



# INTERNATIONAL DEVELOPMENT PROGRAM

*a collection of stories*



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Managed by the Royal Australasian College of Surgeons (RACS), the Australia Timor Leste Program of Assistance for Specialist Services (ATLASS) aims to improve the availability and quality of general and specialist surgical services to the people of Timor Leste through the training of local Timorese doctors and nurses and assisting with the delivery of tertiary health care services.

As the national hospital for Timor Leste, HNGV is responsible for the provision of a wide range of surgical and non-surgical specialist services and it is the only referral hospital for the 5 district hospitals in the country. The ATLASS program currently employs 3 full-time clinical advisors (general surgeon, anaesthetist, emergency department physician) at HNGV and co-ordinates approximately 12 specialist surgical team visits across Timor Leste per year.

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Please send your application including a covering letter and CV to [karen.moss@surgeons.org](mailto:karen.moss@surgeons.org).

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# *a collection of stories*

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*Professor David Watters  
FRACS*



Fellows of the Royal Australasian College of Surgeons (RACS), representing surgeons in Australia and New Zealand, have been involved in surgical outreach throughout the Asia-Pacific region since the 1950s. Initially the involvement was based around individuals and their overseas contacts, then on organisations focusing on a particular specialty. Recognising the value of specialist support, the governments of Australia and New Zealand through their donor agencies, AusAID and NZAID, have sought to develop programs that not only deliver specialist services but also teach, train, transfer skills and so build capacity. These programs have grown large enough so as to incorporate many other specialties, not just surgical ones, and our team members include Fellows and representatives from all the specialist colleges.

## **PARTNERSHIP**

The countries of our region are proudly independent. They are developing fast but face increasing demand from their growing populations for specialist health care. Their peoples suffer not only from tropical diseases and neglected, advanced pathologies but also from the modern scourges of cardiovascular disease, diabetes and malignancy. They invite us to be their partners in the development of better health care, in supporting their existing specialists, and in contributing to specialist education and training. Until now we have accepted their invitation with alacrity and they have suggested we are likely to be welcome guests for many years to come. There is rightly an increasing need to ensure that priorities are determined by the host countries themselves and not by our perception of what is required.

## **LEADERSHIP**

As a result, the coordination and agenda setting of our three largest aid programs are already, or will soon be, based in the Pacific, PNG and Timor Leste, rather than at RACS. We have invited senior representatives from these countries to address us. We rely on their knowledge, culture, capability and capacity to be effective partners. We also depend on their vision, leadership and direction so that our efforts are appropriate and effective. For our part, we need to fit in rather than muscle and barge.

## **HOW CAN WE CONTRIBUTE?**

Fellows and members of Specialist Colleges and Societies in Australia and New Zealand can contribute in many ways:

- We can visit to train and teach specialist skills.
- We can support professional development and standards of those we have already trained.
- We can provide opportunities for specialty experience to be gained under supervision in Australia, New Zealand or other appropriate countries. The funding for such opportunities can be sourced through government donor support or through scholarship funds such as the Rowan Nicks or Weary Dunlop Boon Pong Scholarships, Surgeons International or other travel grants.
- We can contribute through one of our specialty-focused or regional service providers. These include Orthopaedic Outreach, Interplast, Project China, Kind Cuts for Kids, Foresight, Optometry giving Sight, Overseas Specialist Surgical Association of Australia (OSSAA), Operation Smile, Specialists without Borders and the Australian Society of Anaesthetists (ASA).



Each of the specialty groups is welcome to submit a report to the RACS International Committee, and some have representation on it. RACS aims to be inclusive, supportive and facilitative without interfering. The International Committee has a brief to ensure standards are met and rules of engagement are followed by Fellows involved in international development. The relationships with each of the above groups needs to be individualised as each one is quite different. Many groups have had stories published in Surgical News which aims to cover the full scope of international work conducted by the College and its Fellows. Whilst in the past our engagement has been with hospitals and universities in South-East Asia, the Indonesian Archipelago and the South Pacific, an increasing number of Fellows visit other regions of the world. Examples of such places are sub-Saharan Africa, the Indian sub-continent including Bangladesh and Nepal, and the Middle-East.

## ADDING VALUE

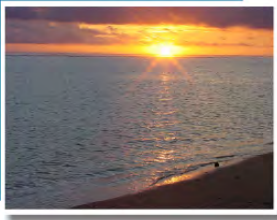
With the exception of full-time employed clinicians in Timor Leste, all contributions as specialists are provided pro-bono. Their value is conservatively estimated at double the value of the contracts RACS holds with AusAID and other funding agencies. For example, if \$4m were a rough annual figure of program activity, the value of honorary contributions and other supporting donations would be at least \$8m. Funding agencies like AusAID are aware of this added value and so they appreciate the excellent return for the funds provided. Like all service providers, RACS charges an overhead to cover the direct costs of project staff and administration. It is important that the running of the international program covers its costs, and does not seek subsidy out of Fellow subscriptions. Any savings made from operations are only realised at the end of a project and a substantial proportion is redirected to a Foundation for International Development work under the control of the International Committee. The guidelines for use of International Committee Foundation funds specify they are to be directed towards one-off ventures that may lead to ongoing activity funded by other agencies. They are not for supporting existing programs, nor for immediate disaster relief, though they could be used to support surgical services in the rebuilding phase where no other funds are available. A recent example was \$20,000 to introduce Primary Trauma Care to Myanmar, following Cyclone Nargis. Primary Trauma Care is an example of a course relevant to and taught by Specialists in Surgery, Anaesthesia and Emergency Medicine.

The RACS also works with Fellows of many other Specialist Colleges to deliver its programs. One aim of this booklet containing articles published in archival editions of Surgical News is to present the extent to which Fellows of this and other specialist colleges have offered their time and expertise to their colleagues in neighbouring countries. We wish to support those who are willing to lend a hand to those less privileged. The answer to the biblical question, 'Who is my neighbour?' could be covered by the words of a very old song, which says, 'Neighbours are nearby and far away... all men are neighbours to us and you'.

A handwritten signature in black ink, appearing to read 'D. Watters', with a long horizontal line extending to the right.

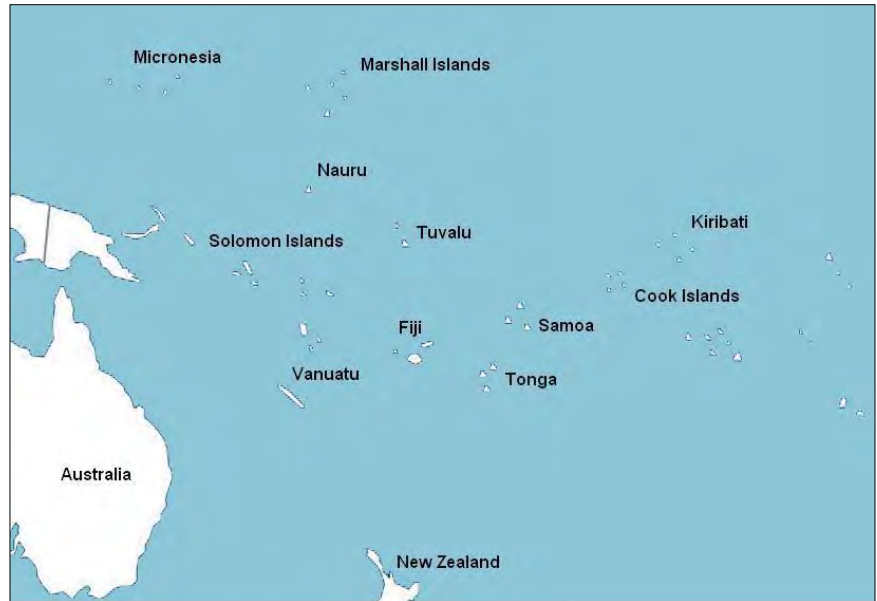
Professor David Watters, FRACS  
Chairman, International Committee

An overview



# PACIFIC ISLANDS

Fellows of the Royal Australasian College of Surgeons, based in both New Zealand and Australia, have been providing surgical services to the Pacific for more than three decades. During the 1980s ASPECT, Interplast and Orthopaedic Outreach each individually obtained donor funding to provide specialist services in ophthalmology, plastic surgery and orthopaedics. Both New Zealand and Australian hospitals have, over the years, offered specialty training for Pacific Island doctors with the result that some have obtained their FRACS, though only a handful of the successful have returned to their home countries.



Significantly, these few surgeons have made enormous contributions to the provision of health services in their countries and the RACS is proud of them. Eddie McCaig (FRACS 1989) is a senior orthopaedic surgeon and the Head of the Clinical School at the Fiji School of Medicine, overseeing postgraduate training. The Hon Villiami (Bill) Tangi (FRACS 1983) is the Minister of Health and Deputy Prime Minister of Tonga. Another Fellow, Eti Enosa (FRACS 1990), was formerly Secretary for Health in Samoa. Eric Pana (FRACS 1995) was Director of Surgery in the Solomon Islands. Jitoko Cama (FRACS 2008) has recently returned to Fiji as the nation's first Paediatric Surgeon.

The Pacific Islands Project (PIP) was established by AusAID in 1995 to fund specialist services to 11 nations shown in the following tables. RACS has managed each of the three phases of the Project according to the agreed project design in consultation with the Ministries of Health of each island nation. In addition to clinical services, support has been provided for equipment, priority health needs, and capacity building. Capacity building, not a primary focus of the early phases, was achieved through transfer of skills from visiting teams to local

health workers and specialists, and by more formal teaching through workshops and courses. Seeing Pacific Island doctors and other health workers being more able to treat their own patients has been one of the most satisfying and enduring achievements of those who have comprised visiting teams. From the perspective of the Pacific, it has proved a popular project. Feedback received from clinical directors and specialists in the host countries has been consistently positive whenever the project has been formally reviewed.

During the same period, NZAID funded the management of some Pacific Island patients in New Zealand, offering a selection of countries a budget for overseas diagnosis and treatment. A few years ago the NZAID program shifted its emphasis to also incorporate visiting teams as well as overseas treatment of carefully selected patients, not able to be treated in their home country. It is much more cost effective to treat patients in the Pacific than to fly them to New Zealand. This scheme is currently being managed by Kiki Maoate and Debbie Sorenson at Health Specialists Ltd.

The Fiji School of Medicine, which has trained health workers since the 1880s, began postgraduate specialist training in 1998. The School was supported in the early years by the Fiji School of Medicine Project (1998-2003), funded by AusAID, and managed by the RACS with Gordon Clunie as Project Director. The School offers Postgraduate Diplomas (one year) and Master of Medicine degrees (four years). Despite many challenges the School has succeeded in graduating 37 surgical diplomates, of whom eight have gone on to complete their MMed with nine others in the process of doing so. Only five of these diplomates are not working in the Pacific, a tribute to the importance of local training programs in retaining specialists. Those who have gained the MMed have, to date, generally been offered a short period of experience in their chosen specialty somewhere in New Zealand or Australia, through the Rowan Nicks Pacific Islands Scholarship.

A visiting specialist team has a number of components to its activity. There is the communication to the public and health workers as to the what (sort of visit), where, when and how (to refer a case). There follows a screening or pre-selection of possible cases by someone local with a knowledge of what can be achieved. This is followed by the arrival of the specialist team who assess cases for treatment or operation, bearing in mind their understanding of local facilities and abilities. Then there is the provision of postoperative care and the management of any complications.

A team comprises not just the visitors but also the local health workers and specialists. The relationship is symbiotic and usually synergistic. The visitors cannot deliver the service without the

locals who provide the patients, the facilities, speak the language and understand the culture. The locals cannot have their patients managed without the special skills of the visitors. The visitors cannot teach if there is no one to learn. The locals cannot acquire skills if there is no one to pass them on. As local specialists become more skilled they develop into team leaders and the visitors start to take a more supportive role.

Each country is different in terms of size, capability and medical/surgical workforce. Some countries are too small to even hope to train a specialist in every area. They will expect some form of itinerant service supported by referrals. It is important that team members are briefed and debriefed. They must also write reports but the value of a report is not just to inform the managing agents (RACS) or the funders (AusAID or NZAID) but also to ensure there is a full account for the host hospital and nation. Ideally reports should be generated in-country and certainly the information provided on patients must be available to the local hospitals and specialists. Recommendations made must be achievable and appropriate. They should be agreed upon by all team members, both local and visiting. In considering negatives, there is a need to understand culture, context, and recent change, before assuming that criticism will be taken positively or advice acted upon.

In discussions of the future of specialist medical aid to the Pacific Islands there has been a consensus that Pacific Island Specialists and Clinical Directors of individual countries should take a stronger role in setting local agendas and providing feedback to a coordinating body. We envisage a future where Pacific Island countries will organise their own teams, in response to their own assessments of their needs.

The following tables give statistics relating to Pacific Islands Project team visits to individual Pacific nations and for the various specialties. Training activities are also outlined.

These numbers testify to the scope of the Project, but the subsequent articles we have chosen from *Surgical News* illustrate the individual achievements and challenges throughout the region in a much more colourful way.

