ASC special, pages 18-24

ALSO THIS MONTH:

PAGE 12: INTERNATIONAL MEDICAL GRADUATES
“I found the system very encouraging, well structured, easy to follow and most importantly, fair.”

PAGE 16: FIRST IMPRESSIONS OF THE COLLEGE
“On entering the Council room for the first time I was struck by the size of it.”

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The College of Surgical Specialties in Australia and New Zealand

THE ANNUAL SCIENTIFIC Congress (ASC) in Christchurch was once again a very successful enterprise, with over 1400 registrants. The organisers are to be congratulated, after two years of detailed planning, endless meetings and abundant moments of anxiety they delivered a fantastic program in a venue that was highly supportive of their endeavours.

The meeting had a strong plenary program based on themes of technology, communication and competence that were relevant to all surgeons, regardless of specialty. There was also a major International Forum, reflecting the College’s commitment to education and training initiatives in the South Pacific. Other sessions appealing to all surgeons regardless of specialty affiliation included medico-legal, military, surgical education, trauma, and pain medicine. In addition to the scientific sessions devoted to general surgery and its sub-specialties, there were sections for six of the nine surgical groups for which the College issues fellowships, namely neurosurgery, paediatric surgery, plastic surgery and vascular surgery.

This widely based program reflected the progressive development of the College as a collegiate body for all of surgery – the College of Surgical Specialties in Australia and New Zealand. The future of the ASC will depend on this being maintained and extended.

In my time as President, I wish to see the College progress to the next stage of governance and educational reform to ensure it remains relevant and properly positioned for its key role as a resource serving and supporting all specialist surgical groups.

Surgical Leadership Forum
Prior to the ASC, there was an all-day meeting of Councillors, Presidents of Specialist Societies and College Regional Board Chairs, where there was an active discussion of the roles of the College and also articulation of possible governance models that might more effectively reflect these. The sessions were chaired by Presidents of Specialist Societies and the agenda was driven by key issues of the day. The discussion reflected a progressive cohesion on the issues that must be addressed.

This forum of surgical leaders will continue to be a debater of key surgical issues, a driver of College direction and vital in assisting Council to set the strategic agenda for the future.

The governance processes of the College have recently incorporated Specialty Councillors with full Council voting rights. This is reflected in the recent election of Robert Black, Otolaryngology Head and Neck Specialty Councillor, as the Chair of the Court of Examiners.

Full fiduciary responsibility for the College sits with all 26 Councillors, who undertake this task willingly and with great energy. The fact that there are only three Council meetings a year makes it difficult for members to stay well informed about day-to-day issues. The Executive Committee of the College acts in the name of the Council between meetings, taking a large role in the monitoring of the day-to-day activities and directions of the College. More modern governance models will need to be considered by the Articles and Governance Committee designed to overcome some of these deficiencies.

A large number of sub-specialties have developed within the traditional specialties; a feature of modern surgical practice. This has led to a number of requests for either new Fellowship categories or a system of post-Fellowship qualifications. A number of presentations about the principles of this development were made and created enormous interest, resulting in substantial support for recognition of formal post-Fellowship training.

The College intends to develop a structure for this to occur with strict guidelines for College accreditation of such training and qualifications. A program leading to a post-Fellowship qualification would have to be based on sound educational principles – an area in which the College has considerable expertise. Any group responsible for such a course would have to truly represent the surgeons practising in the subspecialty. This will be easier in disciplines who already have a course and a strong specialty society such as colorectal and hand surgery, but may be more difficult in areas such as spine surgery (neurosurgery and orthopaedic groups) and trauma surgery. It will be Council’s role to develop the structure and criteria so that groups who aspire to such a qualification must show that they meet them.

I suspect that one of the most difficult jobs will be to find a name for the new qualification.

Foundation for Surgery
As most readers of Surgical News are aware, the College has invested substantial effort in revamping the College’s Foundation. Professor Bruce Barracklough is the Inaugural Chair of the new Foundation for Surgery and he spoke in a number of forums about his new role.

The Foundation will be situated in the New South Wales Regional Office and seeks to position the College meaningfully with major corporate and industry support. The proceeds of the Foundation will be directed to surgical research and outreach activities.

Surgical Education and Training
No article in Surgical News by the President would be complete without a comment on our new educational program. The first selection process is taking place at this time and faces very real challenges in this transition year, due to the large numbers. But this will be a one-off problem.
A most important feature of the new program, designed and approved with maximal input from all specialties, will be meaningful in-service assessment. Surgical supervisors will be responsible for this new role, which requires a new set of skills. This will be enhanced through the Supervisors and Trainers program, which was launched at the ASC and was very well received. It will now be progressively rolled out across all specialties and regions.

There were a number of forums about the new program at the ASC, and College staff and Office Bearers were present at the College stands throughout the week answering questions both detailed and broad. We are currently going through a substantial communication and implementation process, which in itself has presented very real challenges. However, we are well prepared and will now progressively implement this ambitious program. At each stage of the implementation there will be a detailed review to ensure changes are appropriately incorporated and our communication initiatives remain up-to-date and effective.

I look forward to seeing many of you over the next 12 months, particularly in specialty and regional meetings and forums.

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**Advertisement VASM Clinical Director**

**Clinical Director (0.3 FTE) Victorian Audit of Surgical Mortality**

This new part time position will be responsible for the clinical direction and support to the Victorian Audit of Surgical Mortality (VASM). VASM is a state wide, peer reviewed and voluntary process for auditing surgical mortality. The review process identifies areas of clinical management which can be improved. This critically important, quality improvement initiative is funded by DHS.

The initial appointment is for a period of two years with the possibility of renewal and flexible working conditions.

As an experienced and respected Fellow of the Royal Australasian College of Surgeons, you will work with the VASM Project Manager to establish the surgical program within Victoria through liaison with surgeons, hospitals and DHS as well as providing project oversight and acting as Chair of the VASM Management Committee.

A demonstrated ability to meet deadlines and excellent organisational and time management skills are required, as are superior verbal and written communication skills.

Remuneration will be at the appropriate senior specialist level (pro-rata).

Position descriptions can be obtained by email from careers@surgeons.org or visiting our website: www.surgeons.org.

Applications should be addressed to Dr John Quinn, Executive Director of Surgical Affairs (Australia) and sent by email to careers@surgeons.org.

Enquiries:
Dr Wendy Babidge, Director, Research and Audit, RACS
ph: +61 8 8363 7513

Applications will close 4.00pm 13 July, 2007.
The possibility that the College might develop a university has been considered at several meetings over the last few months. The concept has been discussed at the Council and Education Board, a meeting of the section of Academic Surgery, and two meetings of Councillors with Specialty Society Presidents and Specialty Board Chairs, the last meeting including Chairs of Regional Boards. There has been strong support for further investigation.

Why would the College consider such an idea? There are several reasons, including a perception that our current training programs are nearing capacity for efficient delivery. They are dependent on pro bono teachers and this generous workforce may not be assured into the future. In the recent College survey of Fellows, only 30 per cent of respondents indicated that they participated in pro bono teaching activities. Some specialties are already considering partnerships with higher education providers independent of the College for the delivery of parts of their programs. Such collaborations are appropriate when motivated by good educational reasons, but expansion could be seen as a threat to the unity of the College. The College and its Specialty Society partners currently have a controlling influence on the selection of Trainees, accreditation of training environments and assessment, and the College remains vulnerable to accusations of being a “closed shop” and breaches of Trade Practices legislation.

Some believe that the days of pro bono teaching, despite the directive from Hippocrates, are nearing an end. Surgeons formerly served hospitals in an honorary capacity, but those days are long past. Many surgeons will continue to willingly teach and supervise Trainees while remunerated in their teaching hospitals, but may be less enthusiastic about teaching in their own time. With the pressure on public hospitals regarding adequacy of numbers and variety of cases, we will be increasingly reliant on simulated environments to ensure acquisition of technical and non-technical competencies. We need to consider that in the future we may depend on an adequately remunerated surgical workforce to deliver this education and training, and a university could provide a suitable structure.

Universities are institutions of education and they are commercial. Universities charge student fees that are adequate to cover the costs of delivery of their programs, including remuneration of staff. Universities may budget for a surplus to develop and improve their product. Students in Australia are eligible for loans through “Fee Help”. Government funding through the Education budget is available, and a university associated with the College may be able to access health funding, education funding and private funding. Adequate funding would help to develop and deliver better surgical education and training programs and might provide employment options for suitably motivated surgeons.

A major advantage of a university structure, once approved as a higher education provider, is self-regulation of teaching programs and degrees. A university offers qualifications according to the Australian Qualifications Framework, such as diplomas and bachelors, masters and doctoral degrees. A university does not provide a qualification comparable to the FRACS and this would continue as the specialist surgical qualification, even if we did eventually develop a university.

However, it is worth noting the Canadian model of surgical training, in which the Royal College defines the training curricula and assessment standards, but the training is delivered in a university environment. In addition to enhanced pre-Fellowship training, a Specialist Surgical University could provide the opportunity for post-Fellowship qualifications in sub-specialties of the major disciplines and in cross-specialty disciplines.

Changes to Australian federal legislation in 2006 make it possible for the College to apply to become a Specialist Surgical University and we already possess the essential elements that would assure approval. Such a university could be established under federal or state jurisdiction, could be headquartered at a location that was appropriate and have multiple campuses in regions of Australia and New Zealand.

Currently the College is facing at least three major challenges that are relevant to this discussion:

1. How to maintain unity and collaborative relationships with the nine surgical disciplines.
2. How to develop and deliver quality surgical education and training programs now and in the future.
3. How to change the image the public holds that we are a cartel rather than what we believe ourselves to be – a committed group of professionals dedicated to quality and standards of surgical care.

We need to be careful to develop the right model and not to over-extend our resources. If effectively organized, a university could be unifying and strengthening as well as adding value educationally.
The options open to the College:
1. The College continues as we are with minor adjustments.
2. The College transforms into a university, i.e., the College ceases in its current form and is replaced by a university.
3. The College continues and develops a Specialist University that is separate though linked.
4. The College develops collaborations with existing universities to deliver specific components of education and training.
5. A combination of three and four, i.e., the College continues and develops a specialist university and also collaborates with existing universities.

The fifth option is probably the most promising – it would encourage collaborations while our own university develops. It would also help to focus the role of our own university on what we are really good at, instead of replicating educational opportunities that already exist. Furthermore, it addresses the three important challenges identified.

These ideas need further discussion and consideration with internal and external consultation. The Council has established a working party to investigate the options. The membership is Censor-in-Chief Ian Civil as Chair, Vice President Ian Gough, Council-lor Guy Maddern, and a representative of the Academic Surgeons group, John Windsor. The working party will report regularly to the Education Board and Council and the Fellowship and welcomes comments and feedback to: CIC@surgeons.org

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Thank you for finding homes for the Hughes room chairs, the chairs are no longer available.

Medicare Easyclaim, your questions answered

Medicare Easyclaim, the EFTPOS based claiming system that lets practices and patients process their Medicare claims electronically and on the spot, is due to rollout from July 2007.

As Medicare Australia talks to more practices and providers about this additional claiming channel, they are assembling a list of answers to frequently asked questions.

To find out more, visit www.medicareaustralia.gov.au/easyclaim or call 1800 700 199.

Royal Australasian College of Surgeons

Rural Surgical Training Program

Have you applied to the Specialist Training Program in General Surgery this year? Or are you a current General Surgery Trainee?

If you are interested in spending part of your surgical career in a rural setting, or if you are interested in rural rotations during your training, the Rural Surgical Training Program can help you.

Rural Trainees become integral members of the regional communities they serve and have access to a large number of College facilities, such as the RSTP Mentoring Program, and financial assistance for travel to scientific meetings and relevant training courses.

For more information about a surgical experience in rural Australia, please log on to the Fellowship Services webpage at www.surgeons.org and select Rural Services.

For queries please contact Sabina Stuart, Project Officer Rural Services on +61 3 9276 7407, email rural@surgeons.org or Mr Graeme Campbell FRACS, Chairman of the Board of Rural Surgical Training, email ggcnetcon.net.au.

