for family, locum costs, insurance, or any other unspecified costs.

The Fellowship does not incorporate payment for or arrangement of a locum. However, assistance in arranging a locum, if required, can be obtained from the Rural Services Department at the College on (+61 3) 9249 1284.

The Fellow must spend a major part of each week at the appropriate institution and give a guarantee to continue in practice in his local area on completion of the Fellowship. There is no application form. A letter of application including the following should be forwarded to the Scholarship Program Manager:

- The intended Fellowship duration;
- An outline of the experience or skills you aim to gain through the Fellowship and how this will benefit your current practice / hospital;
- An indication of the locations to be visited in order to achieve your aim;
- Two written supporting references.

There is no official closing date for this Scholarship. Applications will be accepted at any time until all funds have been allocated.

NB: This Scholarship is open for travel in 2007.

**Important General Information**

These advertisements are to be used as an initial guide only. Please consult the College website from 1 March at http://www.surgeons.org/scholarships.htm for detailed information about the scholarships, fellowships, and grants offered by the College and relevant application forms and scholarship conditions. Scholarships, fellowships, and grants are offered to RACS Trainees and Fellows as per the criteria stipulated for each award. The availability of the scholarships and fellowships advertised above is subject to funding. Applications must be submitted in both hard copy and electronic format. The hard copy application must be submitted to Mrs Rosemary Wong, Scholarship Officer, Royal Australasian College of Surgeons, PO Box 553, Stepney SA 5069. Tel: +61 8 8363 7513; fax: +61 8 8363 3371; Email: scholarships@surgeons.org. Website: http://www.surgeons.org/scholarships.htm. Electronic applications must be emailed directly to scholarships@surgeons.org. A confirmatory email will be sent upon receipt. It is your responsibility to ensure your application has been received. A scholarship information booth will also be located in the College Boulevard at the Annual Scientific Congress in May.

Applications close 5:00pm on Friday 25 May 2007.
Building up from the bottom

There is a new College specialist support program in Nusa Tenggara Timur

IN EASTERN INDONESIA, hernias, cleft palates and goitres can wreck a person’s life. The ailments are painfully common and people are too poor to travel for treatment. Hernias hobble otherwise healthy young men and grow so large that sufferers can’t walk let alone work. Those with cleft palates are ostracised and kept home from school. Goitres are social stigmata that send people into hiding.

These problems keep people from working, falling in love and contributing to their communities.

Teams of Australian volunteer doctors and nurses, organised by the College, began travelling to the region last year to provide life-changing care and medical training.

The place is known as Nusa Tenggara Timur (NTT), and includes West Timor and islands such as Flores, Sumba and Roti. These remote provinces of Indonesia are desperately impoverished. An aid program called ANTARA (Australia – Nusa Tenggara Assistance for Regional Autonomy) is hoping to turn things around. It began in 2004 and will deliver $30 million over five years. ANTARA is funding the College to send medical teams to Nusa Tenggara Timur to follow up on and complement the work carried out by the volunteers from the Overseas Specialist Surgical Association (OSSAA).

“We provide a service to that community. We’re building from the bottom up, starting with teaching nurses the basics of operating theatre protocols, developing sterile techniques. They are working in the most primitive of conditions,” said NTT Specialist Services Project Director Dr Mark Moore.

“Lots of the doctors in NTT are doing operations on the appendix, ovarian cysts as well as caesarean sections. They are becoming GP surgeons out of necessity, and it makes sense for us to help them. It is really the model, starting at the bottom and building up their skills.”

NTT is the poorest province in Indonesia and it’s long way from Jakarta. Dr Moore, who has made 12 visits to the area, said Indonesian doctors and nurses simply do not want to work there, just like Australian doctors don’t want to work in remote areas of their own country. Dr David Deutscher led the college’s first team of volunteers that travelled to Atambua, West Timor, last August, with very clear ideas on how to approach the gaping cultural divide between the Indonesian and Australian staff.

“We had the philosophy that we wanted to go there and incorporate what we were doing with what the locals wanted. We asked the staff at the hospital in Atambua for their advice and we worked at their pace,” said Dr Deutscher.

“Other teams have had problems with the local staff not showing up in the morning. You have to remember that they get paid a pittance and that they’re tired. We wanted to work at a level that didn’t exhaust them and left them keen to come back for more. And that’s what happened.” Dr Deutscher and his team made a point of having meals with the Indonesian doctors and nurses. They even took part in the hospital’s Friday morning line-dancing and sports activities that kicked off at 6 am.

Building trust, training and performing surgery were all of equal importance for Dr Deutscher. “The surgical staff was really quite junior and clearly there was a need for training. The nursing staff is quite enthusiastic. They need education and they want it.”

Dr Deutscher said some trauma and emergency cases who arrived at the hospital wouldn’t have survived if the Australian team hadn’t been there. “There was a motorbike accident involving a 15-year-old boy. He had suffered a head injury. And a 30-year-old man came in with a perforated small bowel obstruction. There was also a woman with a pelvic abscess,” said Dr Deutscher.

The closest major centre with the capacity to deal with the patients was seven hours away. “The fellow with the bowel obstruction was attended by his young son. They were country people. The boy stayed at his bedside. A day after the surgery, he could tell his father was getting better. He knew his dad was going to be OK and he went back to work in the fields,” said Dr Deutscher. “The trust was amazing. He trusted us to do the work and take care of his father.”

The College has sent a number of teams to the province since then. Dr Glenn Guest led the latest mission, in December, 2006, to Larantuka. “I saw 400 people in Larantuka and one of the first things I noticed was how advanced the pathology was that we were dealing with. You
“We had the philosophy that we wanted to go there and incorporate what we were doing with what the locals wanted. We asked the staff at the hospital in Atambua for their advice and we worked at their pace.”

rarely see this pathology in Australia. These people haven’t had the opportunity to access medical or surgical services in the past,” said Dr Guest.

“I saw a seven-year-old boy who had a growth, a soft-tissue tumour, coming out of the side of his neck that was the size of a grapefruit. He could hardly turn his neck. We were able to operate on that successfully. It was a complex procedure. The smile on the mother’s face and the child’s face was such a reward. More so than in Australia, every surgery we do here is a life-changing operation. It may not be life-saving, but it takes away an impediment to the patient having a normal life. I did 40 operations and every one of them made a huge difference in the patients’ lives.”

Dr Guest saw that hernias were a common problem in the community. “Before we arrived, one of the local doctors was attempting to do repairs on the very large hernias. He attended many hernia operations with us and by the time we left, I felt more confident in his ability to do emergency hernias and so did he. This doctor has since started to tackle some of the smaller hernias and of course it’s much better to deal with them before they start causing problems.”