RACS Support in the Pacific, by country (2002 to 2009)			
Country	Visits	Consultations	Operations
Cook Islands	18	1535	275
Fiji	29	1824	855
Kiribati	25	5818	1303
Marshall Islands	1	220	41
Micronesia	8	882	123
Nauru	33	2791	535
Samoa	21	1297	307
Solomon Islands	35	3821	2317
Tonga	6	5547	1093
Tuvalu	17	2846	373
Vanuatu	30	2925	926
<b>TOTAL</b>	<b>223</b>	<b>29506</b>	<b>8148</b>



<b>RACS Support in the Pacific, by specialty (2002 to 2009)</b>			
<b>Specialty</b>	<b>Visits</b>	<b>Consultations</b>	<b>Operations</b>
Cardiac Surgery	11	1070	299
Cardiology	9	1080	123
Otolaryngology	49	9808	1807
Plastic & Reconstructive Surgery	-	2090	1269
Neurosurgery	6	205	94
Ophthalmology	36	8686	3372
Orthopaedics	21	1837	498
Paediatric Surgery	13	395	319
Urology	6	196	102
Laparoscopy	1	10	6
Gastroenterology	2	102	3
Psychiatry	5	NR	NR
Radiology	7	NR	NR
General Surgery	6	174	100
Gynaecology	2	50	1
Respiratory	1	63	0
Vitreoretinopathy	2	142	56
Renal/Vascular/Nephrology	4	466	94
Dermatology	1	94	NR
Ophthalmology - Screening	6	2028	NR
Orthopaedics - Screening	9	212	4
Otolaryngology - Screening	2	466	1
Cardiac Scoping	1	NR	NR
Mammography	1	332	NR
<b>TOTAL</b>	<b>201</b>	<b>29506</b>	<b>8148</b>

<b>RACS Capacity building activities in the Pacific, participants by country (2002 to 2009)</b>							
<b>Course</b>	<b>Early Mgt. of Severe Trauma</b>	<b>Care of Critically Ill Surgical Patient</b>	<b>Anaesthetic Refresher</b>	<b>Primary Trauma Care</b>	<b>Emergency Mgt. of Severe Burns</b>	<b>Diabetes Training Attachment</b>	<b>ENT Nurse Training</b>
Cook Islands	2	-	8	1	2	-	1
Fiji	26	18	83	29	167	5	
Kiribati	2	2	2	1	1	5	1
Marshall Islands	1	1	10	4	-	-	-
Micronesia	1	-	-	2	-	-	-
Samoa	-	2	11	61	56	-	1
Solomon Islands	5	2	10	90	-	5	1
Tonga	3	2	13	34	18	5	-
Tuvalu	3	-	4	-	2	5	-
Vanuatu	1	2	9	2	4	5	40
<b>TOTAL</b>	<b>44</b>	<b>29</b>	<b>150</b>	<b>224</b>	<b>250</b>	<b>30</b>	<b>44</b>



## Training for the Solomons

The Rowan Nicks Scholarship has helped train some of the first indigenous specialists throughout the Pacific

DR ROONEY JAGILLY, one of the current Rowan Nicks Pacific Island Scholarship recipients, admits that the timing of his arrival here to undertake it could have been easier.

While he was delighted to have received the scholarship which allows him to work in Australia for six months, he arrived here the day after the recent tsunami earthquake devastated parts of his home country, the Solomon Islands.

As a General Surgeon, he said that had he not already been here he would have asked to defer the scholarship to help treat the victims, but decided to stay to expand his skills in paediatric surgery under the supervision of Professor Paddy Dewan in Melbourne.

Dr Jagilly, who works out of the National Referral Hospital in Honiara, said he applied for the scholarship to enable him to treat children, who now at times have to wait for years for definitive treatment from visiting paediatric teams because there are no such specialists in the Solomons.

"We face a very difficult situation in terms of treating children. Some wait for years, some travel for days and we have to keep deferring treatment while we wait for a team to visit. And even then sometimes the caseload is too much for the visiting teams and thus children

have to wait for a second visit," he said.

"It is very stressful for the parents, for the children and for us as surgeons so I feel very fortunate to have the opportunity to expand my skills in paediatric surgery as a way of relieving some of this hardship."

Dr Jagilly is now conducting rounds with Paediatric Urologist Professor Dewan at the Western Hospital in Sunshine and Geelong and at the Western Private Hospital.

He said the majority of paediatric conditions that needed urgent attention in the Solomon Islands included abnormalities of the bowel, anorectal anomalies, undescended testes and chronic urinary tract infections. He said while such abnormalities were not specific to the islands, the children were often treated much later than in Australia adding to complications and causing a profound impact on their quality of life.

"There are obviously subtle differences between the surgery of adults and children. Trained paediatric surgeons have their own way of doing things, they handle the tissue very carefully. They perform finer surgery. So this scholarship is not only about the opportunity of learning procedures it is also about refining my skills," he said.

Dr Jagilly said he was particularly pleased to be working in the field of Paediatric Urology. "Urinary Tract Infections (UTIs) are a common cause of infection in the Solomon Islands but often when children present with a non-specific fever we think of malaria," he explained.

"That is already one of the things that I will be pushing when I go home, to think of UTIs, because if it is not treated and the problem is a blockage, such a condition could ultimately lead to kidney failure."

Yet while Dr Jagilly is grateful for the chance to expand his skills, he also admits that when he goes home he will not have all the paediatric surgical equipment that Australian surgeons take for granted, particularly given the reconstruction costs following the recent tsunami earthquake.

"The provincial town of Gizo was virtually destroyed by the tsunami and the hospital there is almost unusable. That means the hospital in Honiara will be under even more pressure with even less money available to be spent on surgeons' wish lists. When I return I won't have the proper forceps, sutures or retractors. The surgery I will be doing won't be as refined as I would like. Yet at least we will be able to treat most children as they come in and that is the most important thing," he said.



A clinic at the National Referral Hospital in Honiara



Mathew Mcleee, who has worked with Rooney in the Solomons Paddy & Rooney



Paddy Dewan & Rooney operating in Honiara





Picture by Susie Chippendale, Australian Red Cross

Distributions after the tsunami earthquake

Later this year, Dr Jagilly will return to the Solomons for a two week visit, funded by the Kind cuts for Kids Foundation and will travel to Cuba to assist and learn, also funded by the Kind cuts for Kids Foundation.

The Rowan Nicks Scholarships are the most prestigious of the College's overseas awards and through the disbursement of approximately \$1 million have helped train some of the first indigenous specialists throughout the Pacific.

The Chair of the Rowan Nicks Committee, Associate Professor John Masterton said the program was of great importance not only in terms of providing aspiring surgeons with the opportunity to study in Australia but also through the promotion of international friendships between countries.

He said the scholarships were divided into two streams. One is the International Scholarship that is directed at surgeons from developing countries who are destined to be leaders in their home countries and the other, the Rowan Nicks Pacific Island Scholarship. He said in recent times that the International Scholarship had changed its focus from Africa to South East Asia.

"The committee wanted to focus on our own part of the world and so decided to con-

centrate on South East Asian countries such as Vietnam, Cambodia, Laos and Myanmar," A/Professor Masterton said.

"We have actively sought out people from Cambodia for instance because there a whole generation of doctors was wiped off the earth."

He said more than \$100,000 was available for scholarship disbursement each year and praised Rowan Nicks, whom he described as a "dedicated educationalist and idealist", for his generosity. Now in his 90s, Mr Nicks was a cardiothoracic surgeon originally from New Zealand but who has spent most of his professional life in Sydney.

A/Professor Masterton said that even in the last few years, Mr Nicks has established a new scholarship to help raise the level of health and well-being in the aboriginal community, with his own money and funds from the estate of his close friend, artist Russell Drysdale.

"Rowan Nicks lives in Potts Point in Sydney which is not far from Redfern and has always been an astute observer of the human condition. He must have seen the abject poverty in pockets of the aboriginal community and wanted to help, while his friend Drysdale had similar aspirations. So with the support

of the artist's family he has established the Nicks Drysdale Fellowship to assist hopefully, but not exclusively, aboriginal health workers undertake training or research," A/Professor Masterton said.

"This has been running for a few years now and already we have supported a researcher in Katherine in the Northern Territory, Sarita Lawler, who is researching the issues around the incidence of sexually transmitted diseases in Aboriginal teenagers.

"This Fellowship, as dreamt of by Rowan Nicks and Russell Drysdale, is not just about surgeons, not just about doctors, but about people working in the field of health, including mental health, sexual health and well-being."

And though they have never met, Dr Jagilly is grateful for the idealism and generosity shown by Rowan Nicks in terms of his current scholarship that supports his living costs while he studies in Australia for six months.

"Scholarships are not easy to come by, particularly in the Solomon Islands, and for me this was very prestigious to be chosen by the Committee. But while it is a wonderful opportunity for me I think it will hopefully be of most benefit for the children of the Solomon Islands," he said.





## INTERNATIONAL OUTREACH

Alex Cato

# Pacific Islands Project

An early setback put Alex Cato on the road to a career combining his two great passions



*Doing the rounds with Alex and Glenn Guest*



*Alex with Dr Dudley Ba'eroob local surgeon and patient*

As a boy, Alex Cato could not decide whether he wanted to be a pilot or a surgeon. Having learned to fly at 17 through an Air Force Scholarship, he applied for a Qantas pilot cadetship in the following year but, in what he describes as a “lucky break”, was unsuccessful.

Instead, he continued with medicine and now combines his two abiding interests as a urological surgeon and a Group Captain in the Air Force Reserve.

He also owns a Piper Chieftain that he uses to fly not only to his Air Force commitments around Australia but also to make his monthly trips from his Melbourne practice to Mildura as a visiting consultant.

But Alex also travels more widely afield.

For the past five years he has been a central participant in the College-co-ordinated Pacific Islands Project (PIP) as well as visiting the region with the Air Force.

In both capacities he has often traveled to areas during times of civil unrest, first visiting Honiara in the Solomon Islands with the Air Force when Australian defence personnel were initially deployed there to serve as a peacekeeping presence.

He was also a member of the first Urological Surgical Specialist team visit to East Timor in 2002.

He said that much of the work undertaken in the Pacific Islands involved the treatment of prostate obstructions, childbirth injuries and reconstructions.

“Even though most people from the Pacific Islands region have a shorter life expectancy than we do in Australia, there are still a large number of men with prostate obstructions,” Alex says.

“Some of these countries may have a General Surgery service but those resident surgeons are not able to undertake modern surgical treatments either through lack of training or facilities and equipment.

“This means treatment is likely to be old-fashioned surgery not done here in Australia for up to 50 years, so without these visits, patients in the region would have no access to specialist surgical treatment.

“We fly in and take our equipment which we then bring back for use on other trips, with the PIP organising about 10 such visits each year.”

Alex says he had rarely felt insecure in the regions he has visited, not only because of the security support that comes with a military presence but because of the appreciation felt by the local people for the efforts of the visiting medical specialists.

“The community perception of this programme is strong enough to provide security,” Alex says. “People in the hospitals welcome us and put out the word to leave us alone and there is a solid appreciation for our work that from our side can look at times rather meagre but from theirs feels like everything.”

Alex says that while he enjoyed his involvement in the Programme – particularly meeting the people of the region – time limitations placed on such visits, while understandable, were difficult to manage both professionally and personally.

He said he believed more surgeons undertaking the work should be involved in deciding the allocation of resources rather than leaving such matters to bureaucrats.

“The Pacific Islands Project is extremely valuable and involves all the specialties, which means that perhaps a week before the Urological visit, there has been a Paediatric Surgery visit and a week after an Orthopaedic team might visit,” he said.

“But this is one of the problems in trying to provide a continuous service in that even if you could stay on to undertake more work the theatres would be filled with different surgery.

“This in turn means that often we cannot treat more complex cases because we don’t have the time or equipment, so we have to choose four people that we can fix 100 per cent within a four-hour time frame over one person with a more complex problem that would take four hours in theatre and who we could make only 60 per cent well.

“These are extremely difficult decisions to make and communicate and I believe that more of us who have had to make such decisions at triage should be involved in the discussions concerning the allocation of resources.”

However, Alex says the situation will improve, as a local surgeon in the Solomon Islands has received a scholarship to visit Australia to learn the more common urological surgical procedures.



*Combined ADF PIP Urology team in the Solomon Islands*



*Consulting in Timor Leste with scribe interpreter, staff, patient and family.*

Alex said one of the main pleasures of his volunteer work was dealing with local people and said only rarely did cultural differences emerge.

“One of the areas of our work in this region is dealing with childbirth injuries and at one stage we had a young woman in Dili, a nurse who spoke English, who needed surgery to treat a fistula,” he explained.

“However, before that could happen she needed to get consent from the patriarch of the clan who lived in the Oecussi Enclave in Indonesia, as a cultural necessity, but we only had days to undertake the surgery, not nearly enough time to allow her to travel back home and then back to Dili.