Supported by the Commonwealth Department of Health and Ageing.
The highlight of the Annual Scientific Congress was without doubt the Younger Fellows and Trainees Dinner. Competition for tickets was intense again this year – book early for future dinners! Thanks to the work of Maree Weston (General Surgery SST and Royal Australasian College of Surgeons Trainees Association [RACSTA] Conference Representative), a superb venue, dinner and entertainment program were organised. A phenomenal display of dancing was provided by a number of Fellows and Trainees, with the supreme award going to Mr David Moss and Dr Estella Johns.

The Surgical Education Training (SET) program was covered in a number of forums. Presentations were directed at Fellows and covered the reasons for changing to SET, the current state of SET (applications – preparing for interviews) and the need for Fellows to be trained for assessment of Trainees during the SET years. The first Supervisors and Trainers Surgical Education Training (SATSET) course to train supervisors in mini-clinical exams, direct observation of procedures and 360-degree reviews was held at the conference. SATSET courses will be offered bi-nationally throughout 2007. On the final day of the conference, a panel discussion on SET was held and Trainees were represented by myself as the RACSTA Chair.

Our AGM was held on the Wednesday and covered RACSTA’s function, future elections and working parties. E-logbooks will be trialled on General Surgery Registrars in Otago NZ, Victoria and South Australia, at this stage from June this year. The Safe Working Hours draft document was discussed. RACSTA is producing a response to this which will be on our website. Input on the RACSTA welcome pack was received from the Trainees present. Further discussion was held on SET to help develop a letter to Mr Ian Civil, Censor-in-Chief and Professor John Collins, Dean of Education.

The Breast, Endocrine and Surgical Oncology Unit at the Royal Adelaide Hospital has a part-time (2 ½ days per week) training position available in 2008. The position is for 12 months and offers a broad exposure to breast, endocrine and surgical oncology patients.

Any interested Specialist Surgical Trainees should contact Dr Susan Neuhaus (+61 8 8222 4154) for further information.

Highlights from the ASC
‘Dancing with the stars’ at the Younger Fellows and Trainees Dinner was the talk of the congress

Part-time position available
The Breast, Endocrine and Surgical Oncology Unit at the Royal Adelaide Hospital has a part-time (2 ½ days per week) training position available in 2008. The position is for 12 months and offers a broad exposure to breast, endocrine and surgical oncology patients.

TRAINED ASSOCIATION

John Corboy, Chair, Trainees Association
AN EXTREMELY SUCCESSFUL ASC was enjoyed by 1,600 registrants in Christchurch, New Zealand commencing with the Convocation on 6 May, followed by the scientific meetings held over the week 7-11 May. A combination of outstanding speakers, an enjoyable and friendly venue, great weather and very good catering combined for a memorable 76th meeting. A total of 22 sections held scientific sessions, Masterclasses, workshops and keynote lectures. During some periods there were up to 12 sessions running in parallel in addition to the College workshops and the Natural Sciences lectures which proved to be very popular with delegates and associates. The plenary sessions highlighted the directions in which new technologies will be taking us as surgeons within the decade.

With such a cornucopia of parallel sessions it is physically impossible to attend every session that you wish to, unless your interests are very confined to a single field of endeavour. Fortunately our superlative audiovisual company, Kojo, with continuing funding from Ansell make it possible to see the programs you missed or to review the programs you attended.

You can access the Virtual Congress from the College’s website and you do not even need to remember your password. Go to www.surgeons.org and on the left of the homepage click on ‘Annual Scientific Congress’. On the ASC page click on ‘2007 Virtual Congress’. If you have not previously registered for the Congress or if your email address has changed since you logged on last, click on ‘Register’ and after providing the requested details, you will be taken to the Virtual Congress.

If you have registered before and your email address has not changed, then click on ‘LOGIN’ and enter your email address. The home page for the Virtual Congress offers two opportunities – at the top of the page you may click on ‘Scientific program’ and you will be taken to all the slide presentations catalogued according to the appropriate section in which they appeared. Lower on the page you may click on ‘Click here to view the webcasts of keynote speakers’ and you can view the 54 major presentations and over 20 hours that were filmed during the Congress. These cover all aspects of the meeting. In Breast surgery, Dr Chip Cody and his keynote presentation ‘Post-mastectomy and post-conservation local recurrence’; the RACS Visitor, Professor Rolland Parc discussing the limits of sphincter-saving operations for rectal cancer and also in another paper, discussing extra-corporeal circulation of intestinal effluent to avoid TPN; Dr John Dixon on the place of bariatric surgery in adolescent obesity and The Honourable Geoffrey Davies, RACS Visitor for the Medico-legal section and his RACS Lecture ‘Judging doctors’. There are speakers from the majority of the section programs at the Congress.

The entire Wednesday plenary session on the new Surgical Education and Training (SET) program has been recorded with presentations from the surgeons who are leading this innovative program – Russell Stitz, Ian Gough, Bruce Waxman, John Collins, Richard Perry and Ian Civit.

It is also possible to review the lectures from previous years in the archived Congress. This can be accessed from the same website. So if you did not attend the ASC you can review the entire scientific program (simply click the box “Congress program” and then find the papers in the Virtual Congress.

The College is extremely grateful to Ansell for their continuing support for the Virtual Congress.
Many doctors now utilise service companies or companies as trustees of family trusts. Also, many doctors are joining the boards of their hospitals, Colleges, professional societies and community organisations. These bodies are usually companies, and doctors will become directors with liabilities and obligations.

Common Law Duties
At law, directors occupy a special relationship with their company. It is similar to that of a trustee, and includes duties of loyalty and good faith. In general terms, the duties of directors fall into four overlapping categories:
1. A duty to act in the best interests of the company.
2. A duty to exercise the powers as a director for the purpose for which those powers are conferred.
3. A duty not to fetter the future exercise of the director’s power.
4. A duty to avoid being placed in a position of a conflict of interest.

The position of company directors is one in which the exercise of certain skills and discretions is involved. The directors are responsible for the management and affairs of the company and are generally called upon to make commercial decisions.

Whilst the courts will not usually interfere with the directors’ right to manage the affairs of the company, the courts will intervene if the standard of care or conduct of the directors falls below that expected.

The courts are not concerned whether the director has made the best decision, but rather “whether an intelligent and honest person in the position of a director of the company concerned could, in the circumstances, have reasonably believed that the transactions were for the benefit of the company”.

Where a director acts in breach of these general duties, he or she can be personally liable to the company for the loss or damage suffered by it, and for account to the company for any personal gain or benefit which the director may have derived.

Statutory Duties
There are additional statutory obligations imposed by the Corporations Act. The Corporations Act imposes obligations on directors:
1. To act honestly in good faith in the exercise of the director’s powers and discharge of his or her duties.
2. To exercise a reasonable degree of care and diligence.
3. Not make improper use of information acquired by virtue of their directorship to gain any personal advantage.
4. Not make improper use of the director’s position to gain any personal advantage.

Personal Liability
Usually a director is protected from personal liability for the actions of a company (other than clear cases of fraud by the director). However, in a number of situations, this protection can be removed.
1. Negligence.
2. Breach of the statutory obligations under the Corporations Act.

The test for whether a director has exercised due care and diligence is if they:
(a) make the judgment in good faith for a proper purpose; and
(b) do not have a material personal interest in the subject matter of the judgment; and
(c) inform themselves about the subject matter of the judgment to the extent they reasonably believe to be appropriate; and
(d) rationally believe that the judgment is in the best interests of the corporation.

In determining whether a director has breached their duties, or acted negligently, the courts will apply the standard based on the following principles:
(a) The degree of skill that may be expected is no more than may reasonably be expected from a person of that director’s knowledge and experience.
(b) If a director does have special knowledge about the company’s business, the director is required to give the company the benefit of that knowledge.
(c) A director is obliged to obtain at least a general understanding of the business of the company and the effect that the changing economy may have on that business, and directors should bring an informed and independent judgment to bear on the various matters that come to the Board for decision.
(d) The director must be diligent and, although only acting on an intermittent basis, the director is bound to attend regular meetings when the director is reasonably able to do so.
(e) Directors are able, in reasonable circumstances, to rely on the skills and honesty of others, but cannot, on a blanket basis, simply refer the management to others.

“There are many insurance policies available to protect both directors and their companies against claims for negligence, lack of professional duty, etc. Any company of significance, should, prudently, take out such directors’ liability insurance.”

Younger Fellows series
Doctors as directors – before you act!

Michael Gorton, College solicitor,

There are many insurance policies available to protect both directors and their companies against claims for negligence, lack of professional duty, etc. Any company of significance, should, prudently, take out such directors’ liability insurance.”

Michael Gorton, College solicitor,

There are many insurance policies available to protect both directors and their companies against claims for negligence, lack of professional duty, etc. Any company of significance, should, prudently, take out such directors’ liability insurance.”
Public Companies - Personal Interests/Conflict
The Corporations Act requires that, where a director of a public company (i.e., “Limited” compared with “Pty Ltd”) has a material personal interest in the matter under consideration, the director must not only not vote on the issue, but they must take no part in the debate and must physically leave the room. Of course, in the usual manner, notice of their interest must also be declared.

How Can I Minimise Risk?
1. There are many insurance policies available to protect both directors and their companies against claims for negligence, lack of professional duty, etc. Any company of significant size, it may be appropriate to establish a separate audit committee.

3. Companies can also offer Deeds of Indemnity – indemnifying directors for some liability which they may incur. Such Deeds also usually cover access to Board papers after retirement (to defend claims) and a contractual obligation to maintain directors’ insurance (especially after retirement, for future claims).

Michael Gorton
Partner Russell Kennedy Solicitors

STOP THE CLOT

Best practice guidelines for deep vein thrombosis still under used

THE RISK OF HOSPITALISED patients developing venous thromboembolism (deep vein thrombosis or pulmonary embolism) is 25 times greater than for air travellers and 100 times greater than for people in the community, yet use of best practice guidelines is suboptimal within Australian hospitals.

Venous thromboembolism (VTE) is one of the most common preventable causes of hospital deaths. There is strong evidence that effective measures such as anti-clotting medication, graduated compression stockings and early mobilisation can reduce the incidence of VTE.

In their first Evidence-Practice Gaps Report (2003), the National Institute of Clinical Studies (NICS), now an Institute of the National Health and Medical Research Council (NHMRC), identified the need for greater compliance with these preventive measures to reduce the incidence of VTE complications.

NICS established an Australia-wide VTE Prevention Program in collaboration with 40 hospital services to work with surgical, medical, nursing and allied health staff to improve risk assessment and management systems using a ‘whole of hospital’ approach.

The program is clearly regarded as successful by participating hospitals, who, halfway through, have already seen a 30 per cent improvement in compliance with best practice preventive measures in high risk patients.

The multidisciplinary teams are keen to share their collective knowledge and have developed the Stop the Clot guide, a resource for health professionals to ensure VTE prophylaxis is in line with best practice. It includes step-by-step guidance on system improvements, solutions to commonly encountered barriers, and practical resources, such as clinical audit and risk assessment forms, to use in the hospital setting.

To download copies of the Stop the Clot guide, along with its accompanying electronic resources, patient information brochures and posters, visit www.nhmrc.gov.au/nics.

Surgical News is serialising the Stop the Clot guide from this month. See page 13 for the first installment.
The scholarship has given Dr Morris the opportunity to learn research methodology and work under the supervision of respected scholars.

RESEARCH UNDERTAKEN BY Dr Melinda Morris, the RACS Surgeon Scientist Scholarship recipient for 2005, investigated adjuvant chemotherapy in the management of Stage II colon cancer.

Dr Morris, a Specialist Surgical Trainee from Perth, collected her research data via a population-based study of all Western Australian patients with bowel cancer over a ten-year period. The research identified a subset of ‘poor prognosis’ stage II colon cancers that have a significant survival advantage if adjuvant chemotherapy is administered.

Current national and international guidelines advocate surgery alone in the management of stage II disease, however there is a proviso that adjuvant chemotherapy may be considered in the presence of ‘markers of poor prognosis’. The research has provided clarification of pathological and molecular markers of poor prognosis in stage II colon cancer.

Dr Morris undertook her research as part of her PhD at the University of Western Australia and the Department of Surgery at the Sir Charles Gairdner Hospital under the supervision of Associate Professor Barry Iacopetta and Associate Professor Cameron Patel.

