RACS

SURGICAL *News*

Trauma Verification – raising the standard of patient care
Picture: Narooma News

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From the College President

ACCC

The College welcomes the Australian Competition and Consumer Commission (ACCC) decision that we can continue to train all Australian surgeons. The College was recognised for its high standard of training, which was endorsed by the Australian Medical Council.

The report makes some recommendations for change that I believe the College should have no hesitation in implementing. They are no different from what the College is already doing or would wish to do. I particularly welcome the recommendation that State health authorities be involved in assessing hospitals and training posts. We have long voiced our concern about insufficient properly resourced positions. The College has commissioned a new study of the surgical workforce in Australia and New Zealand and this is being undertaken by Dr Bob Birrell, a Melbourne academic demographer. With the benefit of this independent and up to date data the College will be conducting a National Surgical Workforce Forum in June 2003 to which representatives from the ACCC and State Governments will be invited.

It will then be up to State Governments to help find and then fund whatever additional advanced surgical training positions are needed. The College will certainly fill them with talented young doctors wishing to pursue a surgical career. The College also welcomes the committed involvement of State Government in the careful assessment of overseas-trained surgeons.

The College welcomes openness, scrutiny and accountability to ensure that sensible cooperation occurs and standards are not lowered in the process.

President Kingsley Faulkner

Medical Professionalism

A Physician's Charter has been developed by an interested group and published in the Annals of Internal Medicine and in the Lancet in 2002.

The preamble states that professionalism is the basis of medicine's contract with society. This demands placing the interests of patients above those of the doctor, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. Essential to this contract is public trust in doctors, which depends on the integrity of both individual doctors and the whole profession. The charter then outlines three fundamental principles – the principle of the primacy of patient welfare, the principle of patient autonomy and the principle of social justice.

Expanding on those principles, a set of professional responsibilities are then summarised under ten commitments. The first five of those commitments are to professional competence, honesty with patients, patient confidentiality, maintaining appropriate relations with patients and improving quality of care.

The second group of five commitments are to improving access to care, the just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest and to being conscious of those professional responsibilities which include working collaboratively, self regulation, teaching and continuing professional development.

Although most surgeons are conscious of these responsibilities, this is a useful reminder to us.

Structured Settlement

This bill has passed through both chambers of the Federal Parliament and has now been enacted.

Since the process began, the medical indemnity crisis has occurred and has led to the need for more widespread reforms. Nevertheless structured settlements of successful claims made by patients will assist in the eventual resolution of the overall problem.

Some of the initiatives flowing from the IPP Committee recommendations and others introduced by the Commonwealth Government will also assist but there is still a widespread view, not only amongst surgeons, that additional changes are needed to resolve the problem.

The College has established a working party which is meeting via teleconference fortnightly and will have a web page designed to update fellows on developments, conduct surveys of medical indemnity arrangements and include comments regarding possible solutions.

Surgical News

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New Zealand Notebook

ACTIVITIES AND ISSUES

Nurse Anaesthetists

Concerns over this development continue to be addressed primarily through ANZCA and the New Zealand Society of Anaesthetists. The College is supporting ANZCA's approach that the issue needs to be debated before any training programme is developed; and that it is inappropriate to attempt to have such a debate within a group established for the purpose of developing the curricula and training systems. We have received a copy of a report compiled by the Royal College of Anaesthetists that reviews the use of non-medical anaesthetic staff in Holland, Sweden and the USA. The report looks somewhat favourably on the development of nurse anaesthetist / anaesthetic assistant training programmes in the UK with trainees drawn from both biological science graduates and nursing. The graduates of these programmes would be supervised by a medical anesthetist and their work would be restricted to specific areas. The document in circulation in New Zealand suggests a nursing only training programme and allows for the nurse anaesthetist graduates of the programme to be fully independent practitioners without restriction on their areas of work.

Health Practitioners Competence Assurance Bill

Now that the Parliamentary Services are back in action after the Christmas slowdown, RACS can expect to be advised in the near future whether it has approval to present orally to the Health Services Select Committee on this Bill. It is understood that the Select Committee will begin oral hearings in Auckland at the end of January before moving hearings to their more traditional venue in Parliament Buildings in Wellington.

Reaccreditation with the Medical Council

The drafts of the applications for reaccreditation of the nine vocational branches of surgery relevant to this College are close to completion. These are being viewed by the Censor-in-Chief before being forwarded to the Medical Council.

Rural and Isolated Services

The Independent Review Team's (IRT) Report to the Ministry of Health, Northland DHB and the Far North Community on its review of Far North Services was released in December. The IRT stated that "while focus has been on surgery, it is really health status and health inequalities, particularly for Maori, that constitutes the real need". It recommends that services be reconfigured and a new organisation – an Integrated Health Organisation (IHO) – be formed in the Far North that combines hospital and local providers and focuses on preventative care. The Report makes a number of recommendations including the following:

- Kaitaia Hospital should not close but its general surgical staff should be reduced from 3 to 2;
- "acute surgery after 6pm is not necessary (at Kaitaia Hospital) on a clinical and cost basis" and should be stopped;
- "caesarian sections and most inductions should only be carried out (in Kaitaia Hospital) when a specialist clinician and anaesthetist are present";
- Kaitaia and Whangarei Hospitals should not continue their current practice of operating almost entirely independently;
- the local community in the Far North and its hospital should have more input into decision making;
- in addition to preventative care, additional investment is needed into emergency and retrieval systems, improved antenatal care, and medicine; and
- a new Medical Centre, incorporating an Accident and Medical Centre, should be built in the grounds of Kaitaia Hospital and GPs and iwi (Maori tribal) providers should be relocated to the Hospital site.

The IRT recommendation to stop after hours surgery has been accepted and a date set for this to occur. Unfortunately, the recommendation to improve retrieval and emergency services has not yet been actioned.

Medicines Law Proposals

The Medsafe document " Proposals to Amend Aspects of New Zealand's Medicines Law" seeks comments on possible changes to those aspects of medicines law that relate to activities occurring along the distribution chain for medicines (eg. prescribing, dispensing and labelling, licensing issues). These issues will not be covered by the joint New Zealand Australia therapeutic agency (JTA) that has been agreed to by both the Australian and New Zealand Governments. The JTA focus is to be on safety, quality and effectiveness of therapeutic products (medicines, medical devices and complementary healthcare products). The Medsafe document covers issues such as internet sales, electronic prescribing and defining what may constitute being "under a prescriber's care". The NZ National Board response will support the possibility of electronic prescribing so long as there are safeguards and guidelines on when it is appropriate and when a person is "under a prescriber's care".

"Towards a Cancer Control Strategy for New Zealand"

This Ministry of Health discussion document was released just prior to Christmas. It covers a range of issues from primary prevention through screening and early detection, treatment, support and rehabilitation to palliative care. Submissions on the document close on 14 March and it is being reviewed at present to determine relevant areas for RACS comment.

Testing trauma care against

The Trauma Verification Programme, developed by the College, is expected to improve trauma patient outcomes in Australasian hospitals

A young man sits slumped unconscious and badly injured, behind the wheel within the wreckage of his car.

A passing motorist alerts the emergency services and soon he is being prised free, stabilised as best he can be and raced to the nearest, or most appropriate trauma hospital.

He could be any young man, one of hundreds wounded on Australian roads each year.

But if he were your son or brother, how confident would you be that upon entering that hospital, he would receive the best possible trauma care through the most effective system?

Would the right people be on duty? Would the necessary equipment be available? Would there be the most effective procedures in place and in practice to guide the coordination of his care from the time the ambulance drives into emergency until his release?

The RACS Trauma Committee has now established a process called the Trauma Verification Programme, to allow hospitals to answer those questions.

Set up two years ago through a $50,000 RACS seeding grant, the inter-collegiate project has now completed its pilot phase and is available to all trauma-care hospitals throughout Australasia.

Under the system, each hospital wishing to undergo trauma verification receives detailed questionnaires covering pre-hospital, emergency department and in-hospital processes of care for trauma patients.

Responses to these questionnaires, which often take months to complete in the detail required, are then analysed by a multi-disciplinary RACS-appointed team which can include representatives from the Australasian College of Emergency Medicine, the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists, Australasian Trauma Society and the Australian College of Critical Care Nurses.

After completion, the hospital receives an informal consultation visit by a two-member team to critique the hospital's own preliminary review before the more formal visit of the multi-disciplinary verification team, comprising between three and five specialists.

By means of an objective methodology, the team then reviews patients' histories in relation to the process of care delivered, as well as conducting thorough department visits and reviews.