“Finally the situation was resolved by telephone and even that took more than a day to get the necessary people talking together.

“If that had not happened we could not have done the surgery and would not have been back for another year, so at times you sweat on those cross-cultural moments.”

In his day job, on the ground, Alex works out of the Alfred and Cabrini Hospitals in Melbourne.



# The Fiji School of Medicine

For 10 years now, a postgraduate program at the Fiji School of Medicine has been working to keep graduates in the region

## Gordon Clunie

Victorian Fellow

The Fiji School of Medicine (FSM) and its predecessors, the Suva Medical School and the Central Medical School, have provided medical training for the islands of the Pacific since 1885.

Until recently, formal postgraduate training and continuing professional development have not been available for graduates from the school, so that many practitioners have been lost to the islands following experience of practice in other countries, particularly Australia and New Zealand.

To correct this deficiency, a postgraduate training program was developed at FSM



Professor Emeritus Gordon Clunie (former Director of the FSM Project) and Mrs Clunie with the surgical postgraduate trainees at the anniversary dinner.

with the assistance of funding provided by the Australian Agency for International Development (AusAID) and managed by the College. The program provided training for a one-year diploma which was followed by a three-year masters program in the five disciplines of Surgery, Internal Medicine, Anaesthesia, Paediatrics and Obstetrics and Gynaecology.

Additional staff members were appointed

in each discipline, supported by expatriate long-term advisors. Teaching commenced formally in 1998.

Thus, 2008 marked the 10th anniversary of the program, which was celebrated following the completion of both undergraduate and postgraduate examinations by a dinner in Suva attended by FSM staff, external examiners and trainees. The success of the program in training specialists for the Pacific by the Pacific was emphasised by the Acting Dean of FSM, Professor Robert Moulds, although problems of retention of graduates in the Pacific Region remain.

Continued support from specialists for training in the Pacific and from aid agencies in countries such as Australia and New Zealand is essential if the initial successes of the program are to be maintained.

## For further reading, see

- Clunie GJ, McCaig E, Baravilala W. The Fiji School of Medicine postgraduate training project. *Med J Aust* 2003; 179:631-632
- Baravilala W, Moulds RF. A Fijian perspective on providing a medical workforce. *Med J Aust* 2004; 181:602.

## HOMESTAY ACCOMMODATION FOR VISITING SCHOLARS

Through the College International Scholarships Program and Project China, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to 12 months.

Due to the short term nature of these

visits, it is often difficult to find suitable accommodation for visiting scholars. The International Scholarships Department and Project China are seeking expressions of interest from those willing and able to provide homestay accommodation for our visiting scholars. If you have a spare room, and are interested in learning about another culture and language, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a nominal stipend.

**If you would like to help or require further information, please contact the International Scholarships Secretariat on the following details:**

International Scholarships Secretariat  
Royal Australasian College of Surgeons  
College of Surgeons' Gardens  
Spring Street, Melbourne, Victoria,  
Australia, 3000  
Telephone: + 61 3 9249 1211  
Fax: + 61 3 9249 1236  
Email: [international.scholarships@surgeons.org](mailto:international.scholarships@surgeons.org)



# Volunteering off the coast of Tuvalu

Finding the time to volunteer your services is a worthwhile experience

**M**elbourne Ear, Nose and Throat (ENT) surgeon Mr Dayan Chandrasekara must have looked a strange sight as he lunched with colleagues recently on a small island off the coast of Tuvalu. As a member of the AusAid funded Pacific Islands Project (PIP) team which visited the country in March, Mr Chandrasekara's luggage had been off-loaded during transit in Fiji leaving him with nothing to wear for the week but his scrubs. While that was obviously suitable for the hospital, he had no choice but to don them also on the one free Saturday when the team was not operating.

"Clearly, it wasn't ideal. But in the hot tropical conditions we were working in, it wasn't so bad either. I wouldn't recommend it but in some ways they felt quite appropriate for the humid climate," he laughed.

Unfortunately, Mr Chandrasekara's personal luggage was not the only item jettisoned by the pilot in Fiji because of weight concerns. The team,

comprising fellow ENT surgeon Elizabeth Rose, anaesthetist Anthony Hull and theatre nurse Katie Bowley, had taken, as allowed, 15 bags of necessary equipment. More than half of these were off-loaded in Suva without notification.

"On trips such as these we get a luggage waiver of up to 160 kilograms which is crucial in terms of being able to take the equipment we need. Many of the airlines do this as a matter of course, as a good-will gesture, so we can't complain," he said.

"However, we weren't notified of the captain's decision so that when we arrived in Tuvalu we only had seven bags of equipment. The ones left behind contained both anaesthetic and essential surgical equipment including otoscopes and examination headlights which presented us with a few challenges."

The team visited Tuvalu from March 11 to March 20 earlier this year. While waiting for their equipment to arrive on the next flight five days later, Mr Chandrasekara and Dr Rose spent the

first four days consulting, during which time they saw more than 180 patients, providing treatment and generating the operating list. Eight patients were selected for surgery, the most complex of which was a middle ear cholesteatoma.

However, Mr Chandrasekara said the working conditions in the one-theatre hospital were not easy. "The hospital's air-conditioning unit had been out of operation for more than a year so it was pretty hot work. We had to make sure we kept the patients from overheating so we brought in fans and didn't drape the patients extensively. We didn't have temperature probes with us which would have been useful so that might be something to consider for any future visits," he said.

"The cholesteatoma was a particular challenge. It took three hours, which is not unusual, but in the hot theatre that felt quite long and then the microscope stopped working mid-way through the operation. This may have been because it over-heated so we turned it off and used a headlight for half an hour. The light then



came back on which was a great relief.

“We did some long days in there and were exhausted by the heat but all the operations went well which is the most important thing.”

Mr Chandrasekara said the majority of the 180 patients seen in the clinic were suffering from chronic ear disease, perforated eardrums and infections. He said some patients had consequently developed hearing loss and that the next team to visit could look at taking hearing aids.

“Island nations like Tuvalu don’t have ENT surgeons. The local doctors are mostly GPs, though they have recently been supplied with an obstetrician and a paediatrician, both from Cuba,” he said.

“But while chronic ear disease has long been a problem in developing nations, which may be related to hygiene and nutrition, it is also about having access to quality health care sooner rather than later before hearing can be affected. As such these visits are crucial.

“A proportion of the patients we saw with such disease will be cured with medication, a proportion will require ongoing non-surgical care while others will require intervention in the form of surgery and will be put on the surgical list for the next team visit.”

Mr Chandrasekara said that while the visit had been designed to provide a training and education component, the constant heavy work load of local staff mitigated against the plan.

“We originally had aimed to train the local hospital staff in the treatment of basic ENT related conditions but that didn’t happen as we expected. I think they are so under-resourced and over-worked that they take the opportunity of a team visit to do other work, which is understandable,” he said.

Based at the Austin Hospital and Monash Medical Centre in Melbourne, Mr Chandrasekara has only recently returned to Australia after an international Fellowship in Head and Neck Surgery at St George’s Hospital in London.

“There has been a tradition for Victorian surgeons to go to St George’s so I was delighted to have been offered the appointment. The hospital has a large ENT unit. The work was interesting and varied and I still had time to see Europe,” he said.

The March visit to Tuvalu was Mr Chandrasekara’s first outreach visit, an opportunity he had been keenly awaiting.

He said he had long had an interest in volunteer work and some years ago had put up his hand to participate in a team visit to Guam which did not eventuate.



The narrowest part of the island



Dayan in his scrubs cleaning up



Making plates for a picnic



Dayan seeing patients

“The idea of helping people in other parts of the world has always interested me though I would make the point that there is a lot to do here in Australia as well. I would like to do trips like this at least once a year and while I know a lot of surgeons who would like to participate, many simply find it too hard to find the time. I decided, then, to try and schedule a regular volunteer component into my timetable early on, before all the pressures of private practice

come into play,” he said.

“I had a great time on this trip despite the challenges of the luggage, the heat and the lack of equipment. The children, in particular, were just gorgeous and had completely different reactions to the discomfort and pain related to their medical conditions. We were treated well and the local people were very appreciative of our visit. At the end of the trip we were given a huge feast by hospital staff and their families.”



# Pacific Surgeons Meeting

The sixth Pacific Islands Surgeons Meeting was held in Suva, Fiji, in July 2008 was a success



Surgeons from around the Pacific began meeting together in 1996 to discuss both clinical and non-clinical issues of relevance to surgery in the Pacific Islands. One outcome of these meetings was the formation in 2003 of the Pacific Islands Surgeons Association (PISA).

Surgeons from the Pacific Island nations of Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu attended the 2008 Meeting. Surgical Trainees from many of those countries who are currently based at the Fiji School of Medicine (FSM) in Suva also attended; as did a number of New Zealand and Australian surgeons.

As at previous Meetings, the first day focused on the Trainees undertaking the Diploma or Masters in Surgery programmes. This included practice written and clinical "examinations", assisted by the surgeons from the Pacific Islands, New Zealand and Australia; plus presentations on examination techniques and research. The Trainees also participated in the rest of the meeting with presentations of case studies and their research.

The other three days of the meeting were focused around the themes of workforce development, acute surgical care and "Oncology – the Pacific way". Workforce problems in New Zealand and Australia pale in comparison to those in Pacific Islands nations. Developing and retaining their workforce are key issues for these countries. The FSM continues to seek assistance from New Zealand and Australia through access to appropriate clinical placements in our countries as a component of the FSM surgical training programmes.

While Fiji and PNG have populations that enable a degree of access to the technology taken for granted in our countries, that tech-



Above: Diploma and Masters Trainees, FSM with General Surgery lecturer, Mr Waqainabete (back row, 4th from R)

Left: Jean-Claude Theis (Chair, NZ National Board) assisting Stephen Homasi (Tuvalu) at the orthopaedic workshop, observed by Johnny Hedson (Fed. States of Micronesia)

nology is not available in many Pacific Island nations. These meetings provide Pacific surgeons with the opportunity to discuss diagnoses and treatments with colleagues who have similar limitations on technological and staffing resources.

No comment on a Pacific Surgeons Meeting would be complete without mentioning the amazing hospitality of our hosts. From the barbeque at Professor Eddie McCaig's through the Pacific Night at Mr ifereimi Waqainabete's and on to the beach picnic run

by the Trainees all visitors were made to feel very welcome, entertained and exceedingly well fed. The New Zealand and Australian "cultural items" at the Pacific night undoubtedly have a way to go yet to meet the standard of the other Pacific countries – and all could take lessons from the surgical Trainees. New Zealanders and Australians attending future meetings may well have to attend cultural item practice sessions beforehand!!

Thanks are due to NZAid who was once again the primary sponsor for this meeting with some assistance on this occasion from AusAid.

*Written by Justine Peterson,  
New Zealand Manager*



## An overview



# TIMOR LESTE

Timor Leste is a young nation with a population of approximately 1.2 million people. The health indicators are among the poorest in the region and the country has limited human and financial resources to address healthcare problems. Since 2000 there have been significant improvements made in the country's health sector including the rehabilitation of the national hospital and the five referral hospitals in the districts. There are approximately 70 Timorese doctors – eight with specialist qualifications – however, most of the primary and specialist medical services are provided by international medical assistance missions from Australia, New Zealand, Cuba and China.

Australian Fellows have been involved in medical assistance missions to Timor Leste since the 1990s. Organisations such as the Overseas Specialist Surgical Association of Australia (OSSAA) and the East Timor Eye Program (ETEP) responded to the need for specialist services and independently organised and delivered plastic and reconstructive surgery, ophthalmology and optometry support to Timor Leste.

In 2001, the Royal Australasian College of Surgeons was contracted by AusAID to provide surgical, anaesthetic and nursing services. The current program is called the Australia Timor Leste Program of Assistance for Specialist Services (ATLASS).

The goal of the College's Timor Leste Program is to improve the health status and outcomes of people in Timor Leste with surgically treatable illness, disability or trauma. The Program works closely with the Ministry of Health (MoH), hospital administrations, national doctors and health personnel throughout the country.



It provides training and support for Timorese medical and nursing personnel and assistance with systems strengthening, quality assurance and other activities aimed at strengthening the health service. The Program provides a long term resident surgeon, anaesthetist and administrative support personnel in Dili as well as visiting specialist teams to support the Timorese doctors and nurses.

Fifteen specialist visits are delivered per year to Dili and the five regional hospitals of Baucau, Maubisse, Maliana, Oecussi and Suai. By August 2009, over 18,000 consultations and over 7,000 surgical procedures had been provided by visiting teams. A wide range of specialties were delivered including ophthalmology, plastic and reconstructive surgery, paediatric surgery, orthopaedic surgery, paediatric cardiac surgery and ENT surgery.

The success is demonstrable both in numbers and in the skills transferred to local doctors and nurses. Fortunately, the Program has a strong base of dedicated surgeons, nurses, anaesthetists and other health professionals who give their time and skill year after year to assist the Timorese community.