She said her thesis was now under examination but that she had already had her work published in the British Journal of Surgery, the International Journal of Colorectal Disease, the Anti-Cancer Research Journal, the British Journal of Cancer, the Journal of Molecular Diagnostics and the ANZ Journal of Surgery.

“‘I was very fortunate to have established a collaboration with Memorial Sloan-Kettering Cancer Centre, New York’”

II colon cancer, not only in the increasingly cost-effective driven health care system, but also ultimately in delivering individualized patient treatment in the management of cancer.

Dr Morris received the Surgeon Scientist Scholarship for two years which provided gross funding (including the 25 per cent provided by her research department) of $42,000 for 2005 and $60,000 for 2006. She is now completing her specialist surgical training as a Paediatric Surgeon at the Royal Perth Hospital.

She said she chose her subject of research because it offered the opportunity to work under the supervision of such internationally regarded scholars.

“I loved my time working in this field particularly the opportunity it presented to learn research methodology,” Dr Morris said.

“I was particularly honoured to have received the scholarship because research funding is so hard to find.

“I did my first year of research unfunded so to win the scholarship meant that I had a chance to put all my concentration into the work.

“If I could find a way to continue in research I would but at the moment am concentrating on finishing my specialist studies."

Dr Morris said that while the time out to learn research methodology was a great opportunity, she would now not finish her Paediatric Surgical training until 2011.

However she said that if possible she will pursue further research.

“It was a wonderful experience working with Associate Professor Iacopetta who is internationally recognized for his scholarship and with Associate Professor Patel who has great clinical experience,” she said.

“Now I would like to take on a post-doctorate research project but that will have to wait until I complete my surgical training.

“One of the best things about research is that time is your own but it’s a matter of taking the opportunities when they arise. I was very fortunate to have established a collaboration with Memorial Sloan-Kettering Cancer Centre, New York’”

The Surgeon Scientist Scholarship is open to Specialist Surgical Trainees or Fellows enrolled in, or intending to enroll in, a PhD.

Funding now comprises up to $57,500 stipend plus $10,000 departmental maintenance per year for up to three years.
Becoming a Fellow of the College

The College’s assessment system for International Medical Graduates is very encouraging and well structured.

GENERAL SURGEON DR Vivek Singh, an International Medical Graduate (IMG) from India and now a College Fellow, has nothing but praise for the College’s assessment system for overseas-trained surgeons.

He said he now takes the opportunity, when talking to young surgeons from overseas, to tell of his experiences in a system that he describes as “fair, systematic and encouraging”. He said suggestions that the assessment system was designed to exclude rather than include international medical graduates were wrong.

“It is reasonable for people who have come from another country with different training methods and standards to go through a process of accreditation,” Dr Singh said.

My experience has been one of open, enthusiastic engagement, during which I felt that every interaction I had with the College was helpful and supportive.

“I now try and share this experience whenever I can because I know of some international graduates who have been deterred from trying to win positions in Australia because they think it will be too difficult.”

Dr Singh, a general surgeon with a post-doctorate degree in gastro-intestinal surgery, had been a consultant general surgeon in New Delhi for five years before he decided to relocate his family to a developed country. He applied for a position advertised on the internet at Inverell, NSW, and arrived in September 2003. As an area-of-need position, Dr Singh was assigned two supervisors to mentor his progress for two years and advised of his log book requirements and the documentation he would need from supervisors. At that time he was also told that he would have to sit the Part II FRACS exam.

Ultimately, that was unnecessary given his training and experience. “At the time, given that I had passed Fellowship Exams in India and the UK, sitting another examination felt like a backward step but I understood the process. In the first two years I had been preparing for that exam but then I had my second interview with representatives of the College who looked at all my experience in Australia and in India and the UK and deemed the exam could be avoided,” Dr Singh said.

“I felt I was given a fair hearing and fortunately, I was then awarded my College Fellowship. I consider it a great honour for me to be a fellow of this esteemed college.”

Dr Singh saved special praise for his supervisors, Dr Jeff Myers from Armidale and Dr John Fisher from Tamworth, and he said they helped steer him through the process. Dr Singh said the accreditation and specialty recognition processes were reasonable when training and accreditation systems varied so greatly between countries.

He said while his training in India was of world standard, that standard did not apply across the country. “In India there is no central college overlooking the processes of training and accreditation,” he said. “Therefore standards vary depending on the university and depending on regions, some of which have more money for technology and training, for instance, than others.”

Dr Singh spent the first two years of his time in Australia in Inverell before spending another year in Shepparton, Victoria. He is now working at the Tamworth Base Hospital, where he hopes to stay. His wife, who was an ophthalmologist in India, is now studying to become a general practitioner and their children have settled into their new schools.

“One of the most difficult things you can ever do is uproot the family to start a new life in a new country but that is the price you pay for wanting the best for them. Now I hope my practice develops well here so that we can settle into the community,” Dr Singh said.

Dr Singh, who has a brother in Sydney, has now become a permanent resident but travels home each year to visit his parents. He also travels to professional development conferences at which he spreads the news of his experience within the Australian system.

He said while there is no doubt that the system is complex because there are so many layers of Government involved, the College goes out of its way to steer IMG through.

“I totally disagree with suggestions that the assessment processes are part of some kind of closed shop mentality. Many of my friends have had a similar experience as I have so I try to explain to younger graduates that if they approach the situation with a positive attitude and if they previously have had adequate training, there is a good chance that everything will go well,” he said.

“I tell them that if they have heard negative stories they should take them on a case by case basis and not think it is too hard or that the system is there to hinder them. I found the system very encouraging, very well structured, easy to follow and most importantly, fair.”
VTE continues to be a major cause of preventable morbidity and mortality among hospitalised patients, whose risk of developing VTE is 100 times greater than those in the community. Eighty per cent of VTE cases are attributable to hospital admissions.

The evidence base surrounding VTE prevention is clear, yet simple prophylactic measures that are known to dramatically reduce the risk of VTE remain underused within many Australian hospitals.

The NHMRC’s National Institute of Clinical Studies (NICS) is running a national VTE prevention program, working with 40 hospitals across Australia to improve the use of VTE prophylaxis.

NICS’ latest publication, Stop the Clot: Integrating VTE prevention guideline recommendations into routine hospital care, provides practical step-by-step guidance for health professionals to ensure that best practice is being followed in this important clinical area. Surgical News will be serialising the Stop the Clot guide in coming issues. This month we publish the introduction.

Background
Each year about 30,000 people in Australia are hospitalised due to venous thromboembolism (VTE), and an estimated 2000 die as a result, equivalent to the number of people who die annually from transport accidents. For those who survive, there are significant long term costs and consequences.

The majority of VTE cases requiring hospitalisation are related to prior hospitalisation for either surgery or an acute illness. Many of these cases are preventable using safe, efficacious, cost-effective and proven measures. A number of evidence-based guidelines that outline the appropriate interventions to prevent VTE have been available since the early 1990s. In spite of these, the problem persists and continues to be under-utilised.

This situation is not unique to Australia. There are many well-documented reasons why VTE prevention continues to be a challenge across a range of health care settings and clinical conditions. Fortunately, there are effective strategies that have been used to increase the uptake of VTE prophylaxis for patients.

This guide:

• Provides clinicians and risk managers with practical advice on how to ensure that thromboprophylaxis in their health service is in line with best practice.
• Draws on a systematic review of Australian and international experience in introducing and sustaining improvements in VTE prevention, and NICS’ own experience in this area. The suggested steps apply to any health service providing acute and subacute care – metropolitan or country, big or small.
• Covers the main issues that need to be considered when developing a local clinical practice improvement plan as well as providing other resources for further reading.
• Answers typical questions facing clinical practice improvement teams, such as:
  – Do we have a problem?
  – Why do we have a problem?
  – What do we tackle first?
  – Who should be included in the team?
  – How do we engage others?
  – What works best to improve practice in this area?
  – What changes should we try in our hospital?
  – What monitoring do we need to keep improvements on track?
  – How can we make sure we sustain the changes?

Essentially, this guide brings together the experiences of others and attempts to shorten the journey of clinical practice improvement for people who are just starting out or have tried and are looking for new ideas.

For simplicity, we have arranged the advice in the form of a handy step-by-step guide. In practice, you may decide to run a number of the steps together. It is not our intention to impose a rigid structure but we have tried to present the steps in a logical order.

Changing practice takes time. Anyone embarking on a program of clinical practice improvement in this area needs to make a long-term commitment. As a rough guide you would expect that within 12 months you will have developed a whole of hospital policy, audited data on current practice and tested and evaluated a number of change ideas described in this guide. Realistically, within two years you would expect to have embedded new risk assessment and management processes into standard routines, have processes in place to orient new staff and be regularly monitoring compliance.

This process needs resources and executive endorsement for people to do the necessary work. However, the process doesn’t have to be led from the top. People within organisations who don’t necessarily hold official roles in quality improvement can instigate moves towards getting better care processes in place. Clinical leadership is required and clinical leaders in VTE prophylaxis come from a wide range of disciplines.

Enclosed with this guide is a CD containing supporting material. For each step you’ll find additional resources that you can adapt to your local setting.

Next month Surgical News will publish Step 1: Check existing policies.

A full text version of the Stop the Clot guide, and its associated electronic resources, can be downloaded from www.nhmrc.gov.au/nics.

References on page 33
The practice of using human bodies for surgical research and training has a long and chequered history – and the controversy is far from over

**Anatomy Acts**

**T**hey say that if you can remember the sixties you were not part of the changing times. I can remember the sixties, but they were over by the time I commenced my surgical training, and so was the apprenticeship model for surgical training – but only just, on both accounts. Only a decade or two earlier, would-be surgeons were apprenticed to a small number of surgeons confined to a single Teaching Hospital. Rotations were entirely in-house, everyone trained in general surgery, and approval to sit for the Fellowship examination was granted only when the surgeons as a group felt that the product of their training was ready for external display.

The primary examination, conducted viva voce, served as a gateway to training and required a very detailed knowledge of anatomy. Many would-be surgeons took full-time jobs as anatomy demonstrators to get them up to speed. As I shall explain, there were strong traditions behind an emphasis that might now seem to have been disproportionate.

Most surgeons know that William Harvey (1578–1657) discovered the circulation. It is less well known that, although an Englishman, Harvey did much of his pioneering anatomical work in Italy, largely because at the time it was difficult to obtain bodies for scientific study in England. In the 16th century, the royal patronage of Henry VIII made four executed criminals a year available to science. In the 17th century, Charles II increased the number to six. Later on, some murderers were sentenced to both death and dissection. Demand for bodies always exceeded supply and Harvey is believed to have dissected both his father and his sister in his quest for knowledge. In Europe, however, the bodies of those who died in hospitals for the poor were legitimately available to science. Leonardo Da Vinci (1452–1519), as an art student, was given permission to dissect human corpses at the hospital Santa Maria Nuova in Florence, where he worked for a year from 1510 to produce his wonderful human anatomical drawings, many of which survive.

William Cheselden (1666–1709), a surgeon at St Thomas’ in London from 1710, published an anatomy text book in English (rather than Latin) in 1713 which was a big seller, and set up his own (co-located) anatomy school for aspiring surgeons. The Hunter brothers established a museum of anatomy alongside their Scottish anatomy school, and opened it to the public – shades of Gunther von Hagens, whose *Anatomy for Beginners* is currently being shown on SBS television. Thus we have a pattern of integration of medical schools, bodies, dissection and public curiosity established well before the turn of the 19th century.

But the worst was still to come – in the form of Burke and Hare, the former a tenant of the latter, whose collaboration at an urban boarding house provided bodies to the Edinburgh Medical College, principally through the hands of Dr Robert Knox. It all started with a dead tenant who owed four pounds’ rent, but escalated to the murder of pensioners and prostitutes. The conspirators were paid up to 15 pounds for a fresh body – an extraordinary sum at the time. The scandal that followed these “West Port Murders”, and the similar activities of the “London Burkers”, led to the Anatomy Act of 1832, which markedly expanded the legal supply of cadavers. Hare became a prosecution witness in the case against Burke; Knox somehow evaded prosecution. In a particularly quirky twist, the skin from Burke’s (executed) body was used to cover a book which survives among the collection of the RCS Edinburgh. And of course the public attention inspired *The Body Snatcher* by Robert Louis Stevenson and no doubt helped the sales of Mary Shelley’s...
“Dissection also provides an opportunity for Trainees to address our common human fascination with the macabre as well as the social taboos surrounding death and body parts.”