Dr Guest wants to keep returning to teach the local doctors. He knows one visit is far from enough. “The local teams are terribly undermanned. We can’t expect them to soak up everything we say in one go. We have to build up their knowledge slowly over time and introduce new things gradually.”

When Dr Guest was in Larantuka, he penned a long list of patients who needed to be followed up on. He says the best way to build trust is to make a commitment to keep coming back to treat them. “The people were really very excited and pleased to see us. On the first day more than 300 patients showed up. I made an announcement that I would endeavour to see everyone and that was greeted with applause and thanks. Over the six days I was there, I did manage to see them all. Their smiles and thanks were amazing. They so appreciated the time and effort we put in.”

This area of NTT is inhabited by 7.5 million people. Most of them live below the poverty line in remote areas.

“There’s good quality care in Kupang, the closest big city, but people in Flores can’t get there. They are very isolated from surgical services. “We need to make sure we’re going to these isolated areas and not just the capitals. We can make a difference to so many more patients,” said Dr Guest.

-Amy Carmichael
ALTERNATIVE TREATMENTS TO those offered by the mainstream medical systems have been in existence for many centuries, with many of them promoted as natural, self-care alternatives to an impersonal medical system. Although viewed with scepticism by the medical and scientific community, the last two decades have seen an unprecedented growth in their use in the management of a large number of medical conditions, including cancer. Complementary and alternative medicines (CAM) are a diverse group of medical and health care systems practices and products not presently considered part of conventional medicine. While complementary therapies are generally used in conjunction with standard medical treatments, alternative treatments are a replacement for conventional treatment.

In Australia it is estimated that approximately half the population is using non-medically prescribed medicines and that more than 20 per cent visit a CAM practitioner and CAM expenditure represents four times the public contribution to the Pharmaceutical Benefits Scheme.

CAM use is very common among cancer patients (studies suggest that up to 90 per cent of patients use some form of CAM at some stage). People use CAM for symptomatic relief, to improve their quality of life, because of concerns about the toxicity of conventional therapies, congruence with their own values and beliefs, and/or in the belief they can fight cancer or boost their immune system.

Commonly used CAM treatments

It is estimated that thousands of CAM modalities and treatments have been used over the years, either to complement or as an alternative to conventional care. A commonly used classification of these interventions is presented in Table one.

The prevalence of different CAM therapies varies in different countries: herbal remedies are commonly used in Europe, mushrooms, bulbs and shark cartilage in the Far East, homeopathy and herbal therapies in Australia and mind-body techniques in the UK and the US.

Some of the issues relating to the use of complementary therapies as cancer treatments are presented below.

Levels of evidence for CAM efficacy in cancer treatment

A review of a large number of CAM therapies found them ineffective in curing or preventing cancer, but some therapies (such as acupuncture, homeopathy, hypnotherapy, and relaxation techniques) were effective in palliative care. So far, published studies and systematic reviews have not provided sufficient levels of evidence to recommend their wider use in this context.

Safety issues

The list of agents with purported cancer-fighting properties is rapidly growing, but few natural preparations have been tested in rigorous clinical trials. The wide variations in biologic potency among herbal crops, the possibility of contamination by fungi, bacteria or pesticides, or the use of incorrect plant species, the absence of product standardisation (leading to possible substitution adulteration and incorrect dosing or preparation) and inappropriate labelling or advertising pose specific challenges. Some herbal medicines can have toxic effects such as hepatoxicity (e.g. kava), or cause drug-herb interactions (such as those between St John’s wort and pharmaceuticals, leading to sub-therapeutic dosing of medications), or be associated with surgical complications (through interactions with anaesthetic agents, excessive sedation, hypertensive effects, or excessive bleeding). In light of the high prevalence of herbal medicine usage, some authors have suggested the inclusion of questions about herbal medicines in routine history taking.

Disclosure of CAM use to medical practitioners

Doctors underestimate their patients’ use of CAM: a recent study found that more than a third of patients receiving radiotherapy were also using CAM, while treating doctors estimated this figure to be below five per cent. Only about half the patients disclose CAM use to their doctors, expecting them to be disinterested, give a negative response, or because they are unaware of treatment interactions. However, patient-doctor dialogue on CAM is critical for ensuring clear communication about risks and benefits of these treatments, clarifying the role of complementary therapies in cancer care and discouraging the use of ineffective or dangerous therapies.

Medical practitioners’ attitudes and awareness of CAM

Family doctors and psychiatrists use CAM more commonly than other medical practitioners, with surveys of primary care providers in North America and the UK finding the majority had referred patients (or influenced referral) for CAM therapies. Already in 1997, elective courses in CAM were offered in 75 US medical schools, although few courses promoted critical thinking in reviewing the evidence about alternative treatments.

CAM-related research

Despite its popularity, CAM has been understudied. Some of the challenges for CAM research relate to methodological issues, as individualised patient treatment (a cornerstone of CAM treatment philosophy) makes many CAM practitioners reluctant to adopt RCT-type methodologies, difficulties relating to clinical trials recruitment, identifying appropriate outcome measures, or finding appropriate placebo. Establishing research collaboration is problematic, with few clinicians being supportive of CAM research, difficulties in securing...
A nationally agreed process has been in place for the regulation of health professions, taking the prerogative of State and Territory governments, with the power to regulate health professions being the prerogative of State and Territory governments. The Therapeutic Goods Administration (TGA) has been responsible for the regulation of complementary medicines, which are categorised as listed rather than registered products and therefore have to meet safety and quality of manufacture standards, rather than the more rigorous evaluations required of registered products. The quality of complementary medicine adverse reaction reporting is generally limited and more efforts need to be spent in raising awareness of potential treatment interactions.