Over the course of an evening and day, team members interview the heads of each department with more informal discussions also taking place.

The verification process concludes with a confidential detailed report given to the hospital highlighting the strengths, weaknesses and any criteria deficiencies in the delivery of care.

Chairman of the RACS Trauma Committee, Associate Professor Peter

international standards

Pictures: At the scene of a trauma incident

Danne, said the verification process was based on the highly successful programme established in the US ten years ago.

He said the RACS had decided to establish its own programme because of continuing concern at the level of inadequate outcomes in the management of trauma patients across Australasia.

"We decided to take this on at the College because it allows hospitals to accurately assess the effectiveness of their care against international benchmarks," Associate Professor Danne said.

"Since its introduction in the US, our colleagues at the American College of Surgeons swear by it, describing it as the single best thing they have developed and introduced, excluding the ATLS® programme, to help hospitals considerably improve trauma patient outcomes.

"Trauma services often grow up in an ad-hoc manner, often the human and equipment resources have not kept pace with requirements and there is, at times, a lack of coordination between clinicians and hospital administration.

"There have also been considerable advances in the technology and skills available to treat trauma patients.

"The College considers the verification process then as a fairly painless way for a hospital to determine how it is working and what can be done to improve its systems and therefore patient outcomes."

While the College awaits a decision on its application for funding from the Federal Government, the process now costs each hospital around $10,000.

So far, seven hospitals across Australia have undergone the verification process.

Dr Damian McMahon, chair of the RACS Trauma Verification Sub-Committee, said another three were scheduled for this year.

He said while the process was still too new in Australasia, research coming from the US supported its effectiveness.

And he said the other great benefit of verification was that it gave hospitals a clear agenda for change.

"The final report delivered to the hospital can outline recommended changes in everything from the roster system to auditing methods to major equipment purchases," Dr McMahon said.

"Therefore the trauma verification report can lend weight to requests made within inter-hospital funding negotiations.

"At the same time the cost of the process can be recouped in better patient outcomes, fewer complications and shorter hospitals stays.

"Obviously it is not possible to have a trauma centre on every road corner but good trauma care ensures that the right patient gets sent to the right hospital to receive the best and most appropriate care.

"This verification programme allows that to happen by improving systems."

For further information on the Trauma Verification Programme, contact Ms Lyn Journeaux, RACS Trauma Committee Secretariat, on +61 3 9276 7448 or email lyn.journeaux@surgeons.org

Learning from the

Existing cyclone contingency plans were a vital part of Royal

A full-scale annual pre-cyclone season emergency drill, conducted just six weeks before the Bali bombing, played a key role in the Royal Darwin Hospital's ability to manage and treat the scores of critically ill victims who arrived within hours of the tragedy.

As hospitals around Australia conclude reviews into the lessons learnt in the wake of the bombing, attention has now turned to the remarkable role played by the RDH, which acted as the Australian point of entry for 62 seriously injured patients.

Already three key staff have been asked to present papers at conferences around the country detailing how the hospital managed the crisis, with more requests expected to follow.

The director of the Division of Surgery at the RDH, Mr Garrett Hunter, described the 48-hour period following the blasts as a "horrendous weekend" but said the dedication and expertise of staff meant that of all the desperately wounded patients who received emergency treatment at the RDH, only one victim died, in Darwin in the ICU.

"In some aspects, the Royal Darwin Hospital was quite uniquely placed to deal with such a crisis in that we have disaster contingency plans in place because of cyclones," he said.

"Given that we had seven hours notice between the time of the bombings and the arrival of the first Hercules aircraft carrying patients, we were able to put the plan into action."

In that initial period, the ICU was expanded from a nine-bed to a 20-bed unit, one 40-bed ward was completely cleared to become a High Dependency Unit, necessary extra equipment was borrowed from the nearby private hospital and outpatients was closed.

A surgical team from the RDH, headed by Major David Read of the Australian Army Reserve, and fellow Reservist Lieutenant Colonel Sue Winter, an ICU anaesthetist, were seconded to Bali and taken on the first Hercules to leave Australia.

The head of RDH's Anaesthesiology Department, Dr Brian Spain, also took a team out to meet the victims at Darwin Airport, to undertake triage and stagger arrivals.

Pictures: Peter Farkas, Clinical Photographer, Royal Darwin Hospital.

Bali bombing

Darwin Hospital's remarkable response to the Bali tragedy

The Directors of Trauma, ICU, Accident and Emergency and Surgery then co-ordinated the crisis care of the patients.

Mr Hunter said that with theatre staff on stand-by, physicians took over the management of patients within the wards.

At one time 20 patients were in the ICU under ventilation and supervision as well as approximately 40 patients in the High Dependency Unit.

Of those patients a significant number were initially treated within the theatre complex at Royal Darwin Hospital with such things as escarotomies, debridements, amputations, vascular reconstruction and orthopaedic stabilisation.

Two theatres were in use for virtually the entire 24-hour period.

By Monday afternoon following initial stabilisation and the completion of emergency surgical procedures it was apparent that a significant number of patients should be transferred to southern burns units.

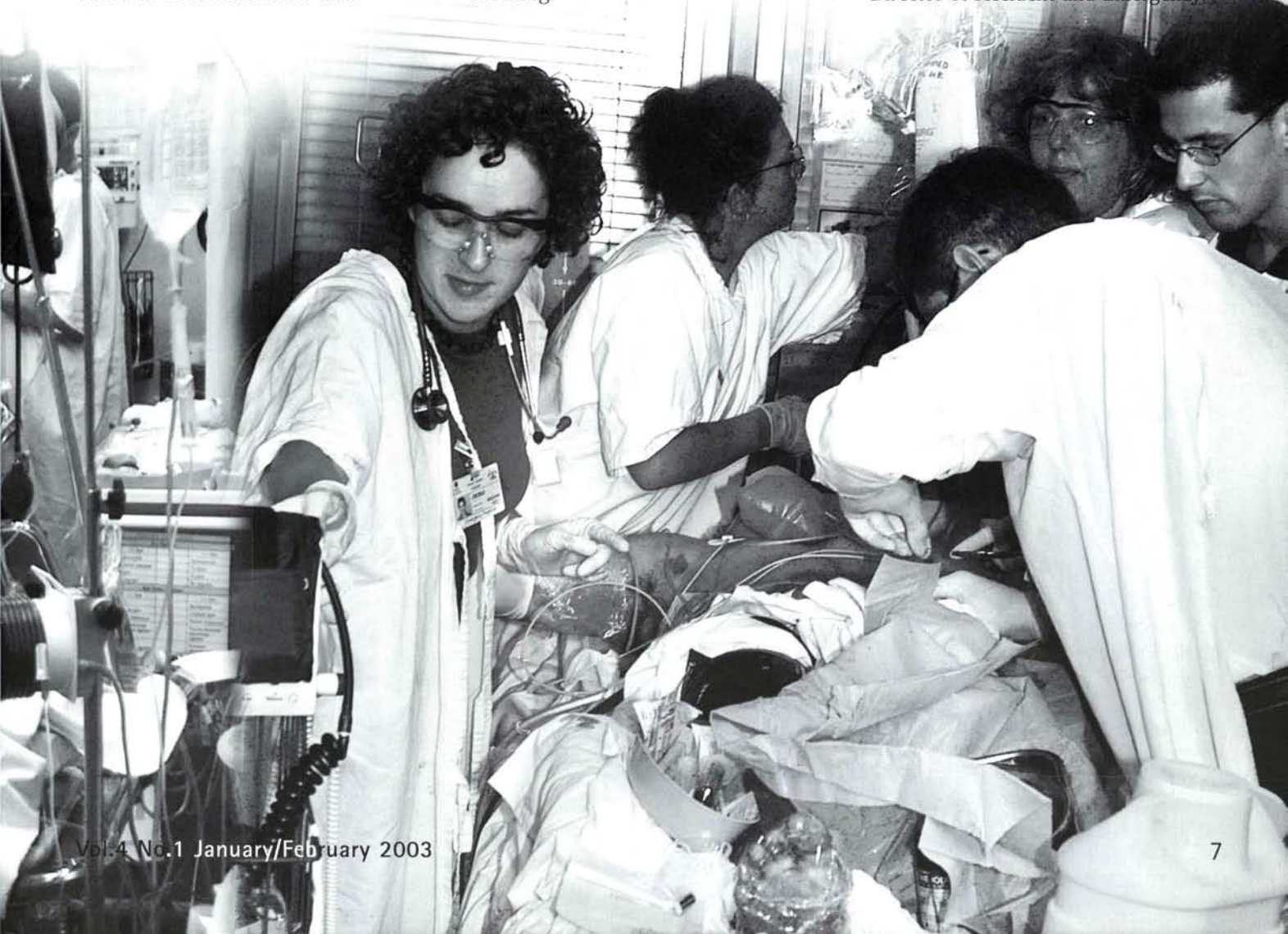
Effort was made to relocate victims to their home states.