Frankenstein, which had been published a few years previously. The medical historian Roy Porter refers to “the dark underbelly of surgery and anatomy” with respect to the practice of seizing bodies without consent.

Perhaps the dark underbelly was exposed again in 2001, when the current affairs television program Sunday made spectacular revelations about experiments on corpses and provision of their body parts, without the knowledge of their relatives, from Sydney’s Glebe Morgue, describing it as “virtually a body parts supermarket for medical researchers”.

“Doctors were allowed to come in if they had a particular research project. They were allowed to come in and get what they needed,” a former morgue worker told Sunday. Some of these specimens were apparently acquired for use in surgical training.

Many have suggested that the bodies they dissect have meant more to medical students over the years than just anatomy; and more again than just an opportunity to learn technical skills. Bodies also act as surrogate patients, allowing unimaginable intimacy with what was, until recently, a living person. Handling a dead body is a potent reminder of mortality and of every physician’s need to disassociate his own from his patients’. Dissection also provides an opportunity for Trainees to address our common human fascination with the macabre as well as the social taboos surrounding death and body parts.

We now live in a time when the need for medical students to access human bodies is diminishing and we may need to completely retrain ourselves from their use. The quality of computerised anatomical demonstrations has reached a level of sophistication that will allow a full three-dimensional understanding of the subject without any need for students to assemble around the formalin-fixed remains of persons. As change occurs, we need to be mindful of the other aspects of the dissection experience. We are working on seeing that basic surgical skills are acquired in simulated environments. With good mentoring, doctors can be steered through the challenges of intimacy with live patients. And we will need to be mindful that our work varies in the extent to which it is dehumanising, and remember how offensive inappropriate conduct can be to those who have not been similarly desensitised, including increasing numbers of our colleagues.

SABBATICAL FELLOWSHIP

Applications are invited for a Sabbatical Fellowship in Otorhinolaryngology Head and Neck Surgery to commence in 2008.

Applicants are expected to be well-established Australian or New Zealand Otolaryngologists who wish to undertake a period of specific training or study to advance their specialist knowledge or expertise, or to undertake a period of research.

The Fellowship will be for a minimum period of six months, but no more than twelve months, and the stipend offered will be AUD100,000 per annum pro-rated, depending on the duration. The successful applicant may also be provided with a contribution towards his or her airfares together with living and family allowances.

Applications in writing are to be accompanied by a full curriculum vitae, a two-page outline of the proposed training/study or research, the names of three referees and a statement of acceptance from the Head of Department in the university or research institute where the applicant intends to work.

Closing Date: 24 August 2007

PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2008.

Project Grants are for a period of up to three years and must be conducted in an Australian or New Zealand university, teaching hospital or research institute. Individuals with a previous history of support from the Foundation are particularly encouraged to apply. Please note that current awardees and recipients of a Scholarship in Otolaryngology Head and Neck Surgery, whose grants or scholarships are due to conclude after 30 June 2008, are ineligible.

The annual level of support will be up to AUD90,000 and, within this cap, grants must include the salary of the applicant and/or research assistant(s), on-costs, maintenance, equipment and all other costs. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 24 August 2007

GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2008.

Grants-In-Aid are for a period of up to two years and must be conducted in an Australian or New Zealand university, teaching hospital or research institute. Otolaryngologists or Trainees in the Specialty who are in possession of the First Part of the F.R.A.C.S. are eligible to apply. Please note that current awardees and recipients of a Scholarship in Otolaryngology Head and Neck Surgery, whose grants or scholarships are due to conclude after 30 June 2008, are ineligible.

The annual level of support will be up to AUD50,000 and grants are restricted to equipment and maintenance. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 24 August 2007
The American College of Surgeons offers International Guest Scholarships to competent young surgeons from countries other than the United States or Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $US8000 each, provide Scholars with an opportunity to visit clinical, teaching, and research activities in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons Clinical Congress.

The Scholarship Requirements are:

Applicants must be graduates of schools of medicine.
Applicants must be at least 35 years old, but no older than 44, on the date that the completed application is filed.
Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant’s country.

Formal American College of Surgeons International Guest Scholar applications appear on the College’s website:
http://www.facs.org/memberservices/igs.html

Supporting materials and questions should be directed to:

Administrator
International Liaison Section
American College of Surgeons
633 N. Saint Clair St
Chicago, IL 60611-3211
USA
Fax: +1-312-202 5021
Email: kearly@facs.org

Completed applications for the International Guest Scholarships for the year 2008 and all of the supporting documentation must be received at the office of the International Liaison Section prior to July 1, 2007.
I AM NEW to Council and thought that I would write down my first impressions. As a person who has not had a lot to do with College matters in the past, I may seem ignorant, but then I suspect that many readers and Fellows will be similarly ignorant. On entering the Council room for the first time, I was struck by the size of it. The centre of the room is dominated by a very large and long table that can easily accommodate 30 people seated. Around the periphery are tables and seats for about 20 other persons.

My first thought was “Why so many?” I realised that there were 16 Councillors elected from the Fellowship at large and nine specialties, all of whom have an elected member. They are Cardio-thoracic, Urology, Plastic & Reconstructive, Neurosurgery, Paediatric Surgery, Orthopaedics, Vascular, ENT and General Surgery. I was a little surprised to see that General Surgery was considered a Specialty, as I always thought that the College was run by East Coast academic general surgeons. However, as I run my eye down the list of Council members, I see that there are only four who could vaguely be described as such. I am surprised to see such a spread of Councillors. Even small specialties such as Neurosurgery and Cardio-thoracic have two elected councillors.

I am also puzzled by the tables and chairs around the periphery. Who are all these extra persons? In time, I learn that these people are the staff who are charged with carrying out the decisions of Council. In time, I also learn that the College has four major divisions (Resources, Relationships, Education and Fellowship) and that each division has a director who runs that area.

On the first morning, I meet Ian Burke, Director of Resources. It is hard not to meet him on the first morning, as apparently tradition has it that in the time between morning tea and lunch the Treasurer takes over and examines the finances of the College. They are complicated and quite involved. Ian answers questions from Councillors regarding such points as why the “allocative funding model” is different for projects compared to other activities (I hope in a later article to try to answer this – first I must understand it!). To say that I was a little confused in this session is an understatement. I do, however, note that the more experienced Councillors ask what appear to be intelligent questions and are greeted not with guffaws of laughter but with equally intelligent answers. I also note that those who have a lot to say when matters of eduction are discussed seem to have little to say about resources. Is there an education clique and a resources bunch? I don’t know at this stage.

The other puzzling thing occurred at the start of the resources session after morning tea. About five or six Councillors to the right of the President suddenly vacated their seats for some new persons who entered the room. Had the Councillors been fired or offended the President? No. The newcomers were the team of financial advisors – retired accountants, business persons and stockbrokers. This must cost the College a bit, I think. It turns out that these persons do this task on a voluntary basis. We surgeons thought that we had a monopoly on pro bono work.

I soon learn that their task is not just two hours on the last Thursday in February, June and October, but that there exists an Audit Committee, a Resources Committee and an Investment Committee; all of these have met in the days prior to Council and indeed have met monthly in the case of Investment Committee. ‘Why do these financial experts do this?’ I ask. Mr Experienced Councillor to my left tells me it is for the honour of being associated with the College. I must remember this next time someone in the tea room rubbishes the College.
CRITICAL ISSUES AFFECTING the surgical profession, such as the increasing drift of surgeons into the private sector, the rising rates of professional burnout and the severe shortage of surgeons in rural areas were some of the main issues discussed at last month’s Annual Scientific Congress held in New Zealand, Christchurch.

More than 1500 surgeons from around Australia and New Zealand attended the 76th Annual Congress held at the Christchurch Convention centre, with more than 800 papers delivered on issues impacting on the profession as well as technological and training developments and the launch of public health campaigns.

New Zealand-trained Professor Murray Brennan from the prestigious Memorial Sloan Kettering Centre in New York said the drift by surgeons from the public to the private sector meant that the long-dreaded two-tiered system that operates in the USA was now a reality in New Zealand and Australia. He said that the growth in private insurance meant we now had a system where privately insured patients received timely care, while the uninsured sick had to wait.

“We need to put the patient first instead of a financial agenda and it is appropriate that Government pays for a safety net. In America, we have failed in the delivery of health care to the 40 million people that are not insured,” Professor Brennan told the Congress.

Alarming results of a recent RACS survey on surgeons’ working patterns show they now spend at least 60 per cent of their working time in private hospitals because, they say, they are so fed up with the public system. Past College President Russell Stitz described the findings as a “huge concern”.

“The problem is how are we going to get surgeons back into the public system? ... What we found [in the survey] is that the existing surgical workforce is already overstretched and works longer hours than any other field of medicine.”

Continually restricting operating time, closing operating theatres for longer than necessary during holiday periods, not paying bills for essential equipment so surgeons can’t operate, not opening enough beds, [and] not employing enough nurses is not going to attract anyone. What we found [in the survey] is that the existing surgical workforce is already overstretched and works longer hours than any other field of medicine.

“We know that the demand for surgery will increase by 50 per cent in the next 20 years ... but there are limited opportunities for training surgeons in the private sector, which rather beg the question: ‘Who is going to be left to train for surgery in the future?’”

That dismal outlook was re-enforced at the Congress with research presented that showed that professional burnout was now a significant problem for surgeons.

Ms Sarah Benson, Manager of General Surgeons Australia, presented the findings of a study that examined the extent of burnout and the relationship between burnout and emotional intelligence in 126 Australian surgeons and surgical trainees. It found that 48 per cent of the surgical sample reported high general burnout levels, while 40 per cent reported high work-related burnout levels. She said the study also found that there was an inverse relationship between age and burnout, with younger, less experienced surgeons reporting significantly higher levels of stress.

“The serious individual and social consequences of burnout are well established and include extreme fatigue, insomnia, increases in drug and alcohol use, depression, relationship breakdown, low self-esteem, anxiety and suicide,” Ms Benson told the Congress.

“We were surprised that the surgical population reported signifi-
significantly higher general and work-related burnout levels than were found in studies of other human service workers and dentists.

“The study also found an inverse relationship between emotional intelligence and burnout. Emotional intelligence involves monitoring, understanding and managing the emotions of self and others, and surgeons with greater strength in these areas reported lower overall levels of burnout. Emotional intelligence training should be included in the surgical training program throughout Australia and New Zealand.”

Creating mentoring relationships and stronger professional bonds and opportunities were also required if more surgeons were to stay in the profession or move to areas where they were desperately needed, the Congress was told.

Dr Phillip Bagshaw, a general surgeon from Christchurch, described the severe shortage of surgeons in rural New Zealand as critical. He said the shortage was so bad that in 25 years there may only be five or six hospitals left in New Zealand.

“If we look at the five most deprived areas in New Zealand, counties such as Manukau, Lakes, Northland, Taarawhiti and Whanganui, where over 40 per cent of the population lives, then you realize there is no equity in outcomes. Not only are the residents of the areas poor, with a much higher proportion of Maori people, but their overall health status is very poor and getting worse. In the 21st century, this is shocking,” Dr Bagshaw said.

The Congress was also used to launch public campaigns to raise the age of unrestricted driving licenses in New Zealand and to push for parents to lock away air rifles.

Dr Cathy Ferguson, the Chair of the College’s New Zealand National Board, said New Zealand, where people as young as 17 can gain unrestricted licenses, was now second only to the US in road fatality rates in the 15–24 age group. Current rates are now more than 50 per cent higher than in Australia, where full licenses are not available until 20 years of age.

She called on the Government to have the courage to change the law.

“We remind the community of the opposition to compulsory seat belt legislation in the 1970s,” Dr Ferguson told the Congress.

“It was the insistence of the College, together with appropriate publicity, which changed the community’s view on the wearing of seat belts from one of disdain to one of acceptance.”