**Table 1**

<table>
<thead>
<tr>
<th>Type of intervention</th>
<th>Examples</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary and nutritional interventions</td>
<td>Metabolic therapies &amp; detoxification (e.g. Gerson diet), megavitamin &amp; orthomolecular therapies, macrobiotic diet</td>
<td>They extrapolate some of the general assumptions about the protective effects of a low-fat diet rich in fruit and vegetables in cancer prevention, claiming that dietary interventions cure cancer, their effectiveness has not been convincingly demonstrated</td>
</tr>
<tr>
<td>Mind-body techniques</td>
<td>Hypnosis, meditation, relaxation techniques, music therapy</td>
<td>Assume one's health can be influenced by one's mind. Some interventions have become mainstream: e.g. hypnosis can improve pain in advanced cancer, music therapy can alleviate anxiety, depression and pain, particularly in palliative care</td>
</tr>
<tr>
<td>Bioelectromagnetics</td>
<td>Magnet therapy</td>
<td>The assumption that magnetic fields penetrate the body and heal damaged tissues, including cancers has no evidential basis</td>
</tr>
<tr>
<td>Alternative medical systems</td>
<td>Acupuncture, acupressure, qi gong, tai chi, Chinese herbal remedies</td>
<td>Substantial research supports the value of acupuncture for pain relief and management of nausea. Chinese herbal teas and relaxation techniques are useful complementary cancer treatments; Chinese green tea and other herbal remedies are the subject of ongoing clinical trials</td>
</tr>
<tr>
<td>Pharmacologic and biologic treatments</td>
<td>Immunoaugmentative therapy (IAT), antineoplastons, shark cartilage, Cancell</td>
<td>These treatments are invasive, biologically active and unproven as cancer treatments</td>
</tr>
<tr>
<td>Manual healing methods</td>
<td>Chiropractic and osteopathic treatments, hands-on massage, therapeutic touch, energy healing</td>
<td>Chiropractic and osteopathic treatments have a large client base, although their effectiveness is questioned by mainstream practitioners; massage can reduce depression and improve sleep scores in advanced cancer; therapeutic touch and energy healing therapies lack a scientific basis</td>
</tr>
<tr>
<td>Herbal medicines</td>
<td>Botanicals</td>
<td>Have long been used as medicines; are commonly used by cancer patients, although most have not been tested in rigorous clinical trials. Data on safety, effectiveness and dosing largely lacking</td>
</tr>
</tbody>
</table>

**Regulatory framework for complementary medicines**

In Australia complementary medicines are regulated under the Therapeutic Goods Act administered by the Therapeutic Goods Administration (TGA). Most complementary medicines are categorised as listed rather than registered products and therefore have to meet safety and quality of manufacture standards, rather than the more rigorous evaluations required of registered products. The quality of complementary medicine adverse reaction reporting is generally limited and more efforts need to be spent in raising awareness of potential treatment interactions.

**Regulation of CAM practitioners**

Under the Australian Constitution the power to regulate health professions is the prerogative of State and Territory governments, with healthcare practitioner regulation taking the form of statutory regulation or self-regulation. A nationally agreed process has been in place since 1995, stipulating occupational regulation was required if the majority of the jurisdiction agreed to it and if certain criteria are met, one of which is the potential for causing harm. The Expert Committee on Complementary Medicines in the Health System recommended that all jurisdictions need to develop more effective self-regulation for CAM professions, but so far progress has been incremental.

**Education, training and credentialing issues**

Educational standards are extremely variable among Australian complementary medicine practitioners and consumers and healthcare professionals lack reliable methods to identify suitably qualified practitioners. Acquiring and updating information on CAM should ideally be part of the undergraduate vocational and continuing medical education, but significant barriers remain in translating this into practice.

**Safeguarding consumer choices**

Research suggests that patients most commonly receive information on CAM from family and friends, from the media, from books and increasingly from the Internet. Using the internet to gather information about CAM can empower individuals and afford them greater choices and opportunities to become active participants in their care, but separating reputable sources of information from those selling “bogus cures” challenges consumers ability to make informed decisions.

**Ethical and equity issues**

The identification of potential CAM-drug interactions, referral of children for CAM treatment, providing advice on CAM in the absence of definitive data on risks and benefits and the duty to educate patients about potential risks are issues with significant ethical and legal ramifications. Practitioners need to also consider equity issues relating to the costs of CAM treatments, which can be significant and are borne largely by patients.

**Integrating CAM into the continuum of care**

In North America, the response to an increased interest in CAM among patients has been mirrored in the clinical field by the...
development of research and clinical programs in integrative medicine in many major cancer centres, such as Memorial Sloan-Kettering, M.D. Anderson, Dana Farber and the University of California-San Francisco. Many hospitals and medical centres have developed research and clinical service programs in CAM, offering a wide array of CAM services, from mind-body interventions to therapies of varying complexity and remote-ness from mainstream care. These efforts, coupled with the creation of the National Center for Complementary and Alternative Medicine (NCCAM), at the National Health Institute (NIH), have contributed to a greater appreciation of the role CAM can play in integrated patient management and created opportunities for collaboration between unconventional and conventional treatment providers.

In Australia integration has been slow to gather momentum, with a recent Senate enquiry capturing the views of the diverse stakeholders involved: conventional practitioners were largely opposing it on the grounds of lack of evidence for effectiveness and safety, while consumer groups and CAM practitioners perceived that alternative cancer therapies were deliberately suppressed, as they challenge the prevailing cancer paradigm.

As CAM therapies are not a passing fad, and in view of their enormous popularity, their potential for harm and the lack of effective mechanisms to safeguard consumer choices, clinicians need to become more familiar with issues around their utilisation. The box at right lists some sources of reputable information about alternative and complementary medicines:

**Acknowledgement**

This review was based on the work of Professor Barrie Cassileth, the Chief of Integrative Medicine Service at the Memorial Sloan Kettering Cancer Centre (and the first health care professional to examine closely the phenomenon of complementary and alternative medicine) and other salient publications in this field. A full list of references is available.

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**Reputable Sources of Information about Alternative and Complementary Therapies**

- Memorial Sloan-Kettering Cancer Center: [www.mskcc.org/aboutherbs](http://www.mskcc.org/aboutherbs)
- American Cancer Society: [http://www.cancer.org](http://www.cancer.org)
- Oncolink (University of PA Cancer Center): [http://www.oncolink.org](http://www.oncolink.org)
- St. Jude Children’s Research Hospital: [http://www.stjude.org](http://www.stjude.org)
- National Council Against Health Fraud: [http://www.ncahf.org](http://www.ncahf.org)
- Quackwatch: [http://www.quackwatch.com](http://www.quackwatch.com)
- US Food and Drug Administration: [http://www.FDA.gov](http://www.FDA.gov)
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For further information on From the Flight Deck visit our website at www.surgeons.org and click on Fellowship and Standards at the top of the page then select the PD link from the drop down menu or call +61 3 9276 7473.
COLLEGE FELLOWS PROFESSOR John Hutson, Jenepher Martin, Bruce Waxman, and Mac “Sawbones” Wyllie joined a team of volunteer GPs, physicians, paediatric registrars and an anaesthetist to provide field medical services to 12,000 Scouts from Australia, New Zealand and around the world at the 21st Australian Jamboree at Elmore, Victoria.

For Melbourne Royal Children’s Hospital paediatric surgeon Professor Hutson, also Group Leader of Australia’s longest-running Scout Group at 1st Malvern, this is his fourth Jamboree and second as Chief Medical Officer.

“It’s a change from cutting up little children,” he said. “Mostly we are seeing presentations of homesickness and gastro, because the Scouts are generally in good health otherwise. Adult leaders, on the other hand, have given us some concerns with heart disease, diabetes and other chronic illnesses.”

A heatwave during the Jamboree combined with circulating viruses to produce several outbreaks of gastroenteritis, resulting in dozens of Scouts being briefly admitted to the makeshift wards for rehydration.