Both the patients in ICU and the High Dependency Unit were transferred out by med jet evacuation and RAAF Hercules starting at approximately 5.30pm on the Monday afternoon and ending the following Tuesday morning.

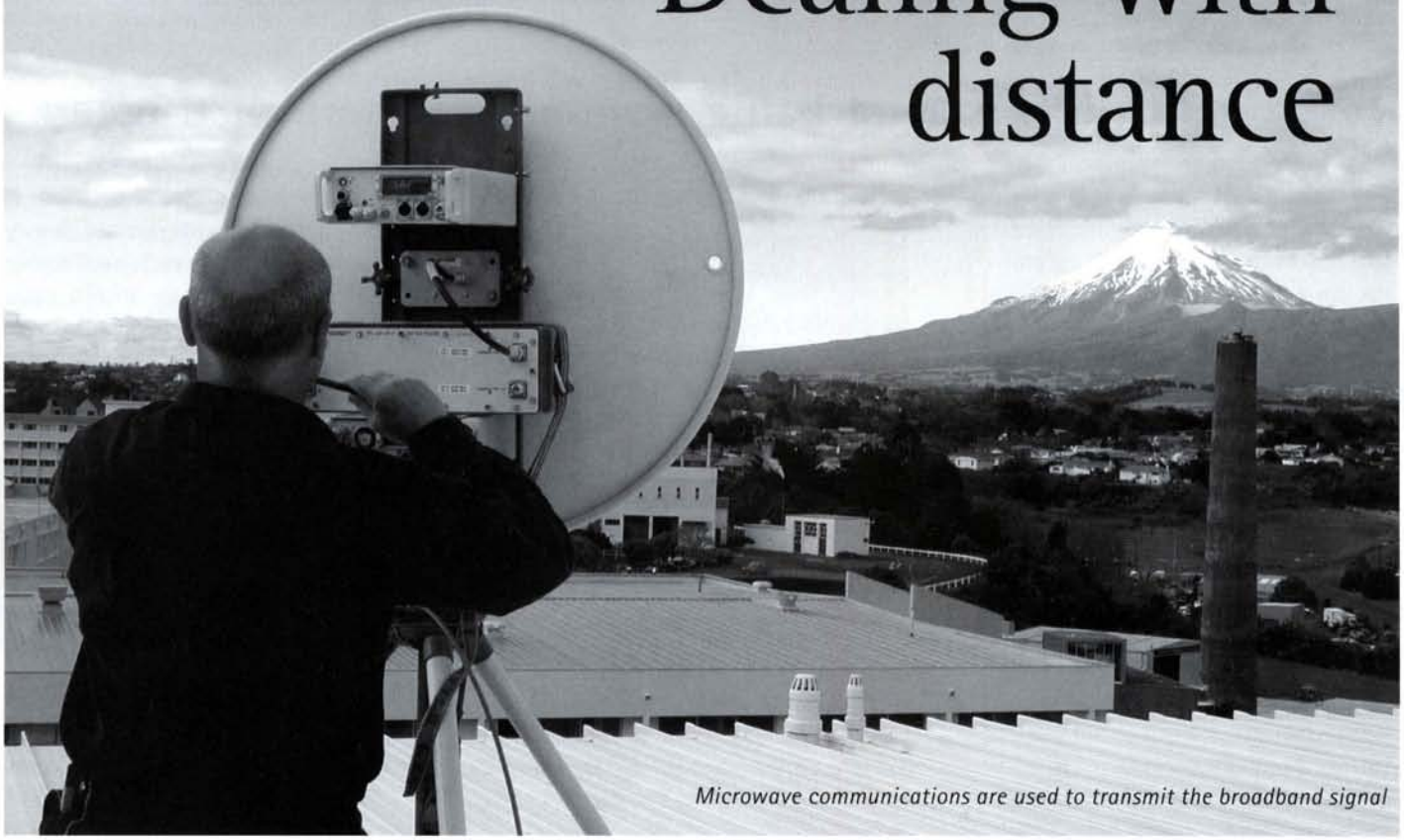
To manage, categorise and relocate this number of patients over such a short period of time was a remarkable effort, coordinated by the Director of Intensive Care, Dr Di Stephens.

The teamwork shown through this horrendous weekend was remarkable, from the excellent work done by the Director of Medicine, Dr Dale Fisher who with his team took it upon themselves to look after patients while the surgical teams were in the theatre complex, to those who volunteered to handle the phones.

Mr Hunter also particularly praised the efforts of Mr Paddy Bade, Director of Trauma, and Mr Didier Palmer, Director of Accident and Emergency.



Dealing with distance



Microwave communications are used to transmit the broadband signal

Urology is leading explorations into a new 'virtual' surgical world

Imagine operating in Sydney with an international expert looking over your shoulder offering support and guidance while sitting in their office in Geneva, or joining the Geneva surgeon as a "virtual" assistant.

Imagine training registrars by allowing them to conduct countless difficult surgical procedures at no risk to the patient, via virtual technology.

Imagine having a robot in the theatre to complete laparoscopic suturing in a fraction of the time usually taken.

Imagine isolation no longer being a problem and hindrance to surgeons wishing to work in rural areas because of broadband telepresence technology.

This brave new world is to be explored in the forthcoming annual scientific meeting of the Urological Society of Australasia (USA).

The conference, titled Urology Technology, is to be held in Queenstown, New Zealand, from 2-7 March, in conjunction with the Australasian Urological Nurses Society, and is expected to attract hundreds of registrants.

Designed around a series of contrasts, the conference will also discuss everyday subjects such as verbal and non-verbal communication skills, with an opening address by a Melbourne urological nurse who has worked in Ethiopia.

Convenor Mr Stuart Gowland said information collection, handling, storage and reporting along with critical appraisal would also be examined.

New Zealand's ground-breaking Mobile Surgical Unit, designed and developed by a team known as the Mobile Surgical Services Project, will also be a feature of the conference.

Now in operation for more than nine months, the project cost more than $5 million, with all the funds raised privately. It is being used in the health system under a government contract.

"The Mobile Surgical Unit is a vehicle which has been fitted out not only with the best surgical equipment but also with broadband video linking equipment," Mr Gowland said.

"The system is interactive in that someone else, somewhere else, can control the cameras to see what they need to see.

"There is no jerking movement, minimal time-lag and no problem with anything or anyone getting in the way of the required images as the communications contract provides quality of service guarantees.

"During the conference we plan to have a colleague conduct a

laprascopic nephrectomy in Christchurch while an expert in robotics and laparascopic surgery sitting in the audience at the conference in Queenstown will work the cameras and comment on the procedure presented on the big screen.

"What we will be saying, what this technology means, is that anyone in New Zealand or Australia can be anywhere in the Northern Hemisphere anytime they need to be."

Mr Gowland said such a mobile unit could also be of great use in Australia and New Zealand in that it could allow many surgeons to become acquainted with new expensive technologies earlier, such as robotics, without the need for individual purchase.

"There is no doubt that technology is the way of the future," he said.

"It has the potential to solve so many problems from training registrars to attracting surgeons to rural areas."

Keynote speakers at the conference include Professor Indy Gill, a global exponent of minimally invasive urology, from the Cleveland Clinic Stable; Professor Freddy Hamdy, an expert in urological cancers and critical appraisal, from the University of Sheffield; and Professor Mark Litwin, who has a special interest in medical data acquisition and outcome analysis, from the UCLA Medical Centre.

The President of the Society, Mr Russell McIlroy, said while technology was already changing the specialty, with the significant rise in laprascopic surgery for such procedures as radical prostatecomies and kidney transplants, the conference would provide a valuable forum to discuss the merits and difficulties associated with such advances.

"There are issues related to training, the length of theatre time needed and the cost of consumables, all of which need to be balanced against less morbidity and less hospital time for patients," Mr McIlroy said.

"It also brings up the issue of sub-specialisation and whether Australia and New Zealand have the case load and population base to make it viable.

"Who will fund the surgeon who only does one type of surgery via one form of technology?"