Christchurch Trainee surgeon Dr Adrian Skinner presented research showing that gun-shot wounds in children were increasing in New Zealand. In 1996 there were only two children shot. By 2004 that figure had increased to 11.

Dr Skinner said there were over a million guns in New Zealand, the majority of them air rifles, which in recent years have caused injury and death. He said they should be locked away for the safety of children.

An American trauma expert also gave a paper to the Congress discussing the failure in dealing with Hurricane Katrina and the Twin Towers disaster. Dr Michael Bosse said the most important thing learned from the disasters was that only one person should be in command and that person should be from the military.

“In Hurricane Katrina there were too many cooks in the kitchen, with everybody in charge and no one in charge, and the so-called decision makers did not know the plan.

“Primarily you need to assign overall responsibility to seasoned professionals, not politicians or political appointees.”

Professor Guy Madden, Chair of the College’s Surgical Mortality Audit, used the Congress to call for the establishment of a national audit of deaths from surgery in New Zealand. He said such audits, now established in most Australian states, saved lives by changing clinical practice, and that plans for an audit in New Zealand had not progressed.

“This is not about finding scapegoats or blaming or shaming, it is about how we can improve surgical performance to get better results. If surgeons want to retain the confidence of the public they need to demonstrate that they are involved in a patient safety program,” he said.
1. Russell Stitz, Sonja Latzel & John Collins judging the dancing at the Younger Fellows & Trainees dinner
2. Peter Sharwood, Michael & Ellen Bosse, Robert & Pauline Atkinson
3. Graeme Campbell, Samuel Kwok, David Watters & John Graham
4. Fiona Neary & David Griffith
5. Andrew Sutherland & D’Arcy Sutherland
6. Justin Roake & John Mercer
7. Patrick Cregan demonstrating surgical simulation
8. Samuel & Kristina Kwok
9. Rosalyn & Natasha Pochin with Ian Civil

Photos courtesy of John Aloysius Henderson
The photos are available on CD & DVD, please contact John Aloysius Henderson
+61 418 158 881
10. Donald Murphy & Cas McNees at the International Antarctic Centre
11. Russell Stitz & Andrew Sutherland with the Johnson & Johnson team
12. Annette Holian & Peter Sharwood
13. John & Angela Masterton, Patrick Cregan & Martin Jones
14. Estella Johns & Dave Moss
15. John Orr, Iain Macintyre, Robert Pearce & Russell Stitz
16. Justine Peterson & Sam Mellick
17. David San Tju & Maree Weston
18. Rob & Pip Robertson
1. Phil Truskett, Malcom Ward, Rob Robertson, Maira Truskett, Hugh & Leslie Carmalt
2. Grant Christey & Maree Weston
3. Wyn Beasley & Phil Sharp
4. Helen O’Connell, Sibby Sutherland, Jennifer Martin, Andrew Sutherland & Anne Deane
5. Ian Civil & James Church
6. Smariti Kapila, Arun Mahajani, Kiriti & Hari Kapila
7. John Corboy, Mary Theophilus, Maree Weston, Kathy Hickey & Fritha Noonan
8. Rowan Nicks, Sibby, D’Arcy & Andrew Sutherland
10. Nagham Al-Mozany & Sam Adie
11. Richard Benny, Lister Lunn, Rooney Jagilley, Rowan Nicks & Manjul Joshipura
12. Rick Tau & Stephen Deane greeting each other with the traditional Maori greeting
13. Siew Kheong Lum & David Minch
14. Russell & Anne Sitz
15. Kathleen & Kingsley Faulkner with Heather Anne & Peter Field
1. Paddy & Peter Cant
2. David Scott, Maria & Peter Woodruff
3. Ian Dickinson, David Watters & John Simpson
4. Stuart Gowland, Gwen Morgan & Brian Morgan
5. Mark & Tessa Smith with their baby & Ann Pethybridge
6. Phil Sharp & Danny Cass
7. Justin Roake, John Mercer & Rob Robertson
8. Catherine Turner, David San Tjiu & Nicole Yap
9. Victor Golpak, George Gende, Rooney Jagilly, Robert Presley, Sauia Piukala, David Watters, Kiti Maade, Lister Lunn, Ifereimi Wagainabete, Siti Traill, Ben Yapo & Glen Guest
ROYAL AUSTRALASIANS COLLEGE OF SURGEONS (RACS)
CONVENERS’ LETTER

We wish to invite you to attend the Conjoint Annual Scientific Meeting of the College of Surgeons of Hong Kong and the Royal Australasian College of Surgeons to be held in Hong Kong in May 2008. It is now over twenty years since the Australasian College last held its Annual Meeting in Hong Kong.

As the Colleges represent surgeons from Hong Kong and all surgeons in New Zealand and Australia respectively, this will be a truly international meeting. A very wide range of interests and craft groups will be represented including plastic surgery. Guest speakers from Asia and the Pacific, Europe and North America have been invited.

We particularly welcome the participation of surgeons from China and all around Asia.

The theme of this meeting will be Advancement through Collaboration and will showcase the benefits to patients and clinicians derived from co-operative management between related surgical craft groups.

The Plenary sessions will focus on State of the Art Technology in Surgery, Short Stay and Minimally Invasive Surgery, Credentialling of Surgeons and Assessment and Remediation of Surgical Practice.

The Hong Kong Convention Centre is a spectacular venue sitting on the edge of the harbour. Please join us in what will be a memorable Scientific Congress and also enjoy the culinary, cultural and social delights that Hong Kong has to offer.

COLLEGE OF SURGEONS OF HONG KONG (CSHK)
CONVENERS’ LETTER

It is a great pleasure for both of us to present to you the Conjoint Annual Scientific Congress.

It is the very first time in history that the two Surgical Colleges, the Royal Australasian College of Surgeons and the College of Surgeons of Hong Kong, will join hands to organise a large scale surgical meeting in May 2008 in Hong Kong. This meeting will gather together prominent surgeons from multiple specialties and subspecialties in surgery from the Asia Pacific region and also from all over the world to explore new frontiers in surgery. This meeting will definitely offer you a unique opportunity to keep abreast and update your knowledge on surgical topics and share experiences in new advances in a spectrum of surgical specialties.

Hong Kong is privileged to have the opportunity to host this conjoint meeting. In this dynamic city where the cultures of the East and West meet in this part of the world, you can be guaranteed a memorable experience and wonderful hospitality. Please do not miss this singular event where you can have both academic and social exchanges in a most friendly and enjoyable environment.

We look forward to welcoming you in person in Hong Kong.
are a number of situations where this occurs. There may be generic and based on the mechanisms of the events rather than the specific information. There are a number of situations where this occurs.

(i) The settlement of a claim after the commencement of legal action may occur at mediation or prior to the hearing in court. This may involve the payment of money by the surgeon’s medical defence organization and the details will be confidential.

(ii) A claim for compensation may be made directly to the surgeon by the patient or the patient’s lawyer and will be managed by the medical defence organization as an unlitigated claim. This will remain confidential.

(iii) A claim for compensation for payment of costs sustained by the patient may be made in the Local Court and is unlikely to be publicized.

(iv) Complaints to the Health Care Complaints Commission remain confidential.

Post-operative complications should put the surgeon on notice that in order to satisfy a medico-legal scrutiny of the care provided, a high standard of care will be required for the entire doctor-patient interaction. The standard of care required is that expected by a peer expert in the particular field that the surgeon practices in. It is not the standard determined by a court, but rather the standard that will be expected by the court if the case were to reach it.

In NSW, for a patient to commence legal action the solicitor must obtain an expert opinion indicating that the standard of care fell below the reasonable standard for that particular operation. The solicitor must comply with the Civil Liability Act and submit the expert report with the Statement of Claim.

The areas in which the surgeon will be scrutinized are usually:

(i) warnings and failure to warn;
(ii) conduct of the procedure; and
(iii) conduct of the post-operative course.

Examples of cases where a disastrous outcome will require a high standard of care for the entire management include paraplegia following spinal surgery, infection following joint replacement surgery and major biliary injury following laparoscopic cholecystectomy. In each case the surgeon would be expected to have considered every possible alternative and outcome, done everything reasonably possible and obtained every reasonably possible assistance and opinions. The patient might be best managed by referral to a colleague or referral to a major centre of excellence. This is a situation where a professor might be handy.

The worse the possible outcome is the more assistance and advice should be sought. The aim is not to leave any options unconsidered or stones unturned. Surgeons should expect the expert peer reviewer to be thorough in the assessment and criticism of the case. The expert will look at the case from an objective and detached viewpoint and will uncover any faults and failings in the entire doctor-patient relationship. Assume that the expert will consider all the possible options, tests, investigations and alternatives in an effort to be critical and show where the surgeon went wrong. You should always ask yourself: “Is there anything else which should be done?” and “What can be done?”

Some medical negligence claims cannot be defended because there were no warnings of risks and complications given at the time of consultation for consent, or the medical records are so bad that an allegation that warnings were not given will be believed by the court. Other claims are settled because the procedure was carried out poorly or incorrectly. Here the fault is easy to understand. However, there are claims that have to be settled in which consent was adequately obtained and the procedure was carried out appropriately, but the post-operative conduct was below standard. In these cases the surgeon failed to consider or treat the complication in a timely manner or failed to treat the complication appropriately. This failure can even occur very late in the time sequence, when the surgeon had been previously adequate but then had a lapse in the standard of care.

Advice for the surgeon

(i) Be honest and explain. Provide the patient and the family with an honest and truthful report of the events, the pathology, the surgery, the complications, the proposed strategy and the alternatives to the treatment with the possible outcomes.
(ii) Be available and involved.
(iii) Seek assistance and advice early. The options are:
(a) A second opinion to confirm the management plan and maintain a team approach if involvement in the management is continued; or
(b) Referral to a larger centre, a teaching hospital or to another surgical team and break the management relationship with the patient.
(iv) If you continue to manage the patient you must maintain a high standard and not drop the ball.

Conclusion

The courts will understand that complications will occur even with the highest standards of care. However, the courts will expect a high standard of care in the management of complications. The standard of care required must be enough to answer reasonable criticism which will be provided by another surgeon.
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DR GRAEME HOUGHTON and Dr Roger Mitchell, both general surgeons and members of a unique four-man partnership, were anonymously nominated for the award which they received at the State Library of Victoria from Treasurer John Brumby.

Dr Houghton introduced vascular surgery to his region, setting up the first vascular unit in the Ballarat Health Services Base Hospital, where he was Director of Surgery until he retired in 2005.

Dr Mitchell, who grew up in Ballarat, returned on rotation from the Royal Melbourne and after post-graduate training abroad. He spent his career as a general surgeon in Ballarat, as well as conducting procedures in neighbouring towns.

Both men said they were extremely honoured to receive the award, which they said also recognized the contribution of their wives and families before the days of instant communication.

“In the early days, it was quite challenging to be a surgeon outside a capital city,” Dr Houghton said.

“There were no mobiles then, no answering machines, the roads were not what they are now, so it was quite difficult for family members on nights and weekends always taking messages and trying to track us down.

“So it is appropriate that these awards recognize their contribution too.”

Both men said the work as general surgeons then was complex and varied with no plastic surgeons and only one orthopaedic surgeon in Ballarat.

“Road trauma was significant then, at that time before seatbelts in cars and helmets for motorcyclists, so the work was extremely complicated,” Dr Houghton said.

“Now a chopper comes out from Melbourne and takes them back to a specialist unit in the city, but then we had to deal with severe burns, with bones (and) with blood loss, because transporting the patient took longer.

“People sub-specialise very early now and they don’t get the wide training and experience that was just an everyday occurrence for us.”

Dr Houghton also said that one of the great challenges of working in the region was what he termed the “supermarket audit”.

“We were basically being audited all the time, before more formal structures were introduced, because if we had a bad result we would see them every week at the supermarket,” he laughed.

“We were constantly being monitored and audited by those at the bowls club, (or) at the pub, but if you are doing good work in a rural community, that community helps you achieve your aims, which is one of the great rewards of working in the country.”

Dr Mitchell said that constant public assessment had also proven challenging when he returned as a registrar.

“It was quite daunting when I returned to Ballarat because some of my patients remembered me as a boy and let me know,” he laughed.