Austin Hospital general surgeon Jenepher Martin, who acted as Professor Hutson’s second-in-command and medical team leader, is a leader at 10th Ivanhoe Scout Group. She was full of praise for the support of Bendigo Hospital through Medical Director Dr Glen Davies and his team. “Bendigo Hospital came to the party with support services from linen, pharmaceuticals, beds, and medical supplies; as well as expediting referral services through ED, pathology and medical imaging.”

“Sawbones” is a general surgeon from Mt Druitt in Sydney West Area Health Service and is also an associate Scout leader at 1st Oakville. “It’s a great pleasure to work with the youth members and watch them growing into good future citizens,” he said.

“I can recommend working at a Jamboree to all my colleagues,” said Bruce Waxman. “It’s good to get away from specialty practice for a while and back to your medical roots. I really enjoy working so closely with a great team of specialists and GPs from around the country.”

The 21st Australian Jamboree was the first official function celebrating Scouting’s 100th year worldwide. It was held at Elmore in Victoria for 12 days in early January, and brought together 12,000 Scouts from around Australia and as many as 30 other countries. The Jamboree site was a tent city with its own radio station, shops, police and fire brigade.
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Professor Frank Frizelle
frank.frizelle@chmeds.ac.nz

Closing date for abstracts 30 March 2007
The unthinking person’s alternative to New Year’s resolutions

“When people pre-plate their food, rather than filling up again from a buffet when their plate empties, or eating from a packet, they eat on average 14 per cent less. If you keep empty bottles and cans on the dinner table, guests drink less.”

Later, diGusto drinkers ranked the wine and the (identical) meal poorly. The Grange drinkers lingered longer over their meals and rated both the meal and wine highly. Both groups strenuously asserted that, while the wine label may have affected others, it had not affected them!

We make 200 food choices a day. Most are well beyond the reach of rationality and many push us towards over consumption. Accordingly, to make leaner food choices, we need the help of the environment to control unconscious decisions. Wansink writes:

The good news is that the same levers that can ‘throw the switch,’ putting large bowls of apples on the table. Unconsciously, we eat more healthily – without thought.

Wansink concludes by recommending that we each take a sheet of paper, write the days of one month across the top and three, doable, non-sacrificial structural changes in the ‘mindless zone’ down the side, then each day we record on this grid how we have gone, aiming to reduce our calorie intake by 100 a day.

If we can tick off 32 of the possible 90 changes in a month, we will shed about 500 grams.

The mindless margin is ‘a zone in which we can either slightly overeat or under eat without being aware of it.’ It is about 100 calories either side of what we usually consume. If we use this mindless margin to our advantage we could shed 5 kg a year.

Wansink offers several ‘reengineering strategies’ to exploit the mindless margin to our advantage. The first is to ‘dish out about 20 per cent less for a meal than you think you might want before you start to eat.’

Wansink’s second strategy is to deliberately see ‘all that you eat’. When people pre-plate their food, rather than filling up again from a buffet when their plate empties, or eating from a packet, they eat on average 14 per cent less. If you keep empty bottles and cans on the dinner table, guests drink less.

So, because we eat 30 per cent more from a big packet of breakfast cereal than from small packets, Wansink suggests that we serve from small boxes, use smaller dinner plates, and limit the number of tempting side dishes.

Toss out leftovers. For healthy food we can ‘throw the switch,’ putting large bowls of apples on the table. Unconsciously, we eat more healthily – without thought.

Wansink concludes by recommending that we each take a sheet of paper, write the days of one month across the top and three, doable, non-sacrificial structural changes in the ‘mindless zone’ down the side, then each day we record on this grid how we have gone, aiming to reduce our calorie intake by 100 a day.

If we can tick off 32 of the possible 90 changes in a month, we will shed about 500 grams.

So in this season of mindless over-eating, Wansink speaks to us with positive proposals for change. But we can turn the tables and use the ‘mindless margin’ – worth considering as an alternative to the New Year guilt trip of failed resolutions!

Stephen Leeder is co-director of the Menzies Centre for Health Policy at Sydney University.
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Strengthening the Trainees Association

New Chair John Corboy is focusing on important issues raised by working parties, including safe working hours.

Developing strong, effective dialogue between the College and surgical Trainees across Australia and New Zealand will be a key objective of the new Chair of the Surgical Trainees Association, Dr John Corboy.

Dr Corboy, a Specialist Surgical Trainee in General Surgery from New Zealand, took up the position of Chair in January and said he planned to build the links between Trainees and the College established over the past two years.

He said the 2002 recommendation made by the AMC to create a stronger presence for Trainees within the College decision-making process had been welcomed by the Trainees Association. He also praised the College for moving so swiftly to establish representation for trainees on relevant committees and boards up to the College Council. “This has been a very important development as it allows insight for the College into trainees’ opinions. That means decision-makers know what is working and what is not, what the problems are as perceived by trainees and of course possible solutions.”

Following his election, Dr Corboy will now represent the Association on both the Council and the Board of Education. Mary Theophilus will sit on the Specialist Surgical Training Committee, Brandon Adams on the Board of Basic Surgical Training, while Co-Chair of the Trainees Association Damien Amato will attend Neurosurgery specialty meetings and those Dr Corboy is unable to attend.

Drs Mitchell Nash and Simon Quinn will represent the association on the Surgical Education Training Working Party.

Dr Corboy also said a key priority for the Trainees Association this year will be to progress the work being done by working parties established over the past year. These include developing a “welcome pack” for Trainees possibly based on the successful project developed in South Australia which gives new trainees both information about the Association and, with the support of sponsorship, one of the textbooks needed for surgical training. “There is a lot to know when you become a surgical Trainee,” Dr Corboy said. “However, much of that information can be fragmented or difficult to source. Given our new standing within the College, we want to let new Trainees know we are here, that there is a forum in which they can raise issues and representatives that will take up those issues as appropriate.”

Dr Corboy said another working party is looking at the development of “e-log books”. “Every Trainee has to keep a log book to track what operations they have done, at what level and what complications were encountered,” he said. “Currently we have to fill them out by hand which makes it difficult for others to read while there is the technology available now to standardise such data and make the process easier for both Trainees and their training boards.”

Another working party has been established to look into the crucial on-going issue of safe working hours with the views of trainees across Australia and New Zealand now being solicited through the Surgical Trainees Association website accessed via links on the College website. “This is an on-going issue that requires constant vigilance,” Dr Corboy said. “Pressures of patient care and service delivery are complex and impact on safe working hours. For example, one year all might be well but then hospitals may see resignations leaving registrars with an impossible workload.

“Therefore it is important that everyone has a concept of what unsafe working hours are so trainees are not left burnt out and disillusioned and they need to know they can contact us and we will take up various matters for them. This is an integral component in the well being of surgeons in training.”