The first Timorese surgeon, Dr. Mendes, returned from training in Indonesia in September 2008, and now works in Dili. In May 2009, he was supported through the Program to visit the College's Annual Scientific Congress (ASC) in Brisbane. Developing the capacity of medical and nursing staff has been a major focus of the Program. A major challenge has been to offer them training in a country where they are also comfortable with the language. These doctors were originally trained in Indonesia which speaks Bahasa. However, the Program's efforts to support training in countries that speak Bahasa such as Indonesia and Malaysia (University Kebangsaan) have met with a number of disappointments.

There have also been some successes. In 2008, the first Timorese doctor gained qualifications as an ophthalmologist. Another is training through the MMed program in Papua New Guinea and is already in the third year. In 2009, the Program is also training a Timorese surgical registrar in cleft lip and palate surgery. He is also being taught to manage club foot. One anaesthetic registrar is training at the Fiji School of Medicine, and there are currently three surgical trainees in Dili at various stages in their training. Twenty-one nurse anaesthetists have been trained and they now work at Dili National Hospital and the 5 referral hospitals. An additional challenge will be for Timor Leste to integrate and enhance the skills of the approximately 600 Cuban trained Timorese doctors who will return to Timor Leste from Cuba in the coming years.



The Program works closely with the Ministry of Health to develop twinning links with institutions

and organisations in Australia and internationally. A partnership between St Vincent's Hospital in Melbourne and the Dili National Hospital has been fostered, aimed at improving the delivery of emergency department (ED) services. An ED physician will be added to the resident team later in 2009. With the MoH and ASSERT (local disability rehabilitation organisation), workshops focused on identification and management of club foot in babies introduced the Ponseti technique into Timor Leste. Through training of relevant health personnel in this technique, children with the condition will no longer need to travel long distances to receive treatment and should be able to be treated in their home district.



The Timor Leste Program maintains long term partnerships with external organisations and institutions that add value and increase the sustainability of its activities. These organisations include Rotary, the Australian Red Cross, St John Ambulance of Australia, St John of God, ProVision Optometry Team (PVOT), the Overseas Specialist Surgical Association of Australia (OSSAA), Orthopaedic Outreach and Foresight. Through the support of these organisations, the Program is able to reach the wider community.

The Program also continues to maintain its links with the institutions that provide out of country specialist training for its trainees at the University of Papua New Guinea, and the Fiji School of Medicine.

The following figures provide some statistics on the Program. The stories which follow vibrantly capture the Program's work in Timor Leste and its achievements and challenges to date.

<b>ATLASS Consultations &amp; Operations by Specialty (2001 to August 2009)</b>			
<b>Speciality</b>	<b>Operations</b>	<b>Consultations</b>	<b>Visits</b>
Orthopaedic	185	836	15
Paediatric (including Paed. Cardiac)	66	178	10
Ophthalmology	2208	14135	27
Plastic and reconstructive	611	1379	16
ENT	106	1147	6
Urology	70	318	3
General Surgery (performed by Long Term Adviser Surgeons)	4032	NA	NA
<b>TOTAL</b>	<b>7278</b>	<b>17993</b>	<b>77</b>



#### **Summary of Training Activities (2001 to August 2009)**

- 1 qualified ophthalmologist
- 21 qualified nurse anaesthetists
- 8 have successfully completed the Basic Surgical Skills Course (BSS)
- 71 have participated in Primary Trauma Care Courses (PTC)
- 1 surgical trainee successfully completed the Early Management of Severe Trauma Course (EMST) in Papua New Guinea
- 2 doctors and 1 nurse participated in a burns training attachment in Australia
- 1 doctor and 2 nurses participated in an Emergency Department training attachment in Melbourne
- 1 radiographer from Baucau referral hospital participated in an image intensifier training attachment in Brisbane
- 6 operating theatre and eye care nurses completed training in theatre nursing for eye surgery
- 2 supported to attend ASC in Brisbane, May 2009
- 1 general surgical trainee continues formal out of country specialist training
- 1 anaesthetic trainee continues formal out of country specialist training
- 3 trainees continue to prepare for out of country specialist training
- 1 trainee has started training in cleft lip and palate surgery and through a training attachment in West Timor





## Pediatric care in East Timor

A special program using Australian surgeons is slowly helping Timor Leste establish its first pediatric service

Pediatric surgeon Dr Brendon Bowkett believes Australia and New Zealand have a close bond to the people of East Timor, particularly when we recall the Timorese people's courage and sacrifice during World War II. Dr Bowkett leads a pediatric surgical team in visits to visit East Timor, which now has one of the highest birth rates in the world. Having made five visits so far, he views the trips as part of the ANZAC tradition of supporting our allies in times of need.

As part of the Australia Timor Leste Program of Assistance for Specialised Services (ATLASS), which is funded by AusAID and managed by the Royal Australasian College of Surgeons (RACS), he visits one of the world's newest countries treating children born with serious birth defects such as alimentary tract abnormalities. His is just one of many specialist team visits as well as many capacity building activities that aim to improve the availability and quality of essential surgical services for the people of East Timor.

Through an innovative system of colour-coded referral cards designed to break-down communication barriers in rural areas, children are brought from throughout the impoverished country to Dili upon being notified of a team visit.

"Children travel from all over the country, sometimes in very arduous conditions, using carts, local buses or walking to get to Dili for what can be an extended stay of weeks while they receive treatment," he said.

Increasingly the children are being brought in advance so that they can receive nutritional supplements to boost their strength prior to surgery. Speaking after his latest visit in April, Dr Bowkett said nutrition continued to be one of the most difficult aspects in providing the pediatric surgical program.

"It became obvious during this last visit that the nutritional problems and deficiencies the children face are still profound. While we



Cipriano, Trainee from Suai; Amanu, anaesthetic nurse from Dili; and Eugenio, Trainee from Dili

were able to work around this using supplements, the deficiencies still mean significant risk for surgery in some cases," he said.

"When you add this to the presence of other tropical conditions such as malaria, the situation can become quite complex."

Based at the Wellington Children's Hospital, Dr Bowkett travels to East Timor with a team comprised of himself, theatre nurse Lynette Brown and anaesthetist Mary Brooker. Working out of the partially re-built Dili General Hospital, the team visit involves outpatient and operative sessions.

"The card system worked very well and the fact that five children with colostomies had been transferred into Dili from distant

villages was a considerable achievement. The recently renovated wards at the Dili hospital were a huge improvement on the former dishevelled wards and advanced the situation in terms of care," he said.

"The pediatric wards and the neonatal facility are also vastly improved compared to a few years ago and the concept of isolation for children is very well developed, almost as good as in the West, which is wonderful to see."

The backbone of the whole program is the combination of supportive Timorese staff and the Australian surgeons and anaesthetists employed by the College program.

Dr Bowkett said that it would be some

“Given that East Timor has one of the highest birth rates in the world, there is much to be done for the children of this country.”



Francisco, qualified anaesthetic nurse from Suai



Flavio, anaesthetic Trainee

time before East Timor had its own fully developed pediatric surgical service and said there was, in consequence, a great ongoing need for specialist visits such as those provided through the ATLASS program. He said the intermediate goal, however, had to be the transfer of knowledge and skills to upcoming Timorese surgeons.

“Given also that East Timor has one of the highest birth rates in the world, there is much to be done for the children of this country. The work we do there, especially anoplasty and Hirschsprung surgery, allows the closure of colostomies, which is life changing for those children and extremely rewarding,” he said.

“We see children with stomas that might only be covered with a cloth and though their quality of life is tremendously affected they

are cared for extremely well because the East Timorese parents love their children. In this last visit, four children lost their colostomies and will go on to lead normal, active lives.”

Dr Bowkett said that while he was grateful to the College and AusAID for the financial support to run the clinic and surgeries, he thought both Australia and New Zealand had an obligation to help the fledgling nation for as long as it took.

“The history of East Timor during World War II is one of immense sacrifice for the cause of good where many lives were lost fighting the Japanese. The nation was forgotten about for nearly 25 years during the Indonesian occupation and much of the infrastructure was destroyed,” he said.

Dr Bowkett said the pediatric service

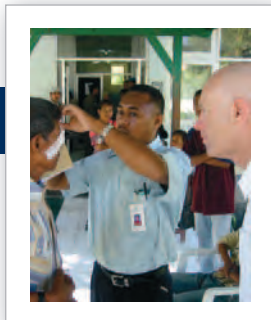
operated with the help of Australian general surgeons who managed the pre- and post-operative care of the children either side of the team’s visits. On one visit, 25 children were treated.

The focus now has to be turned to training the East Timorese to help establish their first pediatric service, said Dr Bowkett.

“Every time we go there, there are improvements; better communication, better hospital care, better nursing standards. I am astounded by their compassion and the love the Timorese have for their children and I find that very moving,” he said.

“The work we do there changes the lives of these kids dramatically and the whole experience of assisting these compassionate and resilient people is an extremely positive one.”





## INTERNATIONAL OUTREACH

*Dr John Kearney in Baucau*

# East Timor Eye Program

The program's goal is to ensure East Timor becomes self-sufficient in the provision of eye care by 2007 and to eradicate preventable blindness by 2010.

While the recent security situation in East Timor forced the postponement of scheduled ophthalmic visits to outlying areas of Suai and Maliana, three teams closely following each other, braved the instability to provide optometry and ophthalmology services in Baucau, Dili and Oecussi in late August and early September.

A small team made up of Ophthalmologist Dr John Kearney, Theatre Nurse Barbara Chantler and Optometrist Andrew Maver visited Baucau for a week. Rather than the usual ten the team was three because of the heightened security concerns.

Dr Kearney, who helped to set up the East Timor Eye Program (ETEP) with Dr Nitin Verma in 2000, said the political situation made this particular trip a challenging experience. "There was a bit of activity around the place because we were there when Major Alfredo Reinado led the mass walk-out from the Dili prison. There were mobs in the street, pelting cars with stones but the biggest problem we faced was that in the last week of our two weeks there, the theatres were filled with people with bullet wounds which limited the work we could do.

A week later another Australian team returned to Dili. Dr Paul McCartney, supported by theatre nurses Alex Shaw and Colleen Hickson were joined by ProVision Optometry Team members Andrew Maver and Micheal Knipe. It was Andrew's seventh trip since becoming involved as the Australian Co-ordinator of the ProVision Optometry Teams. Micheal Knipe, ProVision Eyecare's Chair, was making his first visit despite being involved with the program through ProVision for many years.

The Optometry team spent four days in Dili and one in Aileu a small town 90 minutes by car from Dili. All those examined in Aileu in need of surgery were too afraid to travel to

Dili for the surgery. The surgical team in Dili performed mostly sight restoring surgery from dense cataract.

The Dili week was followed up by a team visiting the remote enclave Oecussi where conditions are even more basic than in Dili. Ophthalmologists Dr Nitin Verma and Dr Bill Glasson were joined by theatre nurses Barbara Chantler and Vicki Greeks. Optometrist Vin Penry joined Andrew Maver to complete the team. All but Bill Glasson were flown in to Oecussi by UN helicopter. Bill, whose departure from Australia was delayed made the journey by the overnight ferry from Dili. Apparently this was an experience in itself. The financial support of the St John Ambulance, was critical to the success of the Oecusse trip as was the help of the the United Nations, particularly, the support of Lt Col Ross Williamson and Mr John Pottinger (air ops).

The last two months have been hectic but very successful for the program. A total of 780 patients were seen, 621 spectacles were issued and 127 surgical procedures performed. According to the visiting ophthalmologists, the main causes of preventable blindness and visual impairment in East Timor are cataracts, uncorrected refractive error and Vitamin A deficiency. Despite the work already, there is apparently still a backlog of 7500 patients requiring eye surgery in the country.

"In East Timor there is a great need for cataract surgery and procedures to treat other eye diseases. Very little work was done during the Indonesian time which apparently helped create this backlog. In

countries where the lifespan is shorter, people tend to get cataracts earlier in life. This means that in East Timor people get them in their 40s and 50s whereas in Australia people get them in their 60s and 70s. That is all we know about the increased occurrence of cataracts – that it relates to limited access to medical care and shorter life spans – and everything else is just conjecture," said Dr Kearney.



*Bill Glasson carrying a patient in Oecussi*



Dr Kearney said that when he first visited Dili in 2001, there were no eye services or specialist facilities and that the ETEP had to start from scratch. He said at that time both the hospitals in Dili and Baucau had holes in the walls of the theatre and unreliable electricity supply while team members had to stay in the wards of the hospital because of a lack of alternative accommodation.

“It was fairly primitive then but there has been some improvement. Now we get power most of the time but when we go to outlying areas we have to take generators with us just in case,” said Dr Kearney.

The program is now well into its sixth year and has evolved considerably during this time. It was originally set up as a personal humanitarian aid project, initially funded through personal funds because the need was so acute. Later funding came from Lions, International Red Cross, WHO, Foresight, Rotary and individual donors before the involvement of AusAID. Now coordinated through the College and funded through AusAID, the program aims to ensure that East Timor becomes self-sufficient in the provision of eye care by 2007 and to eradicate preventable blindness by 2010.