“But the work was extremely interesting and far broader than that of our city colleagues, even then. We did neurosurgery, vascular, thoracic, plastics, head and neck, paediatric surgery, burns and bones.

“Some people are very happy to work in a narrow area but I like the broad nature of the work in a rural area.”

Dr Mitchell said he particularly enjoyed travelling to smaller communities to work.

“I used to spend half a day operating each week at small towns outside Ballarat,” he said.

“We would operate in the small country hospitals with the local GP, often doing the anaesthesia, and the results were very good, with very low rates of infection.

“We always gave people the option but almost all would choose to have the surgery in the country town if they could.

“Before systems were put in place, this more informal way of working offered a very good interface with the GPs and allowed for excellent skills transfer and, very importantly, provided a great home-cooked lunch.

“They were interesting times and I feel honoured to receive this award for our efforts over that time, but mainly I hope such awards act as a boost to encourage people to go into rural practice.”

The Rural Workforce Agency, Victoria (RWAV) initiated and supports these Awards. They are also sponsored by the Victorian Managed Insurance Authority (VMIA).
Risk Management Master Class for Neurosurgeons:
Saturday 25 August 2007, Melbourne.

The 2007 Neurosurgery Master Class is a full day workshop helping participants to develop a high level of skills training to reduce risk of litigation and improve surgeon/patient communication. The morning session uses a series of brief presentations and relevant case studies to highlight issues such as communication, consent, patient selection and handling complex patients. In the afternoon the workshop breaks into small groups and participants have the opportunity to refine their new skills through role plays with highly trained actors focusing on common challenging patient situations unique to their specialty. During this session participants can gain valuable feedback from the facilitator and their peers.

Cost: $535. CPD 19.

Risk Management Foundation:
Mastering Adverse Outcomes
Saturday 1 September, Brisbane.

This full day Risk Management workshop explores general Risk Management principles and how to develop a patient centric practice. The afternoon session focuses on managing the challenges associated with adverse surgical outcomes. The morning session is designed for surgeons and their practice managers to explore practice styles and systems that support patients and protect you through the surgical continuum both in your rooms and in the hospital wards. This is the first session of its kind to cater to surgeons and practice managers. The inclusion of practice managers in the educational journey is designed to inform practice managers as well as surgeons about how to assess and minimise the risks faced by their practice.

The afternoon session specifically for surgeons focuses on the challenges of dealing with real or perceived adverse outcomes. Whether caused by human error or otherwise, eventually all surgeons will need to have these difficult conversations. This workshop aims to provide surgeons with the necessary information and skills to handle these situations. At the completion of this session, participants should understand their ethical and legal requirements to disclose details of adverse outcomes as well as communication strategies to empathise with patients and help resolve issues caused by an adverse outcome.


For more details on these workshops please contact the department of Professional Development on +61 9249 1106, or email at PDactivities@surgeons.org or register online www.surgeons.org and select the Professional Development page.
Legal issues for surgeons as educators

Trainees and staff both need to thoroughly understand the College disciplinary procedures in order to ensure a fair deal for everyone.

**Context**

Surgical education now takes place in an ever changing environment, with increasing demands from Trainees, hospitals, government and even the Australian Competition and Consumer Commission (ACCC).

The importance of a quality surgical education to Trainees cannot be underestimated. It represents their careers, their livelihoods and follows on from an already extensive medical education.

Surgical education takes place in a complex environment, with the College as the responsible training body and hospitals as employers. Sometimes the objectives of the hospital to provide quality medical treatment is not always aligned with its role to provide supervised training for surgical Trainees. These dual roles should always be considered.

**Principles**

The College, through its regulations, provides detailed processes for its training program. The processes and principles for selection of Trainees, assessment of Trainees, discipline and non-performance and requirements for approval to Fellowship are clear.

The College also provides a clearly defined process to deal with underperforming Trainees, with an emphasis firstly on constructive assistance and remediation, before any resort to disciplinary action is necessary. Supervisors of training should be aware of these processes, and note that the College is always available to assist in supporting supervisors when difficult decisions need to be made.

The College’s training program is based on the “Brennan Principles” arising out of the review of specialist training in the mid-1990s. These principles include:

- Objective criteria for selection and assessment; and
- Opportunity for review or appeals in the event of adverse decisions.

There are a number of circumstances in which surgical education may be the subject of legal review. These include:

1. The selection of Trainees.
2. The suspension or removal of Trainees from the training program.
4. Each of these decisions have particular processes to deal with them. These are set out in College regulations and policies.

The decisions are subject to legal rules and principles, including the possible application of the rules of “natural justice” or “procedural fairness”. There is nothing mysterious about the principles underlying “natural justice”, since they accord with common sense and fairness.

The general principles underlining “natural justice” are as follows:

1. **Appropriate notice**
   
   Individuals should have notice of any hearing and have the opportunity to put their views. This right is one of the fundamental principles underlining “natural justice”.

   Appropriate notice should be given to individuals, setting out in general terms the nature of the hearing or meeting, the substance of any particular allegations being made against them or material adverse to them, and the evidence or factual material upon which the committee or body proposes to rely.

   The notice should be given to the individual in sufficient time to enable the individual to properly prepare their case.

2. **Relevance**

   Only material relevant to the actual decision required should be considered.

   In times past, boards or committees, when dealing with Trainees, may have taken into account a range of factors that many today would regard as completely irrelevant to the decision of whether to admit a trainee to a training program. Certainly, in more recent times, legislation ensures that circumstances such as race, religion, gender and a range of other grounds can form no part of a decision regarding trainees, or in relation to any disciplinary action.

   The simple principle is that decision-makers should confine their considerations to material relevant to the decision at hand and any criteria set out for the decision. They should not permit consideration of irrelevant material, and where irrelevant material is presented, it should be made clear that it is not being considered or relied upon in any way.

3. **Bias**

   A selection committee or disciplinary committee must be free of bias. That is, the committee should not include any person previously who has taken part in any substantive decision effecting the individual, and should not have any relationship with the individual (whether family or otherwise), which would preclude them dealing with the matter with an open mind.
“Legal claims can be greatly minimised and the risk of legal action avoided if all supervisors and educators actively ensure that they operate within the approved College policies and guidelines.”

Common sense would dictate the relevant committee should operate impartially and without prejudice, and most importantly, to be seen to be so.

4 Pre-judgment
Similar to the question of bias, is the question of whether the decision-maker has previously made a decision about the individual, which would suggest that they have already prejudged the issue. For example, a person who has carried out an investigation of an individual and may have prepared an investigative report and given a recommendation could then not sit as a committee member to determine the committee’s view of the matter.

5 Procedure
Most of the procedures of the College’s boards and committees remain relatively informal.

However, members of such committees should make themselves aware of any particular requirements, either under the College’s rules or regulations, applicable criteria or guidelines or the principles of “natural justice” generally, so that any necessary requirements can be observed.

There is nothing wrong with informality, so long as any required procedures have been adequately taken into account.

For example, it would be important to determine upon what criteria a decision is to be made before proceeding to deal with the matter.

Additionally, in relation to disciplinary procedures, it might be considered that the individual against whom allegations are made, should be permitted professional legal representation, so much so that any required procedures have been adequately taken into account.

For example, it would be important to determine upon what criteria a decision is to be made before proceeding to deal with the matter.

Additionally, in relation to disciplinary procedures, it might be considered that the individual against whom allegations are made, should be permitted professional legal representation. In most of the disciplinary procedures in which the College is involved regarding disciplinary actions, the individual has been permitted to have legal representation present to advise, but not to act as an advocate. (The rules establishing the College Appeals Committee permit legal representation at the discretion of the Committee itself.)

Obviously, the more important the outcome of the proceedings, that more formality may be required. For example, disciplinary proceedings which may remove a trainee from the program, or proceedings akin to a hearing by a medical board, where a licence to practice may be removed, will require a greater degree of formality and structure.

6 Dealing with under performance
The College has clear regulations and policies dealing with under performance of Trainees.

The process includes:
- Providing honest and objective assessments of Trainees at regular intervals;
- Providing feedback when assessments have been made, which should be more than a perfunctory discussion;
- In the event of under-performance, the Trainee is entitled to appropriate warnings;
- In appropriate circumstances formal notices must be given. College processes require at least two meetings with the Trainee if disciplinary action is to be considered.

Supervisors are recommended to keep detailed notes of all meetings, conversations and decisions in the event of any subsequent challenge. It may be your notes and documents that become critical in the event of any review or appeal against the decision of the supervisor or relevant board.

Defamation
Normally, in relation to disciplinary proceedings particularly, the parties directly involved will not be subject to the ordinary laws relating to defamation. It is said that the protection of “privilege” against defamation applies to these proceedings. This would extend to material prepared prior to the proceedings and the committee’s deliberations, such as statements of witnesses and report providers.

However, statements made by individuals which go beyond what is strictly necessary for the proceedings, may lose protection from defamation, particularly if it is mischievous or malicious.

Thus, while there is some protection against defamation involved in these proceedings, participants should still deal only with relevant matters and not stray into character assassination or clearly irrelevant material.

Appeals
Because the College has its own appeal process, any decision of a selection committee or disciplinary committee may be subject to review by the College Appeal Committee.

There are specific grounds upon which appeals can be made.

An appeal must be made within a specified time of being notified of the relevant decision. The appeal can only be made on specified grounds set out in the appeal regulations.

The College Appeals Committee consists of College Fellows (not involved in the specialty to which the appeal relates), as well as distinguished non-Fellows.

The Appeals Committee can consider all relevant information that it thinks fit, and may invite any person to appear before it to provide information. The person lodging the appeal has the right to appear before the Committee and make submissions, but is not entitled to be legally represented unless the Appeals Committee consents. Normally, the Appeals Committee permits legal representation to advise, but not to act as an advocate.

The Appeals Committee has a broad power to review a decision. The Appeals Committee may confirm the decision, revoke the decision, refer the decision to a relevant board or committee for reconsideration, or replace the decision with its own, as it thinks fit.

Once the College’s appeal process is exhausted, of course, individuals have their ordinary rights at law to seek review before the courts.

Summary
In summary, supervisors of training and surgical educators should:
- Familiarise themselves with the guidelines, processes and policies of the College;
- Be clear about the methods by which decisions should be made and what is being assessed or decided;
- Do not confuse their role as an educator/supervisor with their role as a representative of the hospital/employer. Matters relating to employment should be dealt with separately.

The College is prepared to support its supervisors of training and educators. Staff at the College are always available to assist, answer questions and provide information.

Be reassured, that the College does take steps to protect its educators and supervisors and maintains appropriate professional indemnity insurance in the event of legal claims. However, legal claims can be greatly minimised, and the risk of legal action avoided, if all supervisors and educators actively ensure that they operate within the approved College policies and guidelines.
IT COULD HAVE been the perfect excuse to lie on a Fijian beach and take in the sun. But the AusAID-funded Pacific Islands Project (PIP) ENT team on their way to Tuvalu in September 2006 thought otherwise. Instead, as their small plane was being repaired, leaving them stranded for three days in Fiji, the team which included Mr Suren Krishnan and Ms Libby Rose made their way to the Colonial War Memorial Hospital in Suva and went to work.

Mr Krishnan, who had previously worked in Fiji, knew the medical staff and let them know the team was available to help. The Fijian hospital staff called in those patients who required major surgery and could make it to the hospital in time to be seen by the visiting specialists. While in Suva, the team members assisted in difficult cases including one anaesthesia with a complicated airway, and cancer cases which also provided the opportunity to offer professional support and skills transfer to local medical staff, including ENT surgeon Dr Sue Hong. Mr Krishnan described their enthusiasm as a highlight of the trip.

“The Fijians immediately accommodated us, recognized that an unexpected team was there to help them out and immediately moved in the patients. One of the engines on the plane had a problem but there were no spare parts available so basically we were stranded there for three days. That time could have been wasted but instead we worked with the Fijians on large thyroid cancers, a nasal cancer and ear tumours,” he said.

Mr Krishnan works out of the Royal Adelaide Hospital and is the President of the Australian and New Zealand Head and Neck Society. He said the facilities in Suva were good.

“Fiji has a School of Medicine which is next to the Colonial War Memorial Hospital and that is a good facility. The theatres in the hospital are quite old but certainly better than most of those in most hospitals in the Pacific region. The School of Medicine trains doctors, nurses and allied health staff so we had a strong support team working alongside us,” he said.