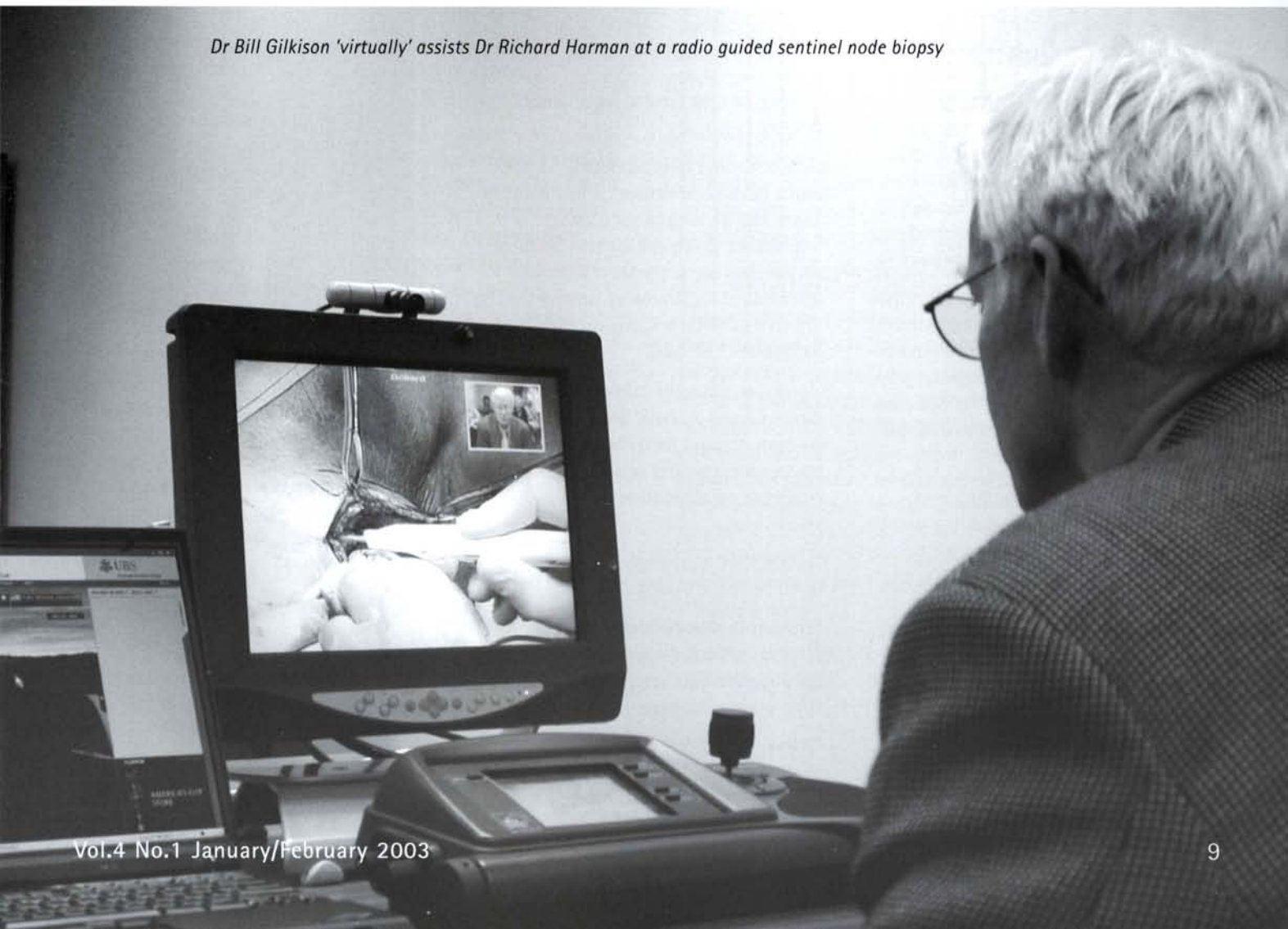
The Urological Society of Australasia appears comfortable being in the vanguard of surgical developments, having late last year become one of the first societies to sign the Memorandum of Understanding with the College.

In July it appointed its first CEO. Mr McIlroy praised the work of the new CEO, Professor David Barr, describing him as a "great asset".

"This appointment gives the Society continuity both in knowledge and on-going negotiations such as those with the College and allows us to move more quickly in many areas than was otherwise possible," he said.

"We are now in the process of working out the specifics of this agreement, which we hope to have finalised within the next six months."

Dr Bill Gilkison 'virtually' assists Dr Richard Harman at a radio guided sentinel node biopsy



Robert Atkinson

With the tragic events of September 11 and the Bali bombing, the importance of military and trauma surgery is being pushed to the political fore. Supporting this move is RACS Councillor Mr Robert Atkinson (Brigadier, Army Reserve for 32 years), who has served on the Council for almost two years and who is probably best known for his contributions to trauma and military surgery.

"In an age where the threat of terrorism in our backyards is intensifying, an urgent duty to meet the challenge of marrying civilian and military surgery exists so that the two groups can collaborate effectively in a crisis and ultimately provide greater protection for our community", says Mr Atkinson.

The same principle applies to natural as well as man-made disaster.

"Military surgeons have training and skills enabling them to work under particularly arduous and threatening circumstances, and providing a sustainable infrastructure for civilian surgeons is a key challenge and one which Council could potentially consider and prioritise," he says.

College Councillor, Mr Robert Atkinson

Although instrumental in raising the profile and progressing issues of military and trauma surgery, Mr Atkinson also identifies a number of other key areas of need.

"Improving the attractiveness and competitiveness of rural surgery and teaching hospitals, expanding CPD standards and progressing the area of medical indemnity are areas of great priority. I support Council in positioning them high on the agenda for 2003," says Mr Atkinson.

One of the driving forces which encouraged his initial standing for Council was to provide a voice for orthapaedics, but far from that alone. He also identifies the importance of the very delicate matter of the College negotiating the needs of the sub specialist groups in an environment where rapidly changing technology means an increasingly splintered fraternity.

Ross Blair

Like fellow Councillor Mr Robert Atkinson, Mr Ross Blair is renowned for his links with military surgery. Mr Blair, a vascular surgeon from New Zealand has been a member of RACS Council since 1999 and in 2000 was elected Chairman of the Court of Examiners.

His military achievements include his time as Director of New Zealand Army Medical Services for three years, Chairman and co-founder of the section of military surgery and surgical deployments to the Solomon Islands, Tonga, East Timor as well as the Gulf War.

"Over the years I have worked very closely with the Australian Army and at times with Robert Atkinson. I have introduced a number of initiatives including the introduction of a programme recruiting medical students as regular force cadets whilst the armed services pays their fees.

More recently his engagement in the military section has been wound back to facilitate other key interests including his involvement with the Court of Examiners and medico legal areas of surgery.

"Military surgery is obviously an area that I have been dedicated to for many years and an area of increasing importance given the current political climate but my interests also extend to the medical legal area of surgery and to my role as Deputy Chair on the Court of Examiners," he said.

"In an increasingly litigious environment on both sides of the Tasman, though its recognised the environments differ somewhat the challenge to solve these issues is a shared one.

"It certainly a privilege to be involved in work at the College," he said

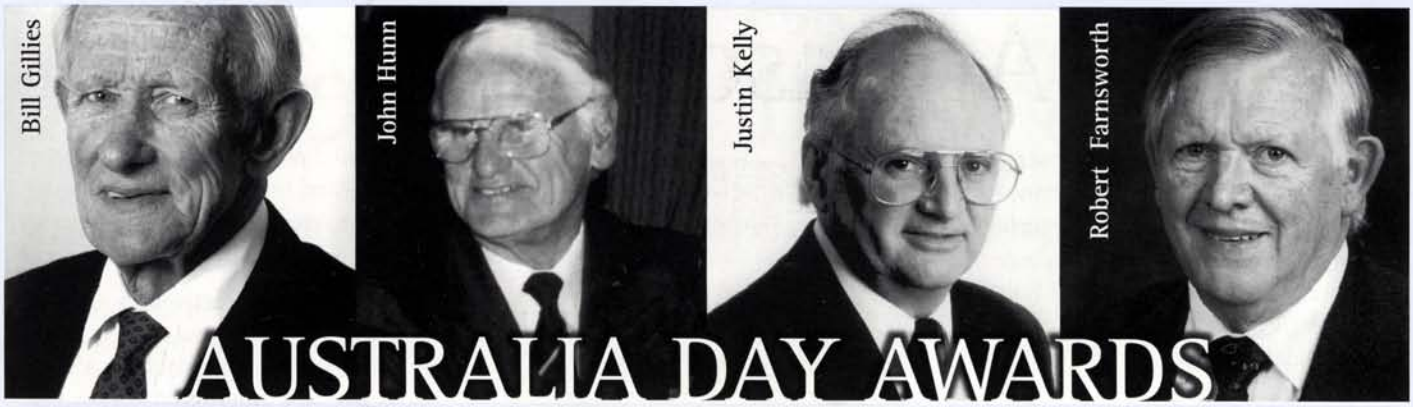
Mr Blair is also currently head of surgery at Waikato hospital, supervising 43 surgeons representing all sub specialties of surgery.