He said he chose to pursue a career as a surgeon because it offered an opportunity to assist people.

“What I liked about surgery, after I investigated other options, was the problem-solving element,” he said. “That is, you see a patient, you take their history, perform an examination, then appropriate investigations, treat them, then allow them to get on with the rest of their lives.”

Dr Corboy is married, with his first child born just weeks ago and said that thanks to his supportive wife, was able to take on the position of Chair of the Association. He believes its work and role is crucial to the lives of trainees and the care of their patients. “It is important for Trainees to support the College and it is important for the College to work for its members,” he said. “I believe that to provide the best care for patients, Trainees need to stand up for the College values of professionalism, service, commitment, diligence, integrity, responsibility, compassion and teamwork. Those values work both ways and my goal is that Trainees recognise that they have a voice in the College through their representatives and that they use them to allow us to make good considered input into the boards on which we sit. The College has put in a lot of work to establish that representative structure and we are now building on that, particularly the work done by my predecessor Dr Deb Amott and the interim Committee. I urge all Trainees to visit our website via the College, get to know the representatives and become involved in the work we are doing.”
COLORECTAL SURGEON ASSOCIATE

Professor Graham Newstead is aware that his stated mission in life is apt to cause a few sniggers outside the surgical profession but he is unrepentant.

Rather, that childlike, almost embarrassed reaction is what drives him in his plan to make bowel screening and bowel cancer prevention dinner table conversation.

As head of the Colorectal Foundation established by him in 1999, Associate Professor Newstead has raised almost a million dollars to fund awareness-raising projects from the mind-boggling giant, inflatable walk-through “super-colon” now visiting shopping centres across Sydney, to community service television advertisements, to a website.

He said he took on the mission having become disenchanted with surgically treating the disease in a society that did little to prevent it or screen for it in its early, treatable stages.

“My mission is to try and make the Australian population aware of the risks of bowel cancer because I don’t believe Governments have done it sufficiently. More than 12,000 people get bowel cancer each year and of those about 6000 will die, Associate Professor Newstead said.

“This is the second most common cancer in men after prostate cancer and the second most common cancer in women after breast cancer and yet we do not have either a nation-wide screening process or even sufficient public awareness that could allow people to understand the risks and that it can be prevented.

“Just recently the Government has offered faecal-occult blood tests for those aged 55 and 65 to determine the efficiency of such tests which in my opinion is inadequate. Firstly, too bad if you are neither of those ages, secondly similar studies were done 30 years ago and thirdly, we’ve known for a long time that if we find the polyps we’ll prevent most cancers.

“We are not saying to the public ‘have a colonoscopy’ - which is the gold standard - but we are saying there are symptoms, there are tests to discover polyps and if you find established cancer early enough there is treatment with good outcomes. So if our awareness programme stops 10, 100 or 1000 people from dying then that has got to be worthwhile.”

And the way to get the message through, for such a formerly-taboo topic, is to use humour and common-sense. One of the world’s largest advertising agencies DDB has signed up to help, some actors starring in advertisements have worked for free and even tattooed rock singer Angry Anderson has put his face to the campaign.

He is the face of the interactive web-site feature on www.getscreened.com.au called “prod-a-mate” which allows those visiting the site to send Anderson, via email, to a friend or partner where he says: “I hear you’ve been neglecting your bottom/bowel/nether region” and urges the recipient to consider the various screening alternatives.

With the image, comes statistics and information. The site has attracted 8000 hits since November.

A more dramatic ad, shown throughout Christmas, shows a person drowning with a voice-over stating the facts of bowel cancer and then asking: “If you don’t get screened and help yourself why should anyone else help you?”

There are also plans in train to create graffiti-type information strips for toilets similar to those used to promote safe sex. “It took people some time to talk openly about breast cancer, it took some time for people to talk about prostate cancer and now we are attempting to start the conversation about bowel cancer,” Associate Professor Newstead said.

“And it is working.

“At the shopping centres, people are initially shocked by the super-colon but then they walk through, they see a cancer, they see polyps but they also read the brochures and watch the DVD on a plasma screen and go away thinking that if other people can talk about it, be so forthright about it, so can they.”

Associate Professor Newstead said his public awareness campaign began after one of his patients, Harry Triguboff, the managing director of the Meriton property development company, expressed frustration that he did not know anything about bowel cancer or the possibility of preventing it before he contracted it.

He told Newstead that he would happily support any efforts to raise public awareness and is now the Patron of the Foundation with a Research Fellowship into bowel cancer carrying his name.

Yet, despite the good humoured approach, Newstead is keenly aware of the politics of health. He said it was understandable the Government was cautious in its approach for fear of the cost of a nation-wide colonoscopy screening programme yet said that by picking up small polyps before they turned malignant, hospital admissions and costs could be saved.

“Theoretically, if every person aged 50 and over had a colonoscopy this year, we believe the costs of the tests would be almost equivalent to the treatment costs for the 12,000 who get bowel cancer,” Associate Professor Newstead said.

“But still we are not calling for that. Instead we are simply wanting to inform the public that there are tests that they can ask for including faecal-occult blood tests which, while they may miss a number of cancers, are significantly better than doing nothing.

“I’ve been on committees talking about this for 20 years and given that 6000 people die each year in Australia, that means that 120,000 people have died while we have been talking. So ultimately, it’s about how you value a life. All we are trying to do is to let the community know it is common, it has early warning symptoms and it can be treated with excellent results if detected early enough.”

“Most importantly, it is preventable.”
April 24 commemorates the 10th anniversary since the College acquired the SA building

AS CHAIR OF the SA State Committee of the College, it gives me great pride to present this article to the fellows of the College, “Commemorating the 10th Anniversary of the SA College Building”.

The South Australian College building is situated in Palmer Place, North Adelaide. It is right in the heart of the traditional SA medical precinct, surrounded by several original medical rooms and residences of historically prominent doctors and many of the traditional SA hospitals. The office is a few doors away from the Australian Medical Association SA Offices based in Newland House, which is named after Henry Simpson Newland, one of the founding fellows of the College.

The elevated location offers spectacular views across the Adelaide CBD, St Peters Cathedral and the Adelaide Oval. The latter feature was quite a distraction to a Regional Board meeting coinciding with the closing minutes of the last years dramatic 2nd Ashes Test.

The College Building represents major key achievements of the College within SA, and has become the focal point for all surgical activities in the State. This building is owned by the College and the activities within are run by the SA Regional Manager and her dedicated staff. Currently, in addition to the College Offices the building is the SA base for:

- Australian Orthopaedic Association
- South Australian Audit of Perioperative Mortality
- Australian and New Zealand College of Anaesthetists
- Royal Australasian College of Physicians
- Royal Australian and New Zealand College of Obstetricians & Gynaecologists
- Royal Australian and New Zealand College of Psychiatrists.