Since it was established, the program has provided consultative services to 20,000 East Timorese, performed 2,200 surgical procedures and dispensed 17,000 spectacles. The program is also training an East Timorese Trainee Dr Marceline Correia, who is currently enrolled in the Diploma of Ophthalmology Program at the University of Sydney. It is hoped that he will complete his degree by early 2007. After this, he will go overseas for further training before returning to East Timor as the country's first ophthalmologist. This is funded partly through the College and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). Dr Verma said “We are currently in the process of finding another young doctor to train so that East Timor will have a reasonable number of ophthalmologists to help ensure its independence and self-sufficiency in eye care delivery”.

Australian volunteer theatre staff also participate in most visits to help train East Timorese nursing staff. The program is also working to help improve the basic medical infrastructure to service the community by establishing a day ophthalmic operating theatre in Dili so that higher volume eye surgery can be carried out without disturbing the main operating theatres. Plans are also being progressed to set up a modern eye clinic there with state-of-the-art equipment including ultrasonography, angiographic and other diagnostic and therapeutic equipment so that patients no longer have to leave the country to receive treatment for more complex and threatening conditions. The eye team is also planning to visit Atambua, a town in the border region of West Timor. This will be the first visit to West Timor.

Dr Kearney said that while the on-going political difficulties being experienced in East Timor were disheartening, the work undertaken by the program was extremely rewarding with problems fading against the delight of people seeing for the first time in years.

“The service advertises our visits through the radio or through various churches around each region and the people get to the hospital for treatment. Some of them have been blind for years. We treated one man this visit for cataracts who was only 36 but had never seen his children. When we removed them and he could see his family the smiles and joy were wonderful to witness,” said Dr Kearney.

*For further information on the ETEP - [www.etepp.org.au](http://www.etepp.org.au)*



1. Optometrists working in the canvas tent in Oecussi  
2. Optometrists Mike Knipe & Andrew Maver in Aileu  
3. Paul McCartney at Dili Hospital  
4. Refugee tents on the Hospital grounds  
Photos by Ellen Smith





*Barbara Chantler, Nurse*

## Timor Times

An "on the ground" look at a College volunteer team working in Timor Leste at Oecussi in July 2007



*Bill Glasson with Timorese friends*

**THE COLLEGE TEAM** members were doctors Bill Glasson and Kevin Vandeleur, nurses Barbara Chantler and Kim Mageean, optometrist Vince Penry and technician Norbert Hoegerl.

On Sunday, July 15 we left our Darwin hotel at 5am for the airport to do our check-in for the flight to Dili. We were carrying 70 kg of excess baggage – all medical equipment and instruments. Although I had an excess baggage waiver issued by Qantas, it depends on the check-in staff whether they allow it.

My usual check-in scenario is

- Present and go through the official documentation.
- A big smile and "please, please, please".
- Explain that it is essential medical equipment.
- Try begging.
- Tell the checker the blind will not be healed if the equipment does not get on the flight.

This is always followed by

- We will do the best we can.
- It is a full flight.
- Which of the 17 pieces of luggage are the four first priority ones?

On arrival in Dili, Kevin was the only traveler who had luggage. Great start! Kevin wore the same clothes on Monday as well, so as not to embarrass the five luggage-deprived team members. And we really were very grotty after working in the hot, dusty storeroom at Dili Hospital all Sunday afternoon.

On Monday, we six plus Marcelino (the local doctor we are training), were assembled in the waiting area for the UN helicopter to Oecussi when the plane carrying our clothes and medical goods landed. We were marched to the chopper before our luggage was unloaded from the flight. So near and yet so far! We flew to Oecussi on a UN helicopter a Russian MI8 more than 30 years old. The flight took one hour.

On arrival we helped unload our cargo. We take all our goods and equipment to do 100 operations. I mean everything – generator, laser, microscopes, sterilizer and distilled water to run it, Ascan, slit lamp, instruments, sterile packs, lenses, fluids and lotions, drugs and drops, glasses, right down to cleaning rags.

We were driven to the hospital in the hospital car, which had threads hanging off the bald tyres, and the steel rims were visible. Scary on the rough, unmade roads. We unloaded, and moved a lot of furniture before we could set up. We soon had two operating tables, each with a microscope connected to the generator, all the equipment and goods in place, and a mile or two of extension cords to weave around.

We then did a quick trip to check into our hotel before we started operating. The College had booked seven rooms for us, but the hotel had seven beds for us. For a while it was to be Bill, Vince and Norbert sharing, with two sleeping in the double bed with a bolster down



*“The personal reward is special, and you could not buy the feeling with all the money in the world.”*

the centre. After a bit of reorganising another room was found, so with much relief the boys removed the bolster, and we regrouped.

Spartan accommodation is the norm. Kim and I had a very small room with two beds with mattress covers and pillows only – no sheets or towels. A small shelf held a fan that did not work because we had no power. Other years the rooms had a candle in a jam tin and no matches to light the candle, so this year I took a box of matches, but now we had no candles! And we did not take towels, but managed to borrow a hand towel from the hospital.

There was not even a nail on the wall to hang our clothes, but luckily no cockroaches or rats this time. The ensuite had a loo that required buckets of water to be thrown in to flush, and a mandy, which is a bricked-up water storage area about half a meter square and a meter high. Every morning we gave the noisy roosters a bit of competition with “wow”, “yikes”, “sh..”, “ugh”, as we all threw buckets of cold water from the mandy over our hot, sleepy bodies.

There was no mirror at the hotel or at the hospital. By day two I found a stainless steel container and polished it up so that I could see to put on a bit of make-up. That night Kevin made a special presentation to me of a mirror he found in his room – sheer luxury. The boys shaved by feel, except Vince who grew a beard.

Breakfast was the usual McUssi – a well fried greasy egg in a bun – and coffee. We had three tea drinkers in the group, and every day it was like pulling teeth trying to get these. Lunches and dinners were great – usual Oecussi rice, chicken and beef (if it is tender it is dog, if it is tough it is buffalo). We knew that tonic water was not available in Oecussi, so did not take gin. We did have other very “top shelf” resuscitation drugs.

Work was a wonderful experience of teamwork and adaptability. Bill and Kevin are tireless and great to work with. Vince slaved away in the optometrist tent in the heat and dust. Norbert was fantastic fixing

and adapting our equipment. One of his magic improvisations was to re-direct all the hospital power to our laser so that it had enough “punch” to fire.

We had generator problems every day because the hospital tends to run out of petrol. It seems that nobody fills it regularly, and when it cuts out we have to send someone to find the guy who has the key. This takes a while because he is often at home. Once the key man is found he has to go to the office to get money for petrol. Then go out and buy it. This can take up to an hour. We finished quite a few cataract operations with Kim and I holding torches for the surgeons because the microscope lights were off.

It was a great team to be part of – we all knew what we were doing and we did it well in difficult conditions. We walked as the sun came up and relaxed as the sun went down.

The personal reward is special, and you could not buy the feeling with all the money in the world. These gentle, poor but happy patients come to us blind and frightened. Some walk for days to get to us. They co-operate totally with us. Lack of language is no barrier because gentle guiding by us, and a soothing voice is all we need. On the morning after the operation, when the eye pad comes off, the smile on the patient’s face is worth a thousand words.

A memorable case was a 43-year-old man, blind in both eyes. He was led in by his family for operation. The next morning when the eye pad came off he gave a little smile when he saw the light. He looked up when Kim and I spoke, then had a huge grin and giggle when he focused on two blonde white women looking at him. Perhaps he had never seen a tall blonde before! We operated on his second eye and when the pad came off we got the biggest smile (Kim and I needed tissues for our own wet eyes).

I feel proud and privileged to be part of the College eye team. We go because we love the people and know that what we do in that short time does make a huge difference to the lives of these gentle people.

1. Waiting for a checkup
2. The team with patients
3. Bill Glasson checking up on a patient
4. Barbara Chandler, Bill Glasson, Kim Mageen & Kevin Vandeleur





## The Club Foot Program

An Australian orthopaedic outreach team is helping East Timor's surgeons on the road to self-sufficiency

The establishment of a treatment program for club feet that has been proven particularly suitable for developing countries is one of the new initiatives now being implemented by Australian surgeons undertaking orthopaedic outreach to East Timor.

Co-ordinated by the College and headed by Canberra orthopaedic surgeon Mr David McNicol, the outreach program is now in the process of rolling out Ponsetti courses for local medical, physio and nursing staff so they can become self-sufficient in the management of the condition.

The Ponsetti technique involves serial plasters, usually percutaneous division of the heel cord, putting the limb in plaster again and the subsequent use of splints. This technique is not only the gold standard treatment in developed first world nations but is highly suitable for poorer countries because it is cheap and can be done without the need for specialist surgeons.

Mr McNicol said East Timor has a higher birth rate of children with club feet because of a genetic/racial predisposition with four to five children of 1000 live births born with the condition compared to one in 1000 in Australia.

He said the Club Foot Program was a pleasing aspect of the gradual capacity building efforts of the outreach programme to help East Timor become self sufficient in its health service provision and therefore less reliant on visiting international teams.

"We have already brought the physiotherapist from Baucau to Australia to undertake the training course in the technique and we will be using her as the focal point to train the local doctors, nurses and physiotherapists. Within the next few months we are also going to help fund a public information campaign to inform parents and medical staff that the treatment is available and affordable," Mr McNicol said.

"We have identified a charitable organisation in Dili, called ASSERT, that will make the splints and have sent them some to use as prototypes and they have already begun to make them within the last couple of weeks.

"Establishing this program is very rewarding because not only is it the gold standard treatment, they can do it themselves. And of course the best aspect is that it works so well, so that after the treatment the foot is nice and flat and flexible and all the treatment requires is some minor surgery, some plaster-of-Paris and a splint. It results in normal walking and therefore a life-time of dividends for the patients."

Mr McNicol said the financial support for the Club Foot Program was currently being provided through the Orthopaedic Outreach Fund but that requests had now been put to AusAid for assistance as well as to the government of East Timor to enhance the sense of local ownership for the project.

A former president of the Australian Orthopaedic Association and now the chair of the Orthopaedic Outreach Fund Management Committee, Mr McNicol has visited the country six times and will go again in November.

He said that while the outreach program had been initially based in Dili, senior health officials had recently asked the team to undertake more regional work.

Consequently they are now based in Baucau, East Timor's second-largest city as well as visiting Maliana for the first time in August 2008.

The current team comprises Mr McNicol, fellow surgeon Dr Phil Aubin, anaesthetist Dr Rashmi Patel, scrub nurse Mr Michael Aiashi and Mr McNicol's wife, orthopaedic nurse Janine McNicol. Together, they conduct patient consultations during the first two days, seeing between 60 to 100 patients, and then conduct up to 20 surgical procedures in a week.

"Establishing this program is very rewarding because not only is it the gold standard treatment, they can do it themselves."

Mr McNicol said that having two orthopaedic surgeons meant that the team could now take on bigger surgeries some of which are to treat patients who have been in pain and distress for years.

"Last visit we nail-plated a femur, reconstructed a man's dislocated elbow and undertook the first procedure to treat a girl with a knee contracture which had fused her calf to her thigh. We are still even seeing the aftermath of injuries from the time of occupation in terms of bullet wounds and crushed feet while the contractures relate to infections left untreated in bones or joints and the deformities of cerebral palsy."

But while it is clear that Mr McNicol finds surgically treating such patients highly rewarding, his enthusiasm is particularly focused on helping the East Timorese care for themselves.

He said a local East Timorese general surgeon, Dr Alito Soares, had recently expressed interest in becoming an orthopaedic surgeon and had worked alongside the team during the last visit to allow them to assess his capabilities. Now, Outreach and the College have asked that he be considered as a Trainee within the Indonesian orthopaedic training program.

"It is pleasing to see the Indonesian medical community supporting the East Timorese and we have a strong relationship with our Indonesian orthopaedic counterparts. We have put his name forward and hopefully he could be East Timor's first home-grown orthopaedic surgeon," Mr McNicol said.



David McNicol operating on a baby with club feet



David McNicol & Phil Aubin trying to get home from Baucau to Dili



Gueterres (right) with his wife recovering from a successful foot reconstruction



The ward staff at Baucau Hospital



David McNicol & Phil Aubin operating on a hip



David McNicol & Phil Aubin with a patient recovering from a hip operation

Mr McNicol also said that while training and support was a priority, particularly in terms of assisting a Cuban orthopaedic surgeon currently working out of Baucau with text books and email advice, practical support was also important.

He said Australian hospitals had contributed equipment and that the orthopaedic equipment industry had been generous supporters. And he said that while facilities were poorer in Baucau than in Dili, gradually the situation was improving.

"We have been to Baucau for the last three visits which means that we are now developing strong relationships with the local staff and patients," he said.

"While the hospital in Bacau is past its use-by date they are in the process of building a new hospital which is desperately needed because Baucau Hospital covers the entire

eastern half of the country.