After the part for the plane was found and fitted, the team of the two surgeons, a nurse and an anaesthetist, traveled to their original destination, arriving a few days late. This meant that instead of a full week to triage and operate, the team arrived on Thursday with the weekend looming. Mr Krishnan said he was impressed with the engagement of the local staff who worked through the weekend to ensure that all 260 patients waiting for treatment could be seen in the remaining four and a half days of the trip. Many patients had traveled from outerlying areas to Funafuti, the capital of Tuvalu, especially for the team’s visit.

“Again we did mainly general ear, nose and throat cases, mastoids, a couple of thyroid cases. Chronic ear disease is a major problem in the Pacific and is a major issue because it affects the ability to learn during vital early years. This is because of a range of things including poverty, hygiene, nutrition and water resource management,” Mr Krishnan said.

In addition to volunteering with the Pacific Islands Project, Mr Krishnan is also involved in a project being developed in conjunction with the Rotary Clubs of South Australia to provide a rehabilitation programme for those affected by chronic ear infection. Mr Krishnan said “When the project is up and running it will send teams to assess people with the condition and develop a range...
of rehabilitation programs such as providing hearing aids, providing operations or organizing classes to teach people to sign. This is such a serious issue in many parts of the Pacific so this project is important, not only to the individuals but to the well-being of the community.”

Mr Krishnan said the hospital in Tuvalu, which was built by the Japanese, was good but maintenance of equipment remained an on-going problem.

“The hospital in Tuvalu is only about ten years old so while it is quite good as a facility, the over-all economic problems mean there is always a problem with equipment. For example they have now autoclaves but no way to maintain them,” he said.

Ms Libby Rose, for whom this was her tenth PIP trip, said the original plan on this journey was for her to go ahead to Tuvalu to prepare the patients but this had not eventuated given the stranding.

“We always seem to have a little bit of trouble traveling through Fiji so I suppose it wasn’t a huge shock. But at least we put our time to good use. They have an ENT surgeon but not Head and Neck and that is Kris’s specialty so we were lucky, given the extremely short notice of our trip, that they could get the patients in that could benefit from the team being there,” she said.

Mr Krishnan laughed about the nerves of team members as they got back onto the plane after three days waiting for the spare part to get to Tuvalu.

“We were all a bit nervous I think. The plane was probably about 40 or 50 years old and we knew that they always carry their own engineer on longer flights. So that was a bit of a double-edged sword in terms of reassurance,” he said.

“Yes they had someone there to help if something went wrong but also they obviously thought the planes were such that they needed someone on board if something went wrong.”
**Winding down?**

There are more than 1200 Fellows in Australia and New Zealand over the age of 60. New workshops are being held on how to “wind down”.

**THE TWO MOST** significant events in a surgical career are probably the awarding of the FRACS after years of work and study and at the other end of a professional life, retirement. There is ample help for the new graduate but less so for the surgeon who is decreasing his/her workload. In June 2005 the College addressed this issue to some extent by holding the first Winding Down from Surgical Practice workshop. This was held in Melbourne with Bruce Waxman, who was the main driving force behind the concept, as convenor. Since then there have been four other workshops: Adelaide, Brisbane, Sydney and more recently, Perth. In the next months there will be two more - Auckland (August 3) and Melbourne again (October 20).

These workshops consider a variety of topics with some variation in content according to local needs. The physical, psychological and financial aspects of decreasing work and eventually stopping practice are addressed by thought provoking speakers. College Fellows also share their ‘winding down’ experiences and demonstrate what life may look like after surgery.

Since I have been involved with this program, I have been amazed at and grateful to the people who give their time as speakers and convenors. I have also been gratified to see that Fellows rate the workshops very highly in their assessments. The last workshop in Perth (Convenor Professor Richard Vaughan AM, FRACS) was given an overall rating of four on a scale of five.

Highlights from the recent Winding Down from Surgical Practice seminar in Perth included sessions on superannuation, income tax and investment, health issues and medico legal matters. There was also a challenging presentation from a futurist!

Participants collectively praised the workshop as a ‘very informative and valuable introduction to the idea of retirement.’ One participant commented that he ‘approached with scepticism (but) left converted’.

Fellows consistently appreciate the opportunity to learn and engage in conversation about topics that directly affect their personal and professional futures.

The program in Auckland (Convenor Mr Patrick Alley, FRACS) will include sessions on financial considerations, life partnership issues, legal aspects of winding down and advice on staying physically fit, to name a few. Also, a group of recently retired Surgeons will take part in a panel discussion; “What’s it REALLY like when you are retired from surgery”.

There are over 1200 Fellows in Australia and New Zealand over the age of 60 who are still surgically active; clearly there will be a need for these workshops on an ongoing basis. I certainly encourage this cohort of Fellows to take up the opportunity to actively inform themselves about the process of winding down and hear how others have navigated this important pathway.

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**GENERAL OTOLARYNGOLOGIST CONSULTANT POSITION AVAILABLE – MACKAY, QLD**

Due to the growing demand for ENT services in the Mackay Whitsunday Region a great opportunity has arisen at the Pioneer Valley Private Hospital Mackay for a General Otolaryngologist with some scope for head and neck surgery.

The Pioneer Valley Private hospital is a 49-bed hospital and day surgery centre affiliated with James Cook University. The hospital boasts state-of-the-art equipment, full audiology and radiology support, on-site medical suite facilities available, access to public hospital and a great team environment.

Mackay is a vibrant and modern tropical city, booming from the wealth generated by sugar and mining industries, in close proximity to the Whitsunday Islands and Great Barrier Reef as well as some of the world’s most prized rainforests. The climate and attractive environment of Mackay offers sunshine, modern shopping facilities, great schools and relaxed family living.

The role would suit someone wanting a change of lifestyle with great opportunity for professional and business growth.

For further details please contact:
Eileen Hordern on 07 4942 1144 or email Eileen.hordern@pioneervalleyprivate.com.au
I think of life as having two phases

There is life before medicine and then after medicine

LIKE MANY WHO have entered our profession I passed through high school in the days when it was not necessary to have 99.9 per cent in the equivalent of today’s HSC. In fact, had that been the case I should never have made it!

I graduated in March 1946 from University of Sydney. We had a truncated course during wartime. There followed the usual residency and for some time in general practice when I decided that I wanted to specialise in ear, nose and throat. Why? I think I was very fortunate in my ENT honoraries, who gave me plenty to do.

In September 1948, Adele, my wife of three months, and I set sail for England as I had an appointment at the ENT hospital in Newcastle-on-Tyne. In that cold winter, full wartime rationing was still on and bomb damage was still very evident. After six months we went to London to other jobs and finally left for home in April 1951 with our twin girls, who were born the previous January.

Back in Sydney, I was fortunate to receive an appointment as an honorary in the ENT department of Sydney Hospital and continued there for the next 38 years. I also had appointments at the Mater North Sydney and the Eastern Suburbs Hospital.

Progress in the specialty was spectacular from the late fifties. The Medical Super of Sydney Hospital talked of the “dying specialty,” but at that time German Surgeons were discovering new approaches to ear surgery and in the USA others were working on operations to improve hearing. The specialty blossomed.

A group of Australians had become interested in nasal reconstructive surgery and spent time overseas attending instructional courses. In Sydney, a group of about six of us spent many Sunday mornings in the morgue of the old Lidcombe Hospital perfecting our techniques.

A big change in my practice occurred when the University of NSW opened its Medical School.

I was invited to take an appointment at the Coast Hospital. I was approached by the late Prof. John Beveridge, Professor of pediatrics and hospital director, to organise the ENT section of the then Prince of Wales Children’s Hospital (now the Sydney Children’s Hospital). I accepted, and this began that period of my life where I found the most satisfaction of all. Children are fantastic beings!

Outside of my practice, I was involved in my professional ENT society. I was on the executive committee for a number of years, first as treasurer and finally national president.

I had an interest in lay bodies associated with disability and was on the board of the NSW Deaf Society and the board of the Australian Council for the Rehabilitation of the Disabled from 1981 till 1990. I was federal president of the Australian Deafness Council. In 1992 I was appointed to the inaugural board of Australian Hearing Services.

My other great interest was Aboriginal ear health and in the mid 1970s the NSW State Health department agreed to fund regular flying visits to about seven outlying NSW country towns if I could find colleagues to join me. I was lucky that I was able to get the necessary numbers and the scheme started and continued well past my retirement. For me this also involved regular visits to the “top end” of the Northern Territory, where I shared the load with the late Dr Rory Willis of Melbourne.

So my professional life kept me busy. I retired in June 1995. From that time I have also been kept busy. I firmly believe that retirement is not the time to “sit and think”, but to “get up and go”.

My present routine involves Probus on third Mondays, where I have been through the offices and am presently the outgoings officer. I go to golf on Tuesday mornings where we play a four ball and say our scores are more akin to cricket scores. So what! Tuesday afternoons I go to art class. My wife is an accomplished artist, and I started in 1995.

Wednesday afternoons I race my Santana 30, “Hinny B,” on Sydney Harbour. Thursdays I am a volunteer at a retirement home. Friday, Saturday and Sunday I take it easy.

For 31 years we used to go to our property at Bilpin, which is on the mountains west of Sydney. We had a small but productive (though not profitable!) 10-acre apple orchard where we went Friday afternoons to pick, grade, pack and send the apples to market. The property was 80 acres and except for the orchard and house area was wonderful native bush, allowing us the pleasure of getting back to nature. This was a great change of pace from my hectic professional life. But it came to an end three years ago when the house burnt down. Luckily, no one was injured. We said we were too old to start building so we sold the property. We also travel.

So this is my story.

From Page 13...

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RURAL CRAFT

Rural Craft Group Audit Project

The audit has created a valuable set of limits for rural surgeons

PARTICIPATION IN SURGICAL Audit is mandatory for all Fellows. In many rural and remote hospitals, there may be little or no support for comprehensive Surgical Audit - despite Surgical audit and peer review being important strategies in the maintenance of standards in surgical care.

In an effort to address this deficiency, over the past nine months, through the financial support of the Support Scheme for Rural Specialists, five major rural centres and three smaller remote centres participated in an audit project in order to provide a basis for comparison of acceptable surgical outcomes in rural/remote hospitals.

Five procedures were selected for comparison of results. They were surgery for Colorectal Cancer (high, low and ultralow), Cholecystectomy (laparoscopic and open), Breast Cancer surgery, Adult Inguinal Herniorrhaphy and Thyroidectomy. Data was collected on all five operations over a defined time-period and collated and the outcomes analysed to define benchmarks for acceptable complication rates in rural surgery.

The first step of this project was to secure the involvement of rural medical centres who agreed to provide full disclosure of audit data. The participants were provided with a short list of potential procedures to consider and it was agreed to collect data on the following surgical procedures:

**Cholecystectomy:**
- Bile leak (intervention required vs settled conservatively)
- Bile duct injury
- Unplanned readmission (limited to three months)
- Unplanned re-operation
- Death
- Retained stones
- Unplanned bile duct intervention
- ERCP rates - Unplanned ERCP for common duct stones
- Elective vs Emergency
- Other

**Adult Inguinal Herniorrhaphy:**
- Haematoma
  - Requiring drainage
  - Not requiring drainage
- Pain requiring pain relief or specialist intervention more than four weeks after surgery
- Early recurrence

**Thyroidectomy:**
- Haematoma
- require reoperation for haematoma
- resolve spontaneously (not requiring operation)

Hypocalcaemia (Define acceptable lower limit for calcium rate as <1.9 corrected or symptomatic) - calcium supplementation: transient vs permanent
- Temporary
- Permanent
- Laryngeal nerve palsy
- Temporary
- Permanent

**Colorectal Cancer Surgery:**
- Stoma rates (define according to CMBS codes)
- Anastomotic leak rates (define according to CMBS codes)
- Elective vs Emergency

**Breast Cancer Surgery:**
Data-set used from the National Breast Audit, including, but not limited to:
- Re-incision
- Reasons for mastectomy (patient preference)
- Actual reconstruction
- Management of axilla
- Sentinel node rates
- Radiotherapy/chemotherapy/hormone therapy
- Multidisciplinary teams
- Documentation

**Outcome indicators:**
Determinants of success or failure for all procedures:
- Unplanned reoperation
- Unplanned readmission
- Unplanned ICU admission or readmission
- Mortality
- Major wound infection – defined as ‘wound that discharges pus’
- DVT pulmonary embolism

At least one key surgeon in each major location was selected to ‘champion’ the project. They then contributed to the establishment of a ‘craft group’ data set to allow useful analysis of the procedures and thereby to have ownership of the data and ensure relevance of the comparisons.