On April 24, the College commemorates the 10th anniversary since the College acquired the building for its use.

Successful draper, Mr William Honeywill built the house in 1901, as the family home to be known as KEYNEDON BROUGHT, North Adelaide. Mr William Honeywill became a partner with Mr Charles Birks in a business known as Charles Birks & Co Ltd of Rundle Street Adelaide (later to be known as David Jones) from 1889 until 1907. The family later returned to England 1910. There are three panels in his memory located at St. Peters Cathedral, North Adelaide.

The house features high quality masonry, brickwork with an Art Nouveau influenced timber veranda. The home was sold in 1910 to Mr Frederick Bullock, a former Lord Mayor of Adelaide, and later sold again to a real estate firm and then to Perretts Medical Imaging.

In 1997, Mr Glen Benveniste the serving Chair of the SA/NT Royal Australasian College of Surgeons Committee recognised the potential for the building to serve as a home for the college in SA. Glen and then members of the College local committee negotiated with Perretts Imaging to acquire the building for use by the College as the SA/NT Regional Office. Two key elements in the acquiring of the building were firstly, the fact that around 90 per cent of SA Fellows lived or worked within 30 mins travel to the location, and secondly, the vision and support of the President of the College, Colin McRae. Colin’s efforts were recognised by SA fellows by the subsequent naming of the building’s major lecture room in his honour. After considerable refurbishing the SA College building was officially opened on 24 April 1997 by his Excellency, Sir Eric Neal, AC, CVO, Governor of South Australia.

Over the past decade the building has seen many events and functions. The College holds the majority of its core activities at Palmer Place as does its tenants and a number of Societies. The building was the original site for the establishment of the College Breast Audit and ASERNIP-S, both of which are major College projects and have moved to larger premises in Adelaide.
The building has been a hub for the Part two Examinations and the ASC when held in South Australia and is a stunning centrepiece for social activities undertaken by the College. Indeed the building has been an official venue for the Adelaide Festival of Arts and has hosted several art exhibitions, some featuring the work of local surgeons such as Tony Rieger. The SA College boardroom has been used as a meeting place during visits to Adelaide by Prime Minister John Howard, most likely because of the views of Adelaide Oval.

In 2006 the building was listed for Heritage by the Adelaide City Council. Under the Heritage Scheme a Grant was obtained to assist with the overall costs of renovations and refurbishment of the building, specifically:

- The external building will be fully restored to its former glory
- Access ramp and handrail for disabled has been added
- Flood lights to emphasise and highlight the front of the building will be included to enhance the building features.
- The front fence will be returned to its original design including piers.
- A complete garden make over returning it to gravel paths and plants from yesteryear are planned as part of the restoration.

The SA College building will continue to serve surgeons locally for many future decades. It is a wonderful asset and venue for all Fellows of the College. For those interested a virtual tour can be undertaken of the SA College building via the college website, following the links to the SA Regional Board (www.surgeons.org). Our college extends a warm invitation and welcomes all Fellows to visit and to take the opportunity to discuss the use of our Conference and Boardroom facilities. The SA Regional Manager and her dedicated staff will be happy to assist you with your enquiries.

ARE YOU a doctor, a nurse, a midwife, a psychologist, laboratory technician, logistics specialist, physiotherapist or finance/admin person?
ARE YOU interested in working overseas with an international medical aid organisation?

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Wednesday 18 April 2007 at 7.00pm

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Wollongong Hospital
Wollongong

- General presentation about Medecins Sans Frontieres and its activities around the world
- Information about recruitment procedures and employment criteria
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Any queries/questions please see our website www.msf.org.au
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“NOT A LEG to stand on” was the headline to a 1995 story in The Wall Street Journal about a diabetic patient who had the wrong leg amputated in Tampa, Florida. It might also describe the figurative predicament of a doctor responsible for a wrong procedure, an incorrect implant, a mismatched blood transfusion, or an operation done at an incorrect site on a patient. These errors, which are uncommon but regularly recurring causes of claims against members, are generally indefensible, extremely humiliating, and very damaging to both the doctor and the institution in which they occur. Major examples are likely to attract adverse media attention. Fortunately, they are amenable to a systems-based approach to prevention and should therefore be avoidable. This article describes the common types of wrong site/wrong procedure errors, sets out the predisposing conditions and outlines a systems approach to prevention.

### Incidence

Data from New York State hospitals indicates that a wrong site procedure occurred in 1 in 15,500 operations and in US Veterans Hospitals a rate of 1 in 25,000 operations is cited (approximately 1/month). In Australia it is estimated that wrong-site procedures comprise 25 per cent of sentinel (serious) adverse events. The Victorian Department of Human Services was notified of 16 wrong-site procedures in 2003, NSW Health recorded 13 in 1.5 million hospital admissions in 2004 and 11 were noted in the WA 2005 sentinel event report. These low figures consist almost entirely of serious cases and are therefore poor indicators of the overall magnitude of the problem. Reliable incidence data is sparse because in the past there has been significant under-reporting of these embarrassing adverse events. Anecdotal data suggests that voluntary incident reporting systems do not solve the under-reporting problem. Medico-legal claims data are of limited value because they represent only a small proportion of wrong site incidents, many of which do not lead to a claim. Wrong-side knee arthroscopy, for example, usually leaves no injury other than a scar and is seldom followed by litigation. It is hoped that more complete information may soon emerge from Medical Defence Organisations, given the increased recognition by doctors of the need for prompt reporting of all adverse incidents. MDA National notifications already point to a much higher frequency in the real world, especially if “near misses” without serious consequences are included.

### Body Site Locations of Wrong Site/Wrong Procedure

#### US Veterans Hospital Data

Data from US Veterans Hospitals in 2002 indicates the following body site distribution of reported wrong site/wrong procedure incidents:

- **Eye**
- **Groin or Genitals**
- **Chest**
- **Leg**
- **Hand, Wrist or Finger**
- **Abdomen**
- **Back**
- **Head, Neck, Mouth, Anus, Colon, Buttock**

**NOTE:** the font size represents approximate relative frequency – with acknowledgement to Dr James Bagian, NCPS Director.

The relatively high frequency of wrong site/wrong procedure in eye operations is probably due, in part, to the high proportion of older patients, many with cognitive impairment, to the usual absence of externally visible ocular pathology and to the potential for insertion of an incorrect lens implant in cataract operations. “Groin or Genitals” includes right-left mix-ups in hernia, testicular or ovarian operations and in operations for Peyronie’s disease (lateral penile curvature). It also includes hernia repair at a non-defective site (e.g. inguinal canal), when the patient actually has a different type of hernia (e.g. femoral or Spigelian).