"When I first went there, they had no orthopaedic equipment but slowly, with assistance, we are gradually equipping the place with the basics. Recently the Princess Alexandra Hospital in Brisbane donated an image intensifier and we are now in the process of organising the local radiographer to visit the Brisbane hospital for two weeks training. In May we also took a flash steriliser so gradually we are building not only the equipment base but the expertise required to use it."

Mr McNicol described his outreach work as pleasing both personally and professionally.

"Professionally you see such amazing orthopaedic problems that you just don't see here. It takes you out of the square, you have to improvise and you have to be able to think on your feet, without all the equipment we are used to here, and at the same time you

can change lives and relieve pain and distress," he said.

"The fact that we, as a team, know each other well and have travelled together often, means that we all know what to expect, what equipment is needed, we know each other's skills and strengths, and I wouldn't go without my wife Jannine. She used to surgically assist for me before our second surgeon Phil Aubin came on board.

"Everyone in the team has a great respect for each other's professional abilities and over the course of our visits to East Timor we have become very good friends. Trainee registrars have also come with us and they are knocked out by the experience. They of course will be the next generation of outreach surgeons."

Based in Canberra, Mr McNicol is a member of the College's International Committee.





Zoe Wainer

## The broken hearts of East Timor

It was an honour to work with such extraordinary individuals contributing above and beyond to help the children



Associate Professor Andrew Cochrane during formal teaching session

In July of this year I excitedly boarded a small Air North aeroplane in Darwin headed to Dili, East Timor. I was fortunate to be one of the doctors on a volunteer paediatric cardiac surgical team from the College and AusAID. Working in developing countries has always been a driving force for me as a doctor, because, put simply, the potential to do good is so great. So as a cardiothoracic Trainee, when the opportunity arose to be the surgical assistant on the Timor Leste paediatric cardiac surgical team I did not hesitate.

The paediatric cardiac team is one of several surgical specialty teams that make up the

Australian Timor Leste program of Assistance for Specialist Services (ATLASS) managed by the College. The aim of the ATLASS program is twofold. Firstly to provide specialist surgical services to the people of East Timor. Secondly to build the health care capacity of the East Timorese doctors and nurses.

Our team was made up of Associate Professor Andrew Cochrane (paediatric cardiac surgeon), Dr David Baines (Paediatric Anaesthetist), Siok Chew (ICU nurse), Cheaw-Shya Lim (Theatre nurse), myself as the surgical assistant, Dr Lance Fong (paediatric cardiologist), Dr Noel Bayley (Cardi-

ologist) and Nic Bayley who provided much needed general support.

The two cardiologists, equipped with their portable echocardiography machines, hit the ground running. Dr Fong and Dr Bayley worked from three main clinics during our stay, the Bairo Pite clinic, The Dili National Hospital outpatients and Bacau hospital. They saw literally hundreds of patients, diagnosing two types. Firstly children with cardiac anomalies amenable to surgery not requiring cardiac bypass, as our team did not have bypass capacity. Secondly patients requiring bypass for whom funding is currently being sought



Dr David Baines teaching



Dr Zoe Wainer, Cheaw-Shya Lim and Associate Professor Andrew Cocohrane

in order to bring them back to Australia for their operation.

We operated on the Monday, Tuesday and Wednesday of our eight day stay. Our patients ranged in age from 11 months to six years old. The operating theatre was relatively well equipped, although oxygen was supplied via bottles, so part of the anaesthetist's job was to ensure the oxygen bottle didn't run out mid procedure. Additionally, suction was via an external machine, which stopped working when the power went off, which was at least one to two times per day. The bullet holes in the theatre walls served as a reminder of the recent troubled history of the youngest nation on earth.

We brought a large amount of equipment, including our own gloves, surgical instruments, endotracheal tubes and anaesthetic monitor, as the ATCLASS teams endeavour to be self sufficient. The aim is to leave behind suitable equipment to assist the ongoing surgery. Lots of bags and quite a bit on negotiating with the airlines regarding excess baggage!

The mosquitos were a new experience in the operating setting, insect spray was mandatory. Initially we had not been alert to the requirement of insect spray as a pre operative treatment for the theatre and as a consequence spent much time catching and dodging mosquitos. Then a scene I am fairly sure none of us will forget as a fly flew into the open chest of a patient. We all froze as we couldn't touch the fly as we were sterile (and we were in very short supply of gloves) so we tried gentle persuasion and were grateful it took the hint. This was followed up with an extra dose of antibiotics for the patient (who recovered from the close encounter with no infection).

The medical staff at Dili National Hospital are a multinational collection with doctors from East Timor, Cuba, China and Australia. Part of the College's ongoing commitment to capacity building of the world's youngest nation is the employment of a full time team including a general surgeon, Ms Emma Lang,

a very experienced ICU nurse Daniel MacKenzie, Operating Theatre nurse Amanda Jennings, program officer Natalie Stephens and anaesthetist Dr Eric Vreede. All do an outstanding job not only in their commitment to the care of the East Timorese people, but also in ensuring ongoing education for the staff of Dili National Hospital.

It goes without saying that being part of a team that makes such a huge difference to the lives of children and their families was inspirational, and a profound reminder of the privilege working in such a setting, and the privilege of the health care we have in Australia. Then there are the people you meet that you cannot help and the stark contrast to their outcome if they lived in Australia. The 14-year-old girl with rheumatic valvular disease and severe heart failure with the only treatment available being digoxin and lasix. The 18-year old girl with post partum cardiomyopathy and severe ascites, and again only lasix and digoxin. These people will stay with me forever. And in fact one must never forget, for their stories are the powerful reminders of why these teams are so important and why we must continue to support and expand such programs.

During our trip the United States Naval Service Mercy ship was anchored in Dili harbour. The Mercy ship is a 1000 bed floating military hospital, which is deployed on humanitarian missions when not required in conflict zones. We had an extensive tour thanks to Dr Bruce Lister, an Australian doctor serving on the ship. The ship was in East Timor for two weeks to provide humanitarian health care to the East Timorese people. The ship is equipped with 12 operating rooms, 60 ICU beds, a very impressive CT scanner and full lab testing facilities. The resources were quite a contrast to the two operating rooms, intermittent x-ray service and five ICU beds at Dili National hospital.

Providing education to the East Timor health care professionals is an important component of the capacity building aspect of the

trip. Assoc Prof Cochrane and Dr Baines undertook both formal and informal education sessions. Both Nurse Siok Chew and Cheaw-Shya Lim worked very closely with local nursing staff. As both nurses spoke Bahasa Indonesia, the education process was smooth and very successful. I was also able to make a contribution to education, in an informal manner. Several of the nurses and doctors approached me with questions about patient care and the surgical procedures. The surgeon and anaesthetist were highly revered and thus local medical staff were hesitant to seek their advice, whereas they appeared to feel more comfortable with me as a Trainee.

I learnt two very important aspects to being a Trainee on such a program. One aim of the Timor Leste program is capacity building. What this means for the Trainee is that should a local doctor or nurse be available to benefit from the role you are playing you must without hesitation step back. For me that meant not scrubbing in when a local doctor was present to do so and not intubating when a local nurse had the opportunity to learn from my senior colleagues.

The second important aspect is to only practice under supervision. I travelled with a senior nursing and medical team who had worked in East Timor previously and understood the local culture and process. So I ensured that I always deferred to their senior medical and local knowledge.

The camaraderie of the trip to East Timor was a spectacular example of team work, leadership and collaboration with each team member being an outstanding leader in their area of expertise. It was an honour to work with and become friends with such extraordinary individuals contributing above and beyond to help the children of the nation of East Timor.

The experience of working in East Timor has been a highlight of my medical career and I unreservedly commend involvement in overseas teams to other Trainees.



## An overview



# PAPUA NEW GUINEA

Fellows of the RACS have been involved in providing specialist services and training in Papua New Guinea (PNG) since the 1950s. The first specialist visits involved thoracic surgery for tuberculosis (1956-1970), and the tradition of cardiothoracic visits resumed in 1993 with '*Operation Open Heart*' which has offered in-country specialist surgery for congenital heart disease.

Surgical training has been supported by Fellows since its inception around independence in 1975, and the support provided by the Australian government has long been formalised through various programs. These have included:

- ☐ The Medical Officers Training Program (MOTP, 1987-1994)
- ☐ Medical Officers, Nurses and Allied Health Professionals (MONAHP, 1995-2002)
- ☐ The Pacific Islands Project (PIP) renamed PNG Tertiary Health Services Project (PNG THS, three phases: 1995-February 2009), and
- ☐ The Medical School Support Program (MSSP, 2003-2008)

RACS managed the three phases of the PNG THS Program and in March 2009, a new program combining the scope of PNG THS and MSSP commenced, called Partnership and Support for Health Education and Clinical Services in Papua New Guinea (HECS). The Project Director is the Dean of Medicine of the University of PNG (UPNG) School of Medicine and Health Sciences (SMHS), Professor Sir Isi Kevau, and the role of the RACS is to be a service provider supporting the agendas set in PNG.

PNG's major training hospitals are based in the capital Port Moresby (which has the UPNG SMHS), Lae, Mt Hagen and Rabaul. Unfortunately the activity of the Rabaul volcanoes has resulted in the need to relocate the centre of specialist services in East New Britain. Specialist training is also conducted in Madang, Wewak and Goroka.



UPNG began specialist training in 1975 and since then over 90 surgeons have been trained, including nine ear nose and throat (ENT) surgeons, 10 ophthalmologists and two oral and maxillofacial (OMF) surgeons.

Specialist training in medicine, obstetrics & gynaecology and paediatrics has also been successful. Radiology and pathology postgraduate programs have produced a handful of MMed graduates. Each MMed course includes four years of supervised training, a research thesis, and clinical skills are assessed by examination. RACS and other specialist colleges in Australia and New Zealand have usually provided an external examiner. Since 1994, 13 subspecialists in orthopaedics, urology, head & neck, neurosurgery and paediatric surgery have completed training. There are two cardiothoracic, two orthopaedic, one neurosurgical, and one paediatric surgeon in training.

The tables below outline the services provided by RACS in PNG between the years 1996 and 2009. The articles that follow present some of the stories that this work has generated; the challenges and successes.

#### **RACS Support in PNG, by specialty (1996 to 2009)**

*From 1996 16786 people have been treated and 6861 operations have been carried out for a wide range of conditions in the following specialties:*

<b>Specialty</b>	<b>Consultations</b>	<b>Operations</b>	<b>Team Visits (2002-2009)</b>
Anaesthetists	-	-	45 (individuals)
Gynaecology	434	102	16
Cardiac	595	380	6
Cardiac Screening	-	-	10
Orthopaedic	4390	1136	21
Paediatrics	605	731	14
Plastics	1453	716	9 (7 funded by Interplast & Rotary)
ENT	1487	341	3
OMF	514	208	16
Ophthalmology	6135	2880	18
Urology	706	285	8
Neurology	467	82	7
<b>Total</b>	<b>16786</b>	<b>6861</b>	

#### **RACS Support in PNG, by location (2002 to 2009):**

<b>Location</b>	<b>Consultations</b>	<b>Operations</b>	<b>Team Visits</b>
Port Moresby	2485	1056	85
Watuluma	75	30	1
(Goodenough Island)			
Alotau	190	75	6
Lae	484	282	21
Madang	343	119	13
Mt Hagen	301	119	13
Goroka	418	241	11
Kiunga, Rumginae & Tabubil	47	-	4
Wewak	977	622	9
Vanimo, Nuka, East Sepik, Maprik	608	524	6
Rabaul	229	124	11
Vunapope	300	199	5
Buka	553	48	6
Kimbe	333	155	4
Kavieng	508	205	5
Aitape	110	43	1
Goglime	86	30	1
Mingende	540	267	2
Kudjip	250	87	1
<b>Total</b>	<b>8837</b>	<b>4226</b>	

#### **RACS capacity building activities administered in PNG (2002 to 2009):**

<b>Courses/Workshops</b>	<b>Participants</b>
EMST	93
EMST Instructors	3
CCrISP	37
DSTC	5
PTC	256
Diploma in Emergency Medicine (including Paed. Emergencies)	31
Advanced Paediatric Life Support Course	1
Sign Nail Orthopaedic Training	2
Emergency Life Support Course	24
EMSB	46
Trauma Workshop (Medical Admin. of Trauma Care)	2
<b>Total</b>	<b>500</b>





## Building capacity in PNG

With a very high incidence of trauma injuries, providing relevant training to PNG's medical and healthcare workers is critical

For the past twelve years, the Papua New Guinea Tertiary Health Services (PNG THS) Project, funded by the Australian Government through AusAID, has provided tertiary health care services to the people of Papua New Guinea. The project aims to deliver clinical services in a range of specialist areas that would not otherwise be available, and to improve the capacity of relevant PNG medical specialists. Since its inception in 1992, the project has delivered over 14,500 consultative services, performed over 5,900 surgical procedures and has trained over 350 local staff.