"Balancing the needs of all sub specialties is an urgent priority particularly in a technological age when surgery is becoming more and more discreet as a result of constantly evolving and complex techniques.

College Councillor, Mr Ross Blair

"And whilst specialisation becomes more pervasive and the needs of each sub specialty need to be looked after, at the end of the day Council recognises that we are all surgeons sharing common political goals.

"The College has recently experienced an evolution in administration and its important we continue innovating whilst maintaining our feet firmly on the ground"



AUSTRALIA DAY AWARDS

Dr Robert Housley Farnsworth AM

For Service to medicine, particularly for his work as a paediatric urologist.

One of the first generation of doctors to train as a urologist in this country rather than overseas, Dr Farnsworth has since been heavily involved as a principal teacher training urologists in NSW for over 30 years.

In 1980 he worked as part of a team, to introduce the rotational training of paediatrics urologists in Sydney's major teaching hospitals. He is currently head of the paediatrics urology department at Sydney Children's Hospital and is the only paediatric urologist in residence. He also currently holds the position of Clinical Programme Director for Surgery at the Prince of Wales Hospital, Sydney.

Emeritus Professor John McLeod Hunn OAM

For service to medicine, particularly in developing the burns treatment unit at the Royal Hobart Hospital, to medical education and to the community.

For 28 Years Visiting Surgeon to the Royal Hobart Hospital, including 16 years as head of the Burns Unit, he was for 10 years Staff Representative on the Board of Management and became the inaugural Director of Surgery. On retirement from the visiting staff Mr Hunn was invited to the Chair of Surgery. In 1994 he led a RACS/MAIB team which developed an Integrated Trauma Service for Tasmania.

A member of the College Council from 1991 to 1997, he was Convenor of the Hobart ASC in 1994, served on the Trauma Committee and is an advisor and facilitator for the Leadership, Management and the Law workshops. In 2002 he was awarded the College ESR Hughes Award. After working in Timor on a number of occasions in the 1990s, in July 2001 he was the initial surgeon at Dili Hospital under the newly established RACS/AusAid programme to supply surgical services and training to East Timor.

Dr Justin Henry Kelly OAM

For service to medicine as a paediatric surgeon.

Dr Justin Kelly has worked tirelessly over the last 41 years as a senior paediatric surgeon at the Royal Children's Hospital where he continues his work as Chief of Surgery.

He best known for his labours in paediatric urology looking at the rare condition of bladder extrophy.

As well as his hands on work, he took on many expert advisory roles, including Chairman of the Board of Paediatric Surgery, President of the Australasian Association of Paediatric Surgeons as time as a senior examiner.

He has also made outstanding contributions to the Pacific region and was presented with the prestigious COE Medal of the Pacific Association of Paediatric Surgeons.

Mr Stephen Wilkinson AM

For service to medicine as a surgeon, researcher, administrator and teacher and to the community as a promoter of healthy lifestyle for children.

Stephen Wilkinson is a General Surgeon at the Royal Hobart Hospital Hobart, with subspecialties in breast, endocrine, bariatric and trauma surgery. He developed and has run the 'Doc's for a Day' programme in which grades five and six children are dressed in theatre gear, taken in groups to the operating theatre, and role-play a mock operation. And also runs the Hero Award at the Royal Hobart Hospital. Mr Wilkinson is a senior EMST instructor, and just finished an EMST Course when the Port Arthur tragedy occurred. He was involved in running the surgical response at the Royal Hobart Hospital. He insists that he could in no-way have carried out any of the activities recognised in his AM award without the constant support of his wife Ris and understanding of his family, Paul and Phil.

Dr William Elliott Gillies OAM

For service to ophthalmology, particularly through the study of glaucoma and strabismus.

Dr Bill Gillies completed his training at the Royal Victorian Eye and Ear Hospital over 51 years ago. During his time at the hospital, Bill was the Head of the Glaucoma Unit, Head of the General Eye Clinic and served many years on the Hospital's Committee of Management . He founded and acted as a Convener of the Australian Squint Club and the International Strabismological Association. He was secretary of the Eye, Ear, Nose and Throat Research Institute and Secretary of the Melbourne Ophthalmic Alumni Association.

Dr Gillies was President of the Royal Australian and New Zealand College of Ophthalmology and his authored well over 100 research papers in his career.

Mr Andrew MacClean Ellis OAM

For service to medicine as an orthopaedic surgeon.

Talk is your best defence

New legislation fosters the concept of openness after adverse events

Recent studies, both in Australia and overseas, have confirmed that one of the prime reasons for patients seeking to make claims against their doctor after an adverse outcome is the manner in which the doctor dealt with them and communicated with them.

In other words, the way doctors communicate with their patients after an adverse event will substantially influence whether the patient considers making a formal claim or even suing their doctor for negligence.

The doctor who is attentive, responsive and sympathetic after an adverse outcome is less likely to be sued than the doctor who is dismissive, distant or less empathetic.

It is common knowledge that there are doctors who achieve less than optimal outcomes, but whose patients would never think of taking action against them. That is because their patients "love" them as a result of the attention, empathy and friendly treatment they receive.

There are certainly occasions when doctors, despite their best efforts, and with no suggestion of legal negligence, nonetheless face claims from patients because of the perception of less than optimal outcomes or the perception of poor care.

Open disclosure

As part of the response by governments, both federal and state, to the medical indemnity crisis, legislation has been introduced into most states to permit "open disclosure". That is, the legislation now permits doctors to have a frank discussion with their patients, without there being any adverse legal implications.

The legislation fosters the concept of openness and a frank discussion with

Honorary College Solicitor, Mr Michael Gorton

patients after an adverse outcome (whether or not there has been negligence). There can be an open acknowledgment of an adverse outcome, and even an apology (to express regret for the fact that the patient has not had an optimal outcome).

It may not be "trendy" in Australia to give an apology. However, in the case of adverse events, an apology may well be a critical factor as to whether a patient sues a doctor or not.

Legislation in most states now allows doctors to deal with adverse outcomes, without there being any admission of liability, by:

- expressing regret or apologising for an adverse outcome
- expressing sorrow or sympathy
- reducing fees or
- waiving fees entirely

Such events will also not constitute an admission of professional misconduct, or otherwise expose the doctors to civil liability for carelessness, incompetence, or unsatisfactory performance.

Open disclosure standards

In addition to these legislative changes, the Australian Council for Safety and Quality Health Care has undertaken a major project to draft standards or guidelines to assist doctors and hospitals in discussing these issues frankly with patients.

The draft standards, developed by the Council address the following issues:

- openness and timeliness of communication
- acknowledgment of the adverse event
- apology or expression of regret
- recognition of the reasonable expectations of patients
- support for staff throughout the process
- processes for risk management and systems improvement
- governance frameworks to ensure appropriate clinical risk management
- confidentiality

The Council is developing a draft standard or guideline to assist doctors, nursing staff and administrators in dealing with the issues raised by open disclosure.

Once an adverse event has occurred, it is important that the patient is kept informed, as appropriate. The clinical team should ensure that:

- they establish the basic clinical and other relevant facts
- assess the event and the level of response required
- identify who will take responsibility for advising the patient
- consider whether an additional patient's report is required
- identify other support and needs
- ensure that all appropriate staff are sufficiently informed and ensure a consistent response to the patient.

Clearly, as matters develop, patients

continued page 14

Instructions to ASC presenters

Adelaide-based group Kojo Productions has been contracted to manage the audio-visual services for the 2003 ASC Congress.