In the leg, prepping and draping of the knee before the surgeon’s arrival is often the setting for wrong-side arthroscopy. “Anus” wrong procedures consist of, for example, sphincterotomy instead of haemorrhoidectomy. “Colon” wrong procedures include resection of the wrong colon segment for a coloscopically identified malignant polyp.

### Types of Wrong Site/Wrong Procedure

Data from US Veterans Hospitals in 2002 indicates the following distribution:

- 44 percent were left-right mix-ups on the correct patient – 56 percent were something else
- 36 percent were the wrong patient
- 14 percent were the wrong implant or procedure on the correct patient
- 7 percent were the wrong site (but not left-right) on the correct patient

### System Factors Predisposing to Wrong-Site Procedures

Although a common element in wrong-site procedures may be the failure of an individual doctor or nurse to follow accepted protocols such as site marking and checking, in most cases latent system errors (described by James Reason as “resident pathogens” in the system?) combine to produce the adverse event. More than one of the following system elements are usually present:

- **Complacency.** “Happens to the hospital down the road, not to us”
- **Operating room (OR) time pressures**
- **High-volume OR lists; stressed or fatigued staff**
- **Emergency operation**
- **Change of OR list order**
- **Cognitively impaired patient (dementia, severe illness, sedation etc)**
- **No externally visible or palpable pathology in the patient**

### System Factors Predisposing to Wrong-Site Procedures

Table: Body Site Locations of Wrong Site/Wrong Procedure

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**Preventable Errors**

Thomas Hugh, Chair
MDA National NSW Advisory Committee

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**Surgical News P38** / Vol 8 No 2 March 2007
• Bilateral pathology e.g. ocular disease, diabetic lower limbs
• Complete clinical notes unavailable at the procedural location
• Delegated preoperative site marking by inadequately briefed or junior doctor
• Same name patients on procedural list
• Patient anaesthetised or sedated before surgeon arrival
• Patient prepped and draped before surgeon arrival
• Different operating surgeon from admitting surgeon
• Imaging studies unavailable in OR or films show poorly visible or incorrect side-markers, leading to left-right mix-ups in horizontally flipped films
• R and L abbreviations used on consent or procedural request form (Fig I)

Figure 1: Operation consent form, with “R.” (Right) abbreviation. The patient had discharge from the right nipple and was moderately demented. There was no palpable breast lump but mammography and needle biopsy showed carcinoma. The mammogram films and report were not sent to the OR. A left mastectomy was done. At least four system elements contributed to this error.

The Systems Approach to Prevention
Rare adverse events such as wrong site procedure may be the most difficult to prevent because dangerous complacency sets in when the things that can go wrong usually go right. The answer to this problem lies in disciplined adherence to an agreed protocol. Most Australian States and Territories health authorities have adopted, or are in the process of adopting, some modification of the 5-steps protocol mandated by the US Veterans Health Administration. The full 5 steps are:

1. A consent form stating the patient’s full name, the procedure, the body site, including laterality if appropriate (written in full, not as R or L) and the reason for the procedure, is signed by the patient. The information should be in easily understandable lay terminology if possible. “Reason for the procedure” (e.g. hip joint replacement for osteoarthritis) is included so that patients may speak up if they believe the wrong procedure is on the form.

2. The operative site is marked, preferably no later than one hour preoperatively, by a doctor member of the operating team. The patient should be involved in the marking procedure whenever possible. All sites are marked with a non-toxic indelible marker as close as possible to the site of the incision because a significant proportion of wrong site procedures are on sites close to the intended site e.g. on the wrong digit or the wrong side of the knee. Non-lateral sites such as midline incisions should also be marked – more than half wrong site procedures are not laterality mistakes, but something else, such as wrong patient or wrong operation. If the site is difficult or impossible to mark, such as the oral cavity or perineum, if a decision about the site is to be made in the OR, or if there are multiple related sites (e.g. laparoscopic operations), a special-purpose wristband naming the procedure and site may be substituted for marking.

The mark may consist of an “X”, the surgeon’s initials, or the word “YES”. It is desirable that there should be uniform agreement about the method chosen in any given institution. Multiple methods of marking may lead to confusion and disagreements between surgeons and nursing personnel. Marking of non-operative sites, such as the contralateral limb (a method previously used in some hospitals), should NOT be done.

Special techniques for identifying the exact operative site may sometimes be required. These include on-table X Rays to determine the vertebral level in spinal operations, on-table colonoscopy to locate the site of malignant polyps and hookwire localisation for breast pathology. The temptation to omit these procedures because of time pressures should be resisted.

3. The patient is identified by a staff member immediately prior to the procedure by being asked to state their name, date of birth, and the site of the expected procedure. If the patient is unable to respond, if possible another person with knowledge of the patient, such as a family member, is asked to do so. The responses are checked against the consent form, the patient’s wristband and the marked site.

4. A “time-out” briefing is conducted in the OR prior to starting the procedure. The time-out is led by a designated member of the operation team and should include the surgeon, scrub and circulating nurse and anaesthetist. The name of the patient, the procedure to be done, the site and the implant to be used (if applicable) are stated for all to agree verbally. The time-out is documented in the clinical notes.

5. Two members of the OR team review relevant radiological images before commencing the surgical procedure. The function of the second member, who need not be a doctor, is to verify that the appropriate images are available and correctly labelled with the patient’s name and any necessary side markers.

The multiplicity of predisposing system factors in wrong site errors means that multiple preventive barriers must be placed. Single safeguards cannot be relied upon. That is why there are 5 steps in the protocol and why all the steps must be done for the steps to work.

Objections may be made to the time required to carry out the 5-steps protocol. Data from the VA National Center for Patient Safety (NCPS) shows that the average total time needed is less than 10 minutes. The Director of NCPS, Dr James Bagian, points out that 10 minutes is nothing compared with the time needed to explain to a patient why you tried to fix something that wasn’t broken.

Some Australian health authorities have produced local instructional posters

When Should the 5-Step Protocol be Used?
As a general rule, the protocol should be used for any procedure that requires signed patient consent. This includes, for example, not only surgical operations but also such things as invasive radiology or insertion of a chest tube (wrong-side chest tube insertions have been reported).

The full 5 steps are not necessary when the consent process and the procedure are done at one sitting by the same doctor.

Conclusion
Successful abolition of wrong site errors requires widespread education and a commitment by institutions and individuals to a disciplined preventive protocol. It also needs to be underpinned by a culture change in attitudes to this problem. This change should acknowledge the universal systemic vulnerability to these errors and needs to be accompanied by a heightened awareness of the system conditions which predispose to wrong-site/wrong procedure mistakes. The resident pathogens are waiting in the system; if they trip you up it is likely you won’t have a leg to stand on.