In recent years, with the development of the medical capacity in PNG and with the wider movement toward sustainability the project has seen an increase in the demand for training opportunities and activities to increase capacity of local staff. Not just for surgeons, but for anaesthetists, nurses and medical support staff such as radiologists and equipment technicians. With this shift, the PNG THS project has evolved to meet the demands of the PNG people and is providing increased training support through the provision of educational programs and clinical training of local staff.

With such a high incidence of trauma injuries in PNG (trauma constitutes approximately 40 per cent of all admissions at Port Moresby General Hospital), providing training for medical and health care workers to improve their skills in managing trauma is critical. Training courses such as Definitive Surgical Trauma Care (DSTC), Early Management of Severe Trauma (EMST), Care of the Critically Ill Patient (CCrISP), ANZBA Burns Workshop and Primary Trauma Care (PTC) have all played major roles in building the capacity of health care workers to deliver care to the acutely injured. Courses such as Primary Trauma Care (PTC) are now well established. Since its introduction in 2002, the PTC course has been conducted in nine locations, with the emphasis on providing training to primary carers in rural, district



Australian Prime Minister Kevin Rudd meets with plastic & reconstructive surgeon John Maihua & visiting surgery team at The Goroka General Hospital

and provincial environments. In 2006 and 2007, thirteen PNG doctors successfully completed the PTC instructors course and are now fully capable of instructing and facilitating the course, with only one Australian instructor required to assist local instructors with the delivery of the PTC program in PNG in 2008.

The project also works with the College Scholarships Programs to provide opportunities for local tertiary health specialists to engage in overseas training. Through the Rowan Nicks Scholarship program, PNG surgeon Dr Lister Lunn and PNG anaesthetist Dr Arvin Karu are both training in cardio-thoracic surgery and currently participating in a twelve month training program at the Chorian Heart Foundation in Chennai, India.

PNG plastic surgeon Dr John Maihua is also newly qualified in his speciality, having sat his final exams in October 2007. Dr

Maihua, supported by Surgeons International Award, spent 12 months training at Flinders University in South Australia in 2004. He is currently supported by THS and Interplast Australia & New Zealand which provide him with continuing medical education and support through involvement in visiting teams, such as the recent trip to Goroka and Lae.

Through the in-country activities of THS and such overseas training opportunities, the capacity of the PNG tertiary health specialists has developed greatly and the project has changed to reflect this. PNG's first two paediatric surgeons, Dr McLee Mathew and Dr Okti Poki, have been supported over the last 10 years by THS and College scholarship programs. The duo are now funded to deliver clinical outreach services with a local team rather than relying on the services of visiting teams. This is an important milestone.

“The project works to provide opportunities for local tertiary health specialists to engage in overseas training.”

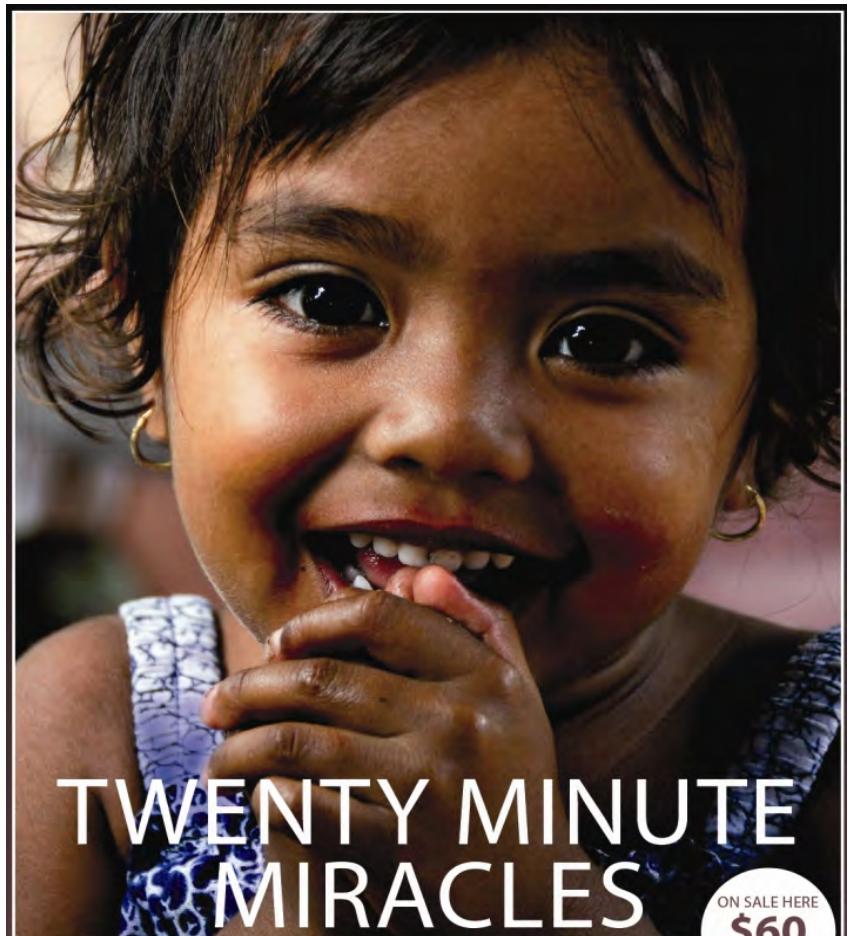


Dr McLee Mathew provides mentoring and support to Paediatric Trainee Dr Ben Yapo during a clinical visit at Mt Hagen General Hospital

Support for paediatric surgery continues with Dr Benjamin Yapo who, supported by the Surgeons International Award, completed his paediatric surgery training at the Children's Hospital Westmead in New South Wales this year. In January, Dr Yapo returned to his home town of Mt Hagen from where he continues to be supported by visiting College surgeons. After Drs Mathew and Poki, on completion of his exams in 2008 Dr Yapo will become the third fully-qualified paediatric surgeon in PNG.

While the surgeons are grateful for the training opportunities provided under the THS project and the College scholarships programs, there is growing concern about the future of tertiary health services in PNG. A common concern among PNG surgeons training offshore is that they will not be sufficiently supported on their return to PNG. Hospitals and health services are increasingly underfunded, which correlates to low pay, lack of essential equipment and poor infrastructure. Still, despite the challenges the project has shown that investing in the development of the PNG tertiary health has been a worthy initiative, one the College can be proud of.

For further information please contact Tanya Edmonds, Project Manager, +61 3 9276 7413 or Christina Savic, Project Officer, +61 3 9249 1230.



# TWENTY MINUTE MIRACLES

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## THE STORY OF THE EAST TIMOR EYE PROGRAM

The East Timor Eye Program is a volunteer service which works to give the gift of sight back to the people of East Timor. Since 2000, the program has performed 3300 surgeries to remove cataracts and restore sight. More than 28,000 pairs of glasses have been prescribed. And 33,000 people have visited the clinics run by the program's volunteers in the capital Dili and many regional centres across the country. Our teams of ophthalmologists, nurses and optometrists have worked for eight years to provide these services to the people of East Timor. They have been supported by dozens of non-medical volunteers and fundraisers. Our mission is to make East Timor self-sufficient in eye care by 2015, and to eradicate preventable blindness by 2020. For more information on our program, or to contact our team leaders, please visit our website at [www.etep.org.au](http://www.etep.org.au)

The East Timor Eye Program is a volunteer service which works to give the sight back to the people of East Timor.

Since 2000, the program has performed 3300 surgeries to remove cataracts and restore sight.

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Our teams of ophthalmologists, nurses and optometrists have worked for eight-years to provide these services to the people of East Timor.

They have been supported by dozens of non-medical volunteers and fundraisers.

Our mission is to make East Timor self-sufficient in eye care by 2015, and to eradicate preventable blindness by 2020.

For more information on our program to download a book order form please visit our website at [www.etep.org.au](http://www.etep.org.au).

Alternatively, please contact Karen Moss, [karen.moss@surgeons.org](mailto:karen.moss@surgeons.org), to purchase a copy of the book.



# PNG surgeons learn surgery success

The program is a triumph for ENT surgery in PNG and for the College

Late last year, Queensland ear, nose and throat (ENT) surgeon Mr Frank Szallasi spent a week in Port Moresby operating alongside ENT local surgeons and registrars undertaking procedures that would even challenge surgeons working in first world conditions. Five patients suffering from head and neck cancers were treated during the week, the surgeons operating for up to ten hours on each to reconstruct faces disfigured after the removal of tumours.

The microvascular free flap transfers, involved the use of leg bone to reconstruct jaws and the transfer of tissue from the arms to rebuild parts of the tongue, mouth and throat. Despite the pressure such complex procedures placed on the staff and hospital facilities, all the surgeries were successful.

It was, in its quiet way, a triumph for both ENT surgery in Papua New Guinea (PNG) and for the College program established in 1991 to help train local surgeons. At that time there was only one ENT surgeon for the entire country, Mr Ardesch Gupta, who himself was the first to work there since 1982. Now there are nine local ENT surgeons and registrars operating out of five ENT centres spread across the nation treating more than 500 people each week.

Mr Szallasi, who operates out of the Ipswich Hospital and the St Andrew's Private Hospital, has been visiting PNG to help train the local surgeons for the past decade. He said he was impressed by the skill levels of the local surgeons as well as their determination to learn new procedures.

"There are no hospitals in Australia where this many microvascular flaps would be done in a week, so I think that the local staff and hospital coped admirably. It does point to the



Operation in progress

success of the program both in terms of the number of surgeons now working and the complexity of the work now being done," Mr Szallasi said.

"While I think there remains a need for visits such as this, you could say they are almost self-sufficient now with their skills increasing all the time. And that is a significant achievement given that the country has a growing, decentralised population of more than four million, which presents major challenges in providing the surgical services needed, where they are needed."

Mr Szallasi's visit took place in November last year under the banner of the Pacific Islands Project funded by AusAid. There, he worked alongside Professor SP Dubey, the Chief ENT surgeon at Port Moresby General Hospital.

Five ENT surgeons, three registrars and one maxillofacial surgeon took part with some surgeons travelling from the regional ENT centres based at Angau Memorial Hospital in Lae, Mt Hagen General Hospital, Goroka General Hospital and Nonga Base Hospital in Rabaul.

The first Australian ENT surgeon sent to PNG in 1990 to assess the local training needs, Mr Chris Perry, is now the College's Specialty Co-ordinator for the PNG program.

He said that after his initial visit to confer with Mr Gupta about the assistance required,

he was then appointed overseer of training, a position which necessitated two trips a year to PNG as well as mentoring the local trainees during their training visits to Australia.

"When Mr Gupta was originally appointed, one of his central aims was to develop a local ENT surgical service for PNG. Then, general surgeons did everything and there was a debate about which should come first – primary health services or specialist services," Mr Perry said.

"But Mr Gupta was determined to provide specialist training to local surgeons and contacted the Australian ENT society to seek assistance. We were very keen to help but we had to start from the basics.

"At the outset there were some early difficulties because Mr Gupta had trained in India, then worked in Zambia for six years which meant that while he was a great ear surgeon, he had missed out on learning more recent endoscopic sinus surgery techniques while CT scans were relatively new to him. This in turn meant that to provide comprehensive ENT training we had to take the trainees back into the anatomy department and then put together a training program."

Mr Perry said this involved the development of a syllabus for a one-year Diploma of Otolaryngology and then three years of further training for a Masters of Medicine Degree, Part Two.



*After less than 20 years the country has the local surgeons it needs to provide treatment.*



Port Moresby Hospital

"We started a Diploma of Laryngology & Otology (DLO) program so that those doctors who did not wish to complete the training would still be recognised for time spent and skills acquired."

He said that until recently, each trainee spent up to six months at the Princess Alexandra Hospital in Brisbane but that now trainees were visiting Australia on month-long rotations at different hospitals in Perth, Sydney, Melbourne and Adelaide.

Able to name each trainee and surgeon trained, Mr Perry is clearly proud of the program and cross cultural surgical co-operation.

"Most of the registrars have stayed at my house. One of them, James Naipao was the vice captain of the national PNG rugby league team and given that rugby league is almost a religion up there he was considered a national hero; a surgeon and a tough front-row forward," he said.

"All of them, however, have been great to work with and get to know and have proven themselves to be excellent surgeons.

"Yet despite the enthusiasm both in Australia and PNG, it has not always been easy to provide this training. At one stage, even though the program was proving highly successful, we had difficulty securing funding but the Australian ENT society was so

committed to it that we raised funds ourselves and through various private and corporate donations to allow the trainees to continue their training visits to Australia.

"There is no doubt in my mind that this is one of the most successful training programs ever run in PNG and as a specialty we are justifiably proud of that achievement."

Mr Perry said there was now work being done to determine the feasibility of setting up a new ENT centre at Wewak to tie in with the school for deaf children, run by the Christian Brothers, while local ENT surgeons were also keen to support the surgical service provided there by Sr Mary Joseph, a Passionist nun and the only general surgeon for a population of 500,000. He said that throughout the history of the PNG program, training and financial assistance had been willingly offered by a variety of surgeons and organisations.