To ensure that every speaker is presented in the most professional way, the following guidelines will apply:

- Presentations will be supported by PowerPoint only (except for devoted video-only sessions).
- Send Kojo your PowerPoint presentations (95, 97, 98, 2000 and XP) via:
- Floppy disk
- CD-Rom
- Zip disk
- Or upload on the Virtual Congress site on www.surgeons.org /virtualcongress or http://virtual congress.surgeons.org
- Kojo can handle PC or Mac-based formats.
- All presentations must be received by Kojo at least two weeks prior to the Congress, by Friday, 18 April 2003, to Speaker Support Co-ordinator, Kojo, 31 Fullarton Road, Kent Town, South Australia 5067.
- If you need assistance converting your presentation from print, photos, video etc, please contact Kojo by Friday 4h April, 2003.
- If you are having trouble choosing an appropriate background for your presentation, a template will be available to you for downloading on the Virtual Congress ASC online website. The template will reflect the theme for the Congress and provide examples of text sizes and fonts for you to give a first-class professional presentation.

All of this will help increase the effectiveness and professionalism of your address.

Speaker PowerPoint presentations are expected to be published on the Virtual Congress website within 24 hours of delivering your presentation at the Congress. To facilitate the usefulness of your presentation, it is imperative that you add speaker notes for each slide in your PowerPoint presentation, as the slides are not always self explanatory.

It is mandatory that you check in to the Speaker Support Room, manned by Kojo, at the Congress the day before your presentation. This will ensure all AV checks are made well in advance and that your presentation is allocated to the correct venue.

If you have any concerns about your presentation please contact Kojo's speaker support co-ordinator on +61 8 8363 8300 or speakersupport@kojo.com.au

Younger Fellows Forum 2003

Fellows within ten years of Fellowship are invited to nominate for the 2003 Younger Fellows Forum, to be held at the award winning Couran Cove Island Resort, South Stradbroke Island, 2 – 5 May 2003. In keeping with past traditions, this will precede the ASC in Brisbane.

An exciting two and a half days of discussion and debate regarding your College and Younger Fellows' issues have been planned. The social programme is equally spectacular, utilising the excellent facilities not only of the resort but the natural scenic beauty of Stradbroke Island and the adjacent Gold Coast.

This is a good opportunity to find out more about your College or voice any of your concerns. Two councillors and special guests will be in attendance and your opinions would be highly valued. Recommendations from the Forum will be presented to Council for consideration. You will meet colleagues with similar and different interests, just starting or nearly established. What better way to spend the weekend before the ASC!

To nominate for the Forum, please contact the Younger Fellows Secretariat on +61 3 9249 1274 or e-mail kylie.mahoney@surgeons.org. Applications close 28th February 2003. The final decision rests with the Younger Fellows committee. Fellows selected will represent a range of surgical specialties and experiences.

I look forward to seeing you at Couran Cove!

Michael Mar Fan
Younger Fellows Forum Convenor

CPD Data 2002

Fellows should by now have received a Recertification Data Form for 2002. This form is to record details of your continuing professional development activities during 2002, and should be returned to the College by 31 March, 2003.

A copy of the CPD Information Manual (2001-2003) was included with the form and you should refer to this in the first instance if you are unclear about your CPD requirements. For any further assistance, contact Sauming Chan on +61 3 9249 1282, email sauming.chan@surgeons.org or Dr Pam Montgomery, Manager CPD on +61 3 9249 1281, email pam.montgomery@surgeons.org

Verification

Each year, 2.5 per cent of Fellows are selected for verification of the information contained in the Recertification Data Form. If you have been selected for 2002, you will have been notified accordingly.

Certificates

Certificates of recertification will be issued after the end of the current CPD triennium (December 2003). In addition, annual statements of participation will continue. You will receive your 2002 statement shortly after returning your Recertification Data Form. Please ensure that this statement is kept securely as you may require it for re-registration with your Medical Board and/or for re-credentialling at your hospital(s).

Guide to Surgical Audit & Peer Review

A sub-committee of the Board of Continuing Professional Development & Standards has recently completed a guide to surgical audit. This contains some useful information about how to carry out audit and peer review, and also describes the RACS recommended data sets. Fellows who participate in the RACS CPD Programme will have received a copy of this publication with their CPD data form. Additional copies are available from Lynne Cruickshank on +61 3 9276 7425, email lynne.cruickshank@surgeons.org

College's professional development workshops in 2003

A number of different workshops will again be offered through the College's Department of CPD during 2003. These workshops cover topics such as risk management and communication, management and business and, for those Fellows engaged in medico-legal work, programmes on writing reports for court and on the role of the expert witness.

In response to specific requests from Fellows, we are also introducing two new workshops in 2003. The first of these, Winding down from Surgical Practice, is designed to provide an introduction to retirement planning. The second, Practice Management for Practice Managers, is available to practice managers and will be conducted in association with the Provincial Surgeons Association conference in Tasmania. Further details are available on the College website.

Australian Council for Health Care Standards

Recognising the value for safety and quality in health care provided by the ACHS, the Board has recently recognised participation in the clinical surveyor programme for CPD credit. Fellows who are surveyors may claim credit for both the surveying itself and for the associated training. Hours should be recorded in Category 5.3 (participation in approved state or national research or quality activities).

The College encourages Fellows to participate in the ACHS clinical surveyor programme. More information is available at http://www.achs.org.au/default.htm

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Law Report from page 12

should be provided with sufficient and up-to-date information, so that they feel appropriately informed. Recommendations for further remedial care should be made as soon as possible. Follow up is an essential part of the process.

Nonetheless, the process should ensure:

- confidentiality, privacy and professional privilege
- responses to any negligent or criminal or unsafe acts (if any) including coronial investigations
- for any disclosure, consideration of whether this might further harm the patient
- consideration of any other insurance or contractual arrangements

These statutory reforms are helpful. They should give confidence to doctors and medical administrators to deal with adverse outcomes (whether negligence or not) in a caring and humane way. It is, after all, human nature to be able to express regret and sympathy where a patient has had an adverse outcome to treatment or procedure, without such concern being considered an admission of legal liability.

The medical indemnity crisis requires much more to be done before the medical profession can be satisfied that all of the issues have been adequately considered. However, moves to greater "open disclosure" by legislative reform are most welcome.

Michael Gorton, B Comm, LLB, FRACS (Hon), FANZCA (Hon)
College Honorary Solicitor
Partner – Russell Kennedy, Solicitors

Colorectal Cancer Care Survey

Australian Clinical Practice in 2000

Surgeon volume and how this relates to outcomes, as applied to colorectal cancer wwas highlighted by The National Colorectal Cancer Care Survey. The management patterns for individuals newly diagnosed with colorectal cancer in a three-month period in 2000 are described therein. The survey took place at the time of dissemination of the NHMRC's Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer (CRC) in order to compare practice with the Guidelines. The questionnaires used were developed from the concurrent NSW patterns of Colorectal Cancer Care Survey.

Funded by the Commonwealth Department of Health and Ageing via the National Cancer Control Initiative,the survey was coordinated by the Clinical Governance Unit, Hunter Area Health Service, New South Wales and the Discipline of Surgical Science, Faculty of Health, the University of Newcastle, New South Wales.

Each questionnaire was generated following the mandatory registration of colorectal cancer to state cancer registriesand sent to the relevant clinician.

The overall response rate was 80 per cent, with an 85 per cent (2015 patients) response rate for the surgical questionnaires and just under 70 per cent for both Medical and Radiation Oncology questionnaires.

Concordance was more than 50 per cent for 15 (65 per cent) of the guidelines. Those guidelines where concordance was less than 50 per cent were:

- the formation of a colonic pouch;
- specific antibiotic prophylaxis (a cephalosporin and metronidazole);
- the use of bowel preparation (the guidelines do not recommend its usage);
- combined modality adjuvant therapy for patients with high risk rectal cancer (2 guidelines);
- hepatic arterial infusion in patients with liver metastases;
- total mesorectal excision (the guidelines do not recommend its usage);
- conduct of laparoscopic surgery with a randomised controlled trial.

Most (83 per cent) patients presented with elective symptoms such as weight loss or blood loss per rectum.

Clinicians were categorised according to the number of patients they saw. The lowest volume surgeons had a higher proportion of their workload made up of emergency patients and the higher volume surgeons had a greater percentage of patients with rectal cancer. These differences were statistically significant.

The location of residence and hospital was categorised into three areas - Capital City / Urban / Rural. For all three questionnaires.

- Patients in rural areas used public hospitals more commonly
- Patients from rural areas had to travel away from these areas for treatment more commonly than residents of other areas

The Dukes stage of resected colorectal cancer was: Dukes A – 23 per cent, Dukes B – 28 per cent, Dukes C – 27 per cent, Dukes D – 18 per cent (unknown 4 per cent). Patients who presented at a younger age were more likely to present with a tumour of a less favourable grade. Patients who presented through screening were significantly more likely to present with a tumour of a more favourable grade. Those who presented as an emergency were less likely to present with a favourable grade.