References
3. The details and rationale of this protocol, together with useful information such as frequently asked questions, may be accessed at: http://www.patientsafety.gov/CorrectSurg.html

Acknowledgement
This article has been reproduced with kind permission from the Winter 2006 edition of Defence Update, the quarterly magazine of the MDA National Group.
Mobile phones in hospitals - what's the risk?

S Derbyshire & A Burgess

THE USE OF MOBILE phones in hospitals is controversial. On one hand, there is evidence that mobile phone use can cause interference when used within one metre of medical devices (e.g. triggers alarms and causes interference when ECGs are being conducted). Another concern relates to the possibility of people using cameras installed in phones to compromise patient confidentiality.

However, on the other hand, there is no evidence that mobile phone use has resulted in serious consequences for patients. In addition, mobile phones enable clinicians to be easily contactable thereby reducing likelihood of communication delays.

Guidelines developed by the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK do not support total ban of mobile phones in hospitals. The guidelines instead suggest that phones should not be used in critical care areas, such as ICUs and special care nurseries.

Reprinted from the Australian Patient Safety Bulletin Newsletter or the NHMRC Centre of Research Excellence on Patient Safety October 2006, issue 4

Transfusion Update 9-11 May 2007
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Join friends and colleagues of the blood banking and transfusion medicine communities.

3 days of multidisciplinary sessions, appealing to a broad range of specialities including surgery, emergency and critical care.

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> Rene Duquesnoy – Professor of Pathology and Surgery, University of Pittsburgh Medical Center, USA
> Richard Seigne – Anaesthetist with experience in both the UK and New Zealand.

For more information or to register online, visit our website at www.transfusion.com.au/news/update or contact Karina Gibson, 02 9333 3210
**CPD Online**

Data collection for the 2007 Continuing Professional Development (CPD) Program is available online via the College website (www.surgeons.org). Fellows are able to access a personal CPD Online Diary using usernames and passwords to maintain CPD records in a real time format.

Fellows using the CPD Online Diary for 2007 will not be required to complete the hard copy recertification data form issued at the conclusion of 2007, however Fellows are encouraged to continue keeping evidence of CPD activities for verification purposes.

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

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**2006 CPD recertification data forms**

Fellows are reminded that the 2006 CPD Program recertification data forms are to be returned to the College by 31 March, 2007. Please contact Kylie Mahoney, Department of Professional Standards, on +61 3 9249 1274 or email kylie.mahoney@surgeons.org if you require assistance completing your data form or require another copy.

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**Surgical Assistants**

In October 2006, the Professional Development and Standard Board revised the College’s position statement on Surgical Assistants. The performance of major surgical procedures requires teamwork which involves the surgeon, the assistant(s), the scrub nurse and the anesthetist. The bigger the procedure the more important it is for the assistant to be fully conversant with the objectives and techniques of the operation, and for all personnel to develop a team approach.

The primary role of a surgical assistant is to facilitate the safe and efficient performance of an operation by the surgeon. The extent to which an assistant participates in the performance of any procedure is determined by the operating surgeon.

The revised position statement on Surgical Assistants has been developed to address the general and specific requirements and expectations of Surgical Assistants and is available at the College website under Publications/ Guidelines and Position Statements. Comments and feedback on the position statement are welcome.

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**College Vacancy – Project Manager, Surgical Competence and Performance**

A six month full time (or up to 12 months part time) position is currently available for a Project Manager to lead a project to enhance surgical performance within the College’s defined surgical competencies. The position will be based at the College headquarters in Melbourne.

The project will involve the development of a robust protocol for assessing competence and performance, including competencies of non-technical nature and the identification of pathways to assist surgeons who require support and/or re-skilling.

This is a collaborative project between the College and the Medical Indemnity Insurers Association of Australia (MIIAA), with the College Surgical Competence and Performance Working Party acting as the steering group. The protocol developed will be generic to the extent that it will have application to other areas of the medical profession and medical colleges.

Ideally, the successful candidate will have a medical qualification, an understanding of surgical education and training and strong communication skills, including the ability to liaise and negotiate with a range of internal and external groups. Demonstrated experience in project implementation, report writing and contract implementation is also required. An attractive salary is available.

A position description and person specification can be found at “College positions vacant” on the College website at www.surgeons.org

Any further enquiries can be directed to Dr Pam Montgomery, Director Fellowship and Standards on telephone +61 3 9249 1241 or email pam.montgomery@surgeons.org.

Applications close COB, 13 April 2007 and must address the selection criteria outlined in the person specification.
PLASTER CASTS OF the living face were made at the time of the First World War as an aid in reconstructive surgery, supplementing photographs and watercolour drawings. They show wounds typical of the horrendous facial injuries suffered by troops in France and Belgium, often received when a soldier raised his head above the top of a trench. These wounds often resulted in loss of large areas of flesh and bone from the nose, maxillary area and the jaw, including soft tissue such as tongue, palate and eyeball.

In 1917 a reconstructive surgery unit specifically for facial defects was set up under the overall command of Sir Harold Gillies (1882-1960) at Queen Mary’s Hospital, Sidcup, Kent. Between 1917 and 1921 about 5000 service-men were treated there. The formation of this unit represents the beginning of modern plastic and reconstructive surgery. For more efficient administration it was divided into sections according to the territories of the Empire. The Australian Section was commanded by Lieutenant-Colonel Henry Newland, an experienced surgeon from the casualty clearing stations in Flanders, who gained an international reputation as a pioneer of reconstructive surgery for his work at Sidcup. Among his many later achievements was his six-year tenure as President of the Royal Australasian College of Surgeons.

Among those working at Sidcup was a war artist, Lieutenant Daryl Lindsay, a member of the famous family of artists and later director of the National Gallery of Victoria. He made colour sketches of many of the wounded as procedural aids for the reconstruction of shattered faces.

The faciomaxillary cast pictured above is that of Private William H Kearsey of the 9th Infantry Brigade, 33rd Battalion. Kearsey enlisted, at the age of 25, on April 10, 1916. He came from Inverell, where he worked as a coach builder. The 33rd Battalion, raised in the New England region of New South Wales, took part in some of the fiercest engagements of the Western Front in 1917-18, including the Battle of Messines, the assault on the Messines-Wytchaela ridge which took place from June 7 to 14, 1917. This action preceded the major British offensive known as the Third Battle of Ypres (Passchendaele). At Messines and Passchendaele the Australian forces suffered their worst casualties of the War. The 33rd also saw action at Villers-Bretonneux. Among the wounded was Private Kearsey.

Kearsey suffered a massive facial trauma, probably a shrapnel wound, which included the ablation of a large tract of bone from the upper nose and between the eyes. But he survived this devastating injury and was evacuated to Britain, where he was treated in the Australian Section of the hospital at Sidcup. Kearsey returned to Australia, and was discharged with the rank of Corporal on May 6, 1919, when the battalion was disbanded.
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