"A few years ago, University of Queensland medical student Rachel Nugent, went to Goroka to work alongside local surgeons and came across a small boy who had inhaled a coffee bean," he said.

"The highlands surgeons then didn't have the equipment needed to remove it which meant that the child was likely to die from pneumonia over months or a year.

"Upon her return to Australia she raised

more than \$4000 from convent school-kids which was matched by the ENT Society of Queensland which was then further matched by a Lions Clubs in Bundaberg and Port Moresby.

"This allowed for the purchase of \$30,000 worth of bronchoscopes, light sources and foreign-body forceps for four ENT centres so that now such children don't have to die from a simple coffee bean. It is efforts like this that have made the ENT program so rewarding."

While PNG has an increased rate of unusual nasal disease such as ozaena and rhinoscleroma, and with leprosy still found there, the main ENT surgical needs relate to the treatment of sinusitis, ear infections, cancers of the throat and mouth and disorders of the thyroid. Yet now, after less than 20 years, the country has the local surgeons it needs to provide treatment.

"This program has been hugely successful in terms of now having five ENT centres and nine surgeons treating hundreds of people each week. I think it shows how programs like this should be developed and delivered and I think it shows, at last, that the days of the great white doctor are over. We don't go there to do cases so much anymore but rather to leave skills on the ground with local surgeons," Mr Perry said.





## Surgical training in PNG

Thanks in part to the College, our northern neighbour now staffs all its hospitals with surgeons born and trained there

The formal and informal collaboration that has existed between the College and neighbouring Papua New Guinea (PNG) for more than 50 years has proven to be one of the stand-out success stories of the College's many international assistance programmes. While the relationship began with individual Australian surgeons working in the impoverished nation to help treat the ill and provide basic training along with short-term specialist visits, the College is now sending surgical academics to assist local candidates trained at the local university to fulfil the requirements of the Master of Medicine Degree (MMed).

When PNG acquired its independence 30 years ago, there were no trained local surgeons to treat the then population of more than two million people and only 16 expatriate surgeons available across the country. However, since the first two local surgeons graduated in 1979 from the University of Papua New Guinea's Medical School, more than 50 general surgeons have followed.

All major hospitals in PNG are now staffed by locally-born and trained surgeons. Surgery is the only medical specialty to achieve this.

While training in PNG remains focussed on general surgery because of both the health needs of the population and limited facilities, a sub-specialisation program, which began in 1994, has now also trained 13 postgraduates in, paediatric (two) and orthopaedic surgery (five), urology (two), neurosurgery (one) and head and neck surgery (three). Nine ENT surgeons, 10 ophthalmologists and two oral surgeons have also graduated MMed since 1993.

Now, too, with the posting of national specialist surgeons to Port Moresby, all modules of the General Surgery Master of Medicine programme are being taught by Papua New Guineans, a development hard to imagine even in 1993.

Yet the College still remains committed to assisting the developing nation, with a request made in 2006 for senior academic surgeons to visit the country to tutor Master of Medicine candidates in preparation for their mandatory theses due to the departure of the UPNG's highly respected Professor of Surgery, Professor Chung (2004-2006).

In the past two years, the Colleges' Tertiary Health Services Project has funded 15 visits by Australian surgical specialists to support the teaching program.

Professor David Watters, who was himself Professor of Surgery at the UPNG from 1992 to 2000, has visited PNG twice this year to conduct tutorials and a research workshop. The workshop covered the purpose and structure of the MMed thesis, helping the candidates develop hypotheses, present statistics, analyse data and access key literature and internet resources.

Some of the thesis research projects include understanding the trauma patterns seen at Angau hospital, the HIV seroprevalence in surgical patients, prostatectomy outcomes in PNG, the causes and treatment of cervical spine injuries, the incidence of abdominal tuberculosis and colorectal carcinoma.

"The quality of the teaching and the calibre of candidates are very high for the MMed program and the Dean of Medicine at the UPNG, a physician cardiologist, Professor Sir Isi Kevau, is an outstanding academic so it is a privilege to be of assistance," Professor Watters said. Further academic support has been provided by Mr David Hamilton who has also visited twice this year and was the surgeon in Rabaul from 1975-1989.

"In the late 1990s, the UPNG embarked on a restructuring program that led to the formation of the School System. At the same time its traditional medical course, which had been taught up to 2000, was replaced by one centred on problem-based learning built

around the Newcastle Model.

"That means the UPNG was ahead of Melbourne University in its approach to medical education and surgery is the outstanding program within the medical school in producing postgraduates."

Professor Watters said the Master of Medicine programme was a four-year postgraduate degree based around general surgery making the training broader but less specialised than that provided in Australia or New Zealand.

While it is not transportable, it is equivalent to the FRACS and was designed with particular attention to local needs and circumstances.

All MMed surgical programs take four years to complete with the first year of study focused on Basic Medical Sciences including work as a surgical registrar, the study of common core subjects relevant to all disciplines and a specialist core.

The surgical specialist core consists of applied anatomy, pathophysiology and surgical pathology. In addition, each trainee must perform satisfactorily as a supervised surgical registrar for all four years.

The first year or two of training are conducted under supervision of a national specialist in a regional/provincial teaching hospital (Lae, Goroka, Mt Hagen, Rabaul or Madang). The third year is sometimes spent overseas in Darwin or Alice Springs.

At least the last year is spent in Port Moresby where there is a critical mass of surgeons and registrars for a vibrant teaching program. The MMed degree is awarded after successfully passing all the components, including the presentation of a thesis up to publishable standard. Professor Hamish Ewing (University of Melbourne) has been external examiner in surgery for the years 2005-2008.

"The aim of the program is to produce a general surgeon capable of being the only surgeon



Surgeons and Trainees at a research workshop, Port Moresby, March 2008, the workshop was conducted by Professor David Watters and Mr Joseph Ragg

in a provincial hospital in PNG. Such a surgeon must be able to carry out a laparotomy, resect bowel, drain an extradural haematoma, open a chest, relieve an obstructed urinary tract, manage complications from congenital anomalies, treat complicated wounds and fix common fractures,” Professor Watters said.

“To an Australian surgeon, the facilities are quite basic and there is not a lot of technology available so local surgeons need to know how to do more with less, and the training program prepares them for this.

“Obtaining the FRACS was not a viable option as it would have required the Trainees to spend long periods in Australia, with their services lost to PNG along with a high risk of them being seduced into staying, adding to the brain drain already occurring from developing nations in the Pacific.

“However, that is also another aspect of the success of PNG’s surgical training program because of the more than 50 national surgeons who have graduated, only five are currently working long-term outside the country.”

Professor Watters also said that initial concerns expressed at the beginning of the specialisation program in 1994 – that such surgeons

could be unwilling to provide general surgical services training – did not eventuate.

Another issue raised at the time was the fear that the specialists would demand better equipment and remuneration. Professor Watters said such specialists had argued well and wisely in demand for such equipment to treat their patients but not always succeeded in being awarded the higher salaries they deserved. There is no doubt their skills had resulted in improved surgical care.

Professor Watters is now a Professor of Surgery at the University of Melbourne based in Geelong Hospital. Chair of the International Committee and a College councillor, he is also the Director of the PNG Tertiary Health Services Project, which is soon to be transformed into a different program managed by the Medical School of Port Moresby. The new program will be called Health Worker Education and Training and Specialised Services in PNG (the “PNG HWETSS Program”). The College component will involve supporting the Medical School in capacity building for specialised services through the education and training of specialist health workers.

Professor Watters also said an international

search was now underway in a bid to find a new Professor of Surgery to lead and maintain the progress in surgical training.

“There has not been a replacement for Professor Chung since 2006 and we are concerned that it may take up to four years to find someone to replace him. It is not a position or a location that would suit everyone,” he said.

“You have to be brave and bold to work in PNG ... my wife and I and family loved our time living there, so if you have a sense of adventure it can be a very rewarding experience, even with young children.

“I think it could also appeal to someone who is older, perhaps, who would like such an adventure as they head toward retirement but they would need to be able to work without all the back-up available in Australia. They would not necessarily have to be currently a professor level but they would need to be academically inclined and ideally have some experience of tropical medicine, even if only as a volunteer on visiting teams.”

Professor Watters said interested surgeons could contact Professor Sir Isi Kevau at UPNG for further information on the chair in Surgery ([isi.kevau@gmail.com](mailto:isi.kevau@gmail.com)).



An overview



# INTERNATIONAL SCHOLARSHIPS

## Rowan Nicks Scholarship

The annual Rowan Nicks Scholarship is offered to young surgeons from selected developing countries who have shown particular promise, and are destined to be leaders in their home countries. The Scholarship is tenable for up to a year in an institution where the recipient will develop their surgical skills and also become involved in teaching, research and administration. Applications open in December of each year and close in the following April. Please contact the International Scholarships Secretariat or visit the College website for further information.



## Weary Dunlop Boon Pong Exchange Fellowship

The Weary Dunlop Boon Pong Exchange Fellowship is a collaboration between the Royal Australasian College of Surgeons and the Royal College of Surgeons of Thailand. The program provides opportunities for nominated Thai surgeons to undertake surgical training attachments in Australian hospitals, in their nominated field of interest.



## International Travel Grant

The International Travel Grant supports surgeons from Asian and Pacific countries to attend the College's Annual Scientific Congress (ASC) and participate in short-term hospital attachments. Applications should be received by the International Scholarships Secretariat by 31st January for the upcoming ASC in May of that year.



## Educational Grant for South-East Asian Surgeons to attend the ASC

The South-East Asian Travel Grant provides complimentary registration for young surgeons from nominated developing countries to attend the College's Annual Scientific Congress. Recipients of this Travel Grant have the opportunity to attend workshops and master classes, and to establish contacts with surgeons from Australia and abroad.



## Surgeons International Award

The Surgeons International Award provides for doctors, nurses and other health professionals from developing nations to undertake short-term visits to one or more Australian medical institutions to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's home country. Applicants should be nominated by a surgeon participating in the College's International Development Program.

**Please contact the International Scholarships Secretariat for further information or visit the College website:**

[www.surgeons.org](http://www.surgeons.org)



**International Scholarships Secretariat  
External Affairs Division  
Royal Australasian College of Surgeons  
College of Surgeons' Gardens  
250-290 Spring St  
East Melbourne VIC 3002**

**Telephone:** + 61 3 9249 1211

**Fax:** + 61 3 9276 7431

**Email:** [international.scholarships@surgeons.org](mailto:international.scholarships@surgeons.org)



## Surgeons International Award

This award aims to help train surgeons from developing countries so they are not reliant on medical visits from overseas teams

PROFESSOR DAVID WATTERS, chairman of the International Committee, states that “one of the College’s highly-regarded scholarship funds is in the process of helping Papua New Guinea fill two crucial gaps in its health care system – the lack of specialist paediatric and cardiothoracic surgeons.”

The Surgeons International Award, established by retired Melbourne surgeon Professor Richard Bennett to assist medical personnel in under-privileged countries, has provided the funding to allow two PNG surgeons time in Australia to gain the expertise they need to boost the quality of care available in PNG.

The program, which is dependent on the professional and personal input from College Fellows, is designed to help train surgeons and other health professionals with the aim of helping developing countries become as self-sufficient as possible so they are not so reliant on medical visits from overseas teams.

Dr Benjamin Yapo, a general surgeon from PNG, is now undertaking the second year of his paediatric training at the Westmead Children’s Hospital in Sydney, and Dr Noah Tapaua from PNG started in 2007 at the Geelong Hospital cardiothoracic unit. Dr Yapo came to Australia in 2005. He began working with Professor Paddy Dewan at the Sunshine Hospital and increased his paediatric urology skills. He is the third paediatric surgeon from PNG to receive training and will sit his final exam in 2008.

“The surgical problems that kids have back home are not always well managed by the medical system there because it is sometimes too adult-oriented. That means that when children come into hospital with a problem, general surgeons are not always confident in managing them,” Dr Yapo said.

“The neonates have particular problems because they need delicate surgery, access to ICU and anaesthetic support but some die within 24 hours because there are

inadequate facilities to support the correct surgical management. Many children only receive basic treatment for certain conditions while they wait for an AusAID-sponsored specialist team visit.

“In contrast to neonates, the older the children are the better they can handle surgery and survive without much need for a paediatric ICU. But there is no doubt that we do not have the in-depth knowledge in this subspecialty needed to reduce the problems that we face in our children.

“However, the two surgeons (Dr Mclee Mathew and Dr Okti Poki) who have already been trained have changed the outlook for children considerably in the past few years. We are now getting to the position where we can manage all but a few complicated cases which still require help from a visiting specialist team from Australia.”

While in Melbourne, Dr Yapo treated undescended testes, hernia, kidney problems and blocked ureters. At the Westmead Children’s Hospital, working under the mentorship of Dr Albert Shun, he has had more experience in hypospadias surgery including the treatment of hernias and undertaking