The 2,015 patients were seen by 550 surgeons. Some 75 per cent of surgeons saw one new patient with colorectal cancer every 47 days. More specifically, there were 523 patients with rectal cancer who had an operation. They were operated on by 252 surgeons over three months, with 90 per cent of surgeons operating on a single patient with rectal cancer every two months.

Patients seen by the lowest volume surgeons were twice as likely to have an Abdomino-Perineal resection and a permanent colostomy compared with those patients seen by the highest volume surgeons. This difference was most pronounced for tumours of the lower third of the rectum. Formation of a colonic pouch, considered best practice for patients with tumours of the lower half of the rectum, was significantly less likely to have been performed in those patients seen by the lowest volume surgeons. However, there was no difference in these outcomes between patients in capital cities and elsewhere.

Higher volume surgeons offered radiotherapy to a greater proportion of their patients with rectal cancer at high risk of recurrence, and were significantly more likely to give this pre-operatively, as is recommended in the guidelines.

The survey identified the need for the NHMRC to improve its system of keeping guidelines up to date. The rapid uptake of total mesorectal excision by surgeons exemplifies how practice moved ahead of the guidelines as new evidence merged that was not reflected within them.

The delivery of care delivered by a large number of surgeons who treated relatively few patients with colorectal cancer and especially with regard to rectal cancer, with differing outcomes, was noted. Options to improve guideline concordance such as meaningful continual professional development, incentive payments and recredentialling, are suggested in the report.

Of the 185 patients who had died at the cessation of data collection (22 March 2001), 30 (16 per cent) did so not as a result of their disease but as a complication of their treatment.

The full report (140+ pages, 24 figures and 168 tables) is available from the National Cancer Control Initiative, phone +61 3 9635 5108, or on the NCCI Web site, www.ncci.org.au or www.ncci.org.au /pdf/Colorectal_care_survey.pdf .

Acknowledgements

Thank you to the surgeons and oncologists who participated in this survey.

New College Treasure

A generous Fellow of the College who wishes to remain anonymous recently donated a valuable HJ Johnstone painting, "Waterfall Gully Panorama". The gift is in honour of his mentor Sir Benjamin Rank. Painted in 1876 it depicts a view from the Adelaide Hills, looking West over the plain to Gulf St Vincent. The house in the painting belongs to J Elder, the painting's first owner. The painting is now part of the College's Art Collection and hangs in the President's Room in Spring Street.

LIBRARY/WEBSITE NEWS

The College website is now a year old. It has grown in leaps and bounds, with some months recording in excess of 100,000 hits. The website continues to evolve as an information resource, as a promotion of the work and ideals of the College and as a benefit to Fellows.

Next month a survey will be sent out to seek feedback and recommendations from Fellows and Trainees about the College Library and website. Your comments and experience will help us to continue to develop the best possible services.

Home Page

Your home page is the page that appears every time you open Internet Explorer. If you'd like to your home page to be the bright new College home page, you can use the following steps to set this preference -

Firstly, open Internet Explorer.

- On the Tools menu, click Internet Options.
- Click the General tab.
- Under the Homepage section, in the Address box type in <www.surgeons.org>.
- Click Apply.
- Click OK.

Next time you open Internet Explorer, the College home page will come up. You can then do your normal searching by clicking on your favourites list or typing the URL you want into the address field.

Thank You

A big thank you to all generous sponsors who made the International newsletter possible.
And an especially big thank you to Ron Keys, Sales Manager at Excelsior printing who coordinated the sponsorship.

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DALTON FINE PAPER

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Dalton Fine Paper

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Thank you Mr Henderson

Thank you to Fellow Mr John Aloysius Henderson for supplying a photograph for publication in the 2002 International Newsletter, which he had snapped at the 2002 ASC featuring Rowan Nicks and the 2002 Rowan Nicks scholars.

Celebrating a great contribution

Dear Editor

This letter is written on behalf of the surgeons of Princess Alexandra Hospital, Brisbane, Queensland. Professor Strong is an internationally recognised Australian surgeon who is Professor of Surgery at the Princess Alexandra Hospital. He is soon to retire. Staff at the Princess Alexandra Hospital have organised a Festschrift to be held on the 4-5 May, 2003. This will precede the ASC, which will be held in Brisbane in 2003. The surgeons of Princess Alexandra Hospital Liver Transplant Unit and the Hepatopancreatobiliary Unit wish to invite all Fellows interested in celebrating Professor Strong's contribution to surgery to join us on the 3-4 May, 2003, for a meeting with academic, social and sporting activities. Please write to or contact

the organisers by e-mail (s.lynch@ug.net.au)

Daryl Wall

Companions on a historic journey

Dear Editor

Regarding "Four generations of genius" (Surgical News, September 2002). This a great and well-deserved tribute to the Windsor family.

However, you could bring to the author's attention that there is one small error. Harry was flown down from New Guinea on a Martin-Marriner gull-winged flying boat of American origin and crewed by the RAAF. The trip took three days from Port Moresby only reaching Bowen, Queensland, due to headwinds on the first day and then Brisbane the second day, having lost one of the two engines, finally arriving at Rose Bay on the third day.

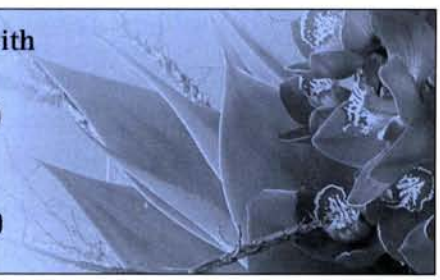
How do I know? Harry and I were companions for the journey! Best wishes to Windsor descendants.

Keith Jones

Death Notices

The College has recently been advised and notes with regret the passing of the following Fellows:

Mr Brian Maxwell ANDREA 1925 (NSW)
Mr Bruce GEANEY 1926 (Qld)
Mr Gregory B CONLON 1929 (NZ)
Mr Trevor T.E.C. WILLIAMZ 1926 (NSW)
Dr Helen Anne WARD (NSW)



Obituary

Tim Beamish *Assistant Secretary of RACS 1957-1961*

Born 24, January, 1924
Died 19, October, 2002

Tim Beamish was 78 years old when, sadly, he passed away in October last year. After joining the State Bank of Victoria and steadily working his way up the ranks, he undertook the position at the College as Assistant Secretary, a post in which he served for four years. He later joined the Victorian Road Transport Association (VRTA) as an executive director, where he built a strong reputation as a fearless advocate and earned the legacy of being one of the longest serving directors of an Australian transport association.

meetings

Sydney, NSW

WHAT: The Australasian Pancreatic Club
WHEN: March 29, 2003
WHERE: The Australasian Pancreatic Club
CONTACT: Dr Amanda Dawson, convenor, Email: a.dawson@garvan.org.au
Or for more general information about The Australasian Pancreatic Club contact A/Prof Gino Sacccone, Department of General and Digestive Surgery,
Tel : +61 8 8204 5223, Fax +61 8 8204 5966, Email: gino.saccone@flinders.edu.au or Dr Minoti Apte, Pancreatic Research Group, Tel: +61 2 9828 4931, Fax: +61 2 9828 4970, Email: m.apte@unsw.edu.au

WHAT: The 6th Australasian Day Surgery Conference
WHEN: 13-15 August, 2004
WHERE: Hilton Hotel, Sydney
CONTACT: Kevin Wickham, Conference Organiser, Tel: +61 3 9859 6899, Fax: +61 3 9859 2211 Email: daysurgery@wickhams.com.au

Surfers Paradise, QLD

WHAT: 4th Joint Conference of Infection Control Practitioners Association of Queensland and Queensland Wound Care Conference
WHEN: 11-13 September 2003
WHERE: Surfers Paradise Marriott Resort, Qld
CONTACT: WIC 2003, C/ Intermedia Convention and Event Management, Tel: +61 7 3858 5510, Fax: +61 7 3858 5538, Email: wic03@im.com.au

Boston, USA

WHAT: Fifth International Congress on Ambulatory Surgery
WHEN: May 8-11, 2003
WHERE: Boston Massachusetts, USA
CONTACT: The Preliminary Program for the 5th International Congress on Ambulatory Surgery is currently being mailed and the web site for the Congress is being updated with complete program information at the new address of www.iaascongress.org

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The Qantas Club

The New Qantas Club Member corporate rates for RACS members are:

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- 2 Year Membership - $689.53 (Saving you $179.63)
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For more information or an application form, please call RACS MemberAdvantage on **1300 853 324.**

^This price includes Qantas Club joining fee and $55 Member Advantage administration fee.