The five major sites were funded to employ secretarial/data entry support for one day per week for the duration of the project; to collate and analyse collected data after a nine month period. All sites, were provided with a copy of the Filemaker Pro/Runtime pre-defined database for use on their existing computer systems. Some sites preferred to use other existing database systems, including Excel and in-hospital systems. All sites were provided with the College ‘Minimum Data Set’, the list of additional Clinical Indicators to be reviewed and contact details for further support.

Using the information collected, ‘acceptable’ and ‘unacceptable’ limits have been defined to be applied to the selected indicators in order to allow participating surgeons to perform CUSUM analysis on their individual data. The data supports these suggested definitions. The result is that a sustainable craft group audit system has been established which can be utilized to define outliers and encourage regular review of performance. The outcomes of this project will help to decide what the standards of good practice are for the practice areas selected for the study.

Information about the project was presented at the Provincial Surgeons of Australia conference, and the results were presented by David Watters at the 2007 ASC.

For information please contact ssrprojects@surgeons.org.
The NHMRC NICS Fellowship Program, established in 2003, identifies and supports health professionals who are future leaders in evidence-based health care to address an evidence-practice gap in clinical practice.

NHMRC CEO Professor Warwick Anderson says that the unique two year, half-time Fellowships provide health professionals with mentoring, training, national and international networking and practical support to ensure their success.

“The NHMRC, through it’s National Institute of Clinical Studies, has partnered with a number of key health organisations to offer two-year Fellowships starting in 2008 and our Fellows are already having an impact, sharing their knowledge and influencing evidence-based policy and practice at many levels,” he said.

Fellowships have previously been awarded across the range of health disciplines for research implementation projects in areas such as mental health, osteoporosis, stroke management, clinical practice guidelines and cardiovascular disease.
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Surgical News P38 / Vol 8 No:5 June 2007
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SURGICAL NEWS P39 / Vol 8 No 5 June 2007
Radiofrequency ablation for the treatment of liver tumours

THE AUSTRALIAN SAFETY and Efficacy Register of New Interventionsal Procedures - Surgical (ASERNIP-S) looked at the safety and effectiveness of radiofrequency ablation (RFA) for the treatment of liver tumours, compared with other treatments.

The following summary has been prepared to inform patients making decisions with their doctors on their treatments.

Main messages
This information refers mainly to the most common form of primary liver cancer, hepatocellular carcinoma. (see ‘What are liver tumours?’ below)

Safety
Current research provided limited information on RFA for the treatment of liver tumours, although it suggested this was slightly safer than other ablative treatments.

Effectiveness
ASERNIP-S could not determine the effectiveness of RFA for the treatment of liver tumours compared with other ablation techniques.

ASERNIP-S concluded that more studies on RFA for the treatment of primary and metastatic tumours (see definitions below) are needed. ASERNIP-S recommended that cancer registries collect data on RFA for the treatment of liver tumours.

What are liver tumours?
The liver helps to metabolise food and removes harmful substances, or toxins, from the blood. A liver tumour is an abnormal growth of cells in the liver. A tumour is malignant if it has the potential to invade other tissues or organs. Liver tumours consist of either liver cells (primary liver tumours), or tumour cells that originated elsewhere in the body and travelled to the liver (metastatic liver tumours). Hepatocellular carcinoma (HCC) is the most common form of primary liver cancer. It is usually associated with liver cirrhosis, caused by hepatitis B or C, alcohol intake or toxic factors. If untreated, patients may only live a short time from diagnosis, but with treatment many live much longer. Metastatic liver tumours often originate in the colon or rectum.

Treatment of liver tumours
Surgical removal (resection) of a liver tumour is the only treatment that currently offers a possible cure for liver tumours, but only one in five patients is suitable for this surgery. For other patients alternative techniques are available, including chemotherapy, cryoablation, microwave coagulation therapy, laser therapy and ethanol injection.

Radiofrequency ablation
A new procedure called radiofrequency ablation (RFA) has also been developed. This involves placing an electrode in the liver tumour: either through the skin using a local anaesthetic; by inserting a long thin telescope called a laparoscope through a small cut in the abdomen; or through a wider cut during an open operation. The electrode delivers a high-frequency current that produces heat, destroying the tumour and surrounding cells.

What were the findings of ASERNIP-S’ updated review?
ASERNIP-S looked at all the research comparing the safety and effectiveness of the different treatments and found that:

RFA compared to chemotherapy:
Safety - Very limited data suggested that fewer complications occurred after RFA compared to chemotherapy.
Effectiveness - It was unclear which was better at controlling tumour growth.

RFA compared to cryoablation:
No suitable studies were found.

RFA compared to microwave coagulation therapy:
While reports of major complications were similar for these procedures, minor complications were more common in microwave therapy patients (four out of 36 patients, compared with one out of 36 RFA patients).
Effectiveness - In one study, treatment was completely effective in 96 per cent of nodules treated with RFA and 35 per cent of nodules treated with microwave therapy. In another study, more tumour cells were destroyed by RFA than microwave therapy.

RFA compared to laser therapy:
Safety - While reports of major complications were similar for these procedures, minor complications were more common in microwave therapy patients (four out of 36 patients, compared with one out of 36 RFA patients).
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RFA compared to microwave coagulation therapy:
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RFA compared to ethanol injection:
Safety - While reports of major complications were similar for these procedures, minor complications were more common in microwave therapy patients (four out of 36 patients, compared with one out of 36 RFA patients).
Effectiveness - In one study, treatment was completely effective in 96 per cent of nodules treated with RFA and 35 per cent of nodules treated with microwave therapy. In another study, more tumour cells were destroyed by RFA than microwave therapy.

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RFA compared to surgical resection:
Safety - There was no research available comparing these treatments.
Effectiveness - The only available study suggested that tumours removed by RFA were more likely to come back (39 per cent of patients) than those removed by surgical resection (24 per cent). Recurrences also tended to occur sooner after RFA.

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What is ASERNIP-S?
The Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S) is a program of the College. ASERNIP-S conducts literature reviews on the safety and effectiveness of new surgical techniques before they are widely accepted into the healthcare system. Each review collects all relevant information, or evidence, on new and standard techniques used to treat a medical condition. The quality of evidence is assessed. ASERNIP-S then makes recommendations on the safety and effectiveness of the procedures, which are endorsed by the College.

Reviews are regularly updated. ASERNIP-S' recommendations are sent to hospitals and surgeons in Australia and overseas, and published on the website with summaries for surgeons in Australia and overseas, and published on the website with summaries for consumers. One of the procedures reviewed is radiofrequency ablation for the treatment of liver tumours.

Glossary
Ablation: removing or destroying cells.
Benign: a term used to describe a tumour which enlarges locally, not invading tissue or spreading remotely, as opposed to a malignant tumour, which can invade other parts of the body.
Chemotherapy: the treatment of tumours using drugs.
Cirrhosis: a condition of the liver in which death of liver cells leads to fibrosis and regrowth of liver cells in small lumps or nodules.
Cryoablation: liquid nitrogen is used to kill tumour cells, thus destroying the tumour.
Electrode: a device that generates heat through the passing of electricity.
Malignant: a term usually used to describe cancerous tumours which can invade other tissues or organs. The term is opposite in meaning to benign.
Microwave coagulation therapy: an electrode is placed into the tumour. A high frequency electromagnetic wave generates heat and destroys tumour cells.
Nodules: small, solid-like lumps of tissue occurring anywhere in the body.
Open operation: operation in which the surgeon accesses the site through a large surgical cut.
Primary liver tumours: liver tumours consisting of liver cells.
Recurrent tumour: tumour that grows back after treatment.
Resection: surgical removal.
Tumour: an abnormal growth of cells in the body.

For more information on RFA for the treatment of liver tumours, see the full systematic literature review on the ASERNIP-S website: http://www.surgeons.org/asernip-s

For more information, contact:
Professor Guy Maddern, ASERNIP-S Surgical Director,
PO Box 553, Stepney, South Australia 5069,
tel: +61 8 8363 7513, fax: +61 8 8362 2077,
email: asernipsconsumer@surgeons.org

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Postgraduate Course in Clinical Anatomy

The Course will provide postgraduate training in anatomy for graduates wishing to advance their knowledge in anatomy. Though designed for trainees preparing for Specialist College examinations, the course is open to graduates from any health discipline at any appropriate professional stage.

The Course will be taught by anatomists from both Monash University & University of Melbourne and relevant specialist surgeons. It will involve use of the Museum and Dissection Room facilities at the Clayton campus. The Course will consist of 16 sessions on Monday evenings from 6.30-9.30pm and will cover the anatomy and surgical anatomy of the entire body. Participants will have access to the Anatomy Museum during the session. Examiners for the College of Surgeons will give optional formative assessments if requested. The course will not involve cadaveric dissection, but will include examination of wet specimens.

Attendees will receive a CD of relevant software (Dissectional, Radiographic, Emergency & Surface Anatomy Images) and a 300 page syllabus. Each participant will receive a copy of the new anatomy text “General Anatomy – Principles & Applications” (McGraw-Hill 2007). Participants completing the Course in 2007 will receive a Certificate of Attendance. Further details of the Course are provided below:

Dates: Monday June 25 to Monday October 8 2007
Venue: Department of Anatomy and Cell Biology, Monash University (Clayton campus)
Cost: $990 including GST
Registration is due by Monday June 18. Purchase your registration online at http://workshops.med.monash.edu.au/clinicalanatomy/ if you have any questions please contact mira.petruzalek@med.monash.edu.au; ph +61 3 9594 5500.

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SURGICAL NEWS P41 / Vol 8 No 5 June 2007
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.

2006 CPD recertification data forms overdue
Fellows are reminded that the 2006 CPD Program recertification data forms are now overdue. Please contact Maria Lynch, Department of Professional Standards, on +61 3 9249 1282 or email at cpd.college@surgeons.org if you require assistance completing your data form or require another copy.

COUNCIL RESULTS

Results of 2007 Council elections and referendum to change the name of the College

The results of the 2007 Council elections and the referendum to change the name of the College were tabled at the Annual General Meeting in Christchurch on 9 May 2007.

Congratulations to all successful candidates and sincere thanks to all candidates who nominated.

The pro bono contribution of Fellows has been, and continues to be the College’s most valuable asset and resource. We are grateful for your commitment.

General Elected Councillor
There were eight General Elected Councillor positions to be filled.

Re-elected to Council are
Robert Neville Atkinson, Orthopaedic Surgeon, South Australia
Jenepher Ann Martin, General Surgeon, Victoria

Newly elected to Council are
Spencer Wynyard Beasley, Paediatric Surgeon, New Zealand
Graeme John Campbell, General Surgeon, Victoria
Julian Anderson Smith, Cardiothoracic Surgeon, Victoria
Swee Thong Tan, Plastic & Reconstructive Surgeon, New Zealand
Marianne Vonau, Neurosurgeon, Queensland
David Allan Watters, General Surgeon, Victoria

Specialty Elected Councillors
Cardiothoracic Surgery - Mark Gordon Edwards, Western Australia
Orthopaedic Surgery - Simon Alan Williams, Victoria
Paediatric Surgery - Hugh Charles Martin, New South Wales
Vascular Surgery - Michael John Grigg, Victoria

Referendum to Change the Name Of The College
To change the name of the College to ‘Royal Australian and New Zealand College of Surgeons’ requires 75% of Fellows voting in a referendum to be in favour of amending the Articles of Association to achieve this.

Number and per cent for and against

| For a name change | 1426 | 57% |
| Against a name change | 1055 | 43% |

Although a majority were in favour of changing the name, the necessary percent was not reached. Consequently the name stays the same.

Our thanks once again to the scrutineers Campbell Miles and David Scott.
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