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Western Australian Interactive Virtual Environments Centre

Doctoral Scholarship Top-ups (Round Two)

The Western Australian Interactive Virtual Environments Centre (IVEC, www.ivec.org) is a joint venture of Central TAFE, CSIRO's Division of Exploration and Mining, Curtin University of Technology (Curtin), and The University of Western Australia (UWA). IVEC is a Partner in the Australian Partnership for Advanced Computing (APAC, www.apac.edu.au) and a Foundation Member of the Centre for Networking Technologies in the Information Economy (CeNTIE, www.centie.org). IVEC has created the Western Australian IVEC Doctoral Scholarship (WAIDS). WAIDS carries a top-up scholarship of $5000 per annum and a project support grant of up to $5000 per annum for current holders of APA, APA(I) or similar awards. Applicants must be an eligible doctoral student undertaking an agreed research project within one of the four IVEC member organisations, Central TAFE, CSIRO Exploration and Mining, Curtin or UWA. Recommendations will be made to the IVEC Education Advisory Committee via the member's representative on the committee.

Applications

Applications for Round Two of WAIDS will close on Friday, 21 February, 2003.

Subhead>Further Information

For further information regarding the conditions of the award or for an application form, please contact the scholarships office at your institution or visit www.ivec.org.

2003 COLLEGE DIARY CORRECTION

The contact details for the Neurosurgical Society of Australasia and The New Zealand Association of Plastic and Reconstructive and Aesthetic Surgeons appeared incorrectly in the 2003 College Diary. The correct details are as follows:

Neurosurgical Society of Australasia
C/- Ms Stacie Gull
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street
MELBOURNE VIC 3000
Tel: +61 3 9249 1294
Fax: +61 3 9249 1240
Email: stacie.gull@surgeons.org

The New Zealand Association of Plastic and Reconstructive and Aesthetic Surgeons
26 Bracken Avenue
Takapuna, NEW ZEALAND
Tel: +64 9 489 8374 Fax: +64 9 486 4369

Fellowship in Pain Medicine

The Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists is a multicollegiate Faculty with Fellows from ANZCA, RACS, RACP, RANZCP and AFRM (RACP).

Training is concurrent with the primary specialty training, followed by one year in an approved training position. Training can be undertaken in the Post Fellowship year. Training positions are available in all Australian States as well as in New Zealand.

Surgeons in training and interested in a career in Pain Medicine as well as surgery, are encouraged to enrol as soon as possible during their training.

For further details please contact:
Executive Officer
Faculty of Pain Medicine
ANZCA
Tel: +61 38517 5337
Fax: +61 39510 6931
Email: painmed@anzca.edu.au
www.fpm.anzca.edu.au

The Faculty of Pain Medicine is holding a Refresher Course day of Friday, May 2, 2003 in Hobart. Speakers include Professor Henrik Kehlet, Professor of Surgical Gastroenterology at the Hvidovre University, Denmark.

For further details, please contact the Faculty of Pain Medicine -
Telephone: +61 3 8517 5337, or
Email: painmed@anzca.edu.au
www.fpm.anzca.edu.au

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The course dates are:
Sydney: 30 & 31 July 2003
Melbourne: 18 & 19 August 2003 and 25 & 26 November 2003

(N.Z. : T.B.A.)
contact details:
Melbourne & Auckland: Judy Forsyth, Royal Melbourne Hospital. Tel: +61 3 9342 7232. Email: Judy.Forsyth@mh.org.au.
Sydney: Charmaine Miranda, Liverpool Hospital. Email: charmaine.miranda@swsahs.nsw.gov.au'

Australasian Post Fellowship Training Programme In Colon and Rectal Surgery

Applications are invited for this two-year Programme commencing in January 2004. The programme is organised by a Conjoint Committee representing the Section of Colon & Rectal Surgery of the College and the Colorectal Surgical Society of Australasia.

Enquiries:
Mr Philip Douglas – (+61 2) 9650 4222

Closing Date:
25 April 2003

Applications:
There is no form - applications should be by letter, including a Curriculum Vitae and the names and addresses of 3 referees.

Mr Philip Douglas, Chairman
Training Board in Colon & Rectal Surgery
PO Box 5039
Greenwich NSW 2065 Australia
E-mail: janstuart@bigpond.com

THE UNIVERSITY OF ADELAIDE DEPARTMENT OF SURGERY
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Professor Glyn Jamieson, former Editor, *Gullet*
Professor Guy Maddern, Author,
Questions You Should Ask Your Surgeon
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Professor David Watson, Successful NHMRC grantee

Registration Form

Name: _____

Institution: _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

Name preferred on badge: _____

Registration (including lunch, morning and afternoon tea) $55
Full time students $22

Please forward registration form and cheque made payable to The Queen Elizabeth Hospital to **Professor Guy Maddern, Department of Surgery, The Queen Elizabeth Hospital, Woodville 5011.**
A tax invoice will be forwarded on receipt of cheque.

Closing date for registrations: 28 February 2003

Thursday 6 March 2003
0800 – 1700

Board Room Level 1 Eleanor Harrald Building
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Director, Medical Teaching Program Wollongong & Shoalhaven

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The Organisation and Position

This position represents an outstanding opportunity to be at the forefront of a new and exciting development in academic medicine in Australia. The Wollongong and Shoalhaven Medical Teaching Program, has been established by the UNSW Faculty of Medicine in collaboration with the Illawarra Area Health Service, for the further development of clinical education of medical students.

The University of New South Wales has a fully developed Medical Faculty operating from a number of sites in Sydney and has a rural clinical school across the Mid North Coast and Greater Murray Areas of the state. Illawarra Area Health Service is one of the major health services in New South Wales, Australia's most populous state. The Illawarra offers a great lifestyle in a beautiful coastal region just over one hour's drive south of Sydney, or alternatively, is commutable from the Southern suburbs of Sydney. For families, the region is well serviced educationally by public and private schools, and the University of Wollongong. Geographically, the region offers an outstanding mixture of beaches, mountains and coastal plains, along with many lakes, rivers and the magnificent Jervis Bay. Wollongong also offers a range of leisure, cultural, and sporting facilities and has teams in major national and state sporting codes.

The focus of teaching in the Medical Teaching Program will be in the clinical education of medical students and the educational programs will be based around both hospital and community-based practice settings, providing substantial opportunity for developing creative teaching programs. The aim is to provide diversified educational offerings in medical practice for UNSW medical students. This role may also involve oversight of postgraduate research students and participation in teaching of junior medical staff. Opportunities for development of research programs will occur in concert with the development of the teaching program.

The Person

In essence, we seek someone who can:

- effectively perform the administrative and interpersonal aspects of setting up and running a clinical school
- demonstrate clinical leadership in a particular area of specialty
- demonstrate an interest in conducting and/or facilitating relevant research as well as teaching.

Essential criteria for appointment at either level: Medical qualifications registrable in NSW; successful completion of postgraduate training through a relevant professional College or equivalent; a record of excellent achievement in teaching and supervision at undergraduate and postgraduate levels; a record of achievement in administration in a tertiary institution or equivalent; experience in implementing equity and diversity policies and programs.

Additional essential criteria for appointment at Associate Professor level: a record of effective leadership; an excellent record of research, research funding and publication in a relevant discipline; a record of successful interaction with Government authorities and professional organisations.

Additional essential criteria for appointment at Professor level: a distinguished record of scholarship and excellent leadership; a distinguished record of research, research funding and publication in a relevant discipline; a strong record of successful interaction with Government authorities and professional organisations.

Desirable criteria: a higher degree preferably PhD or MD.

A generous remuneration package is on offer for the position. It will include salary, clinical loadings and superannuation from UNSW, with additional components payable by Illawarra Area Health Service under the 'Remuneration Arrangements for Senior Medical Practitioners (Academics)'. Further details are available on enquiry. Subject to the terms of the University's Paid Outside Work Policy, an appointee may be able to undertake one day per week private practice.

Suitably qualified women and people from EEO groups are encouraged to apply. This position is full time (continuing). Membership of a University approved superannuation scheme is a condition of employment for this position.

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Enquiries or applications can be made, in confidence, to Wayne Bruce, on 02 9232 8148 (phone) or by email to wayneb@trakrecruit.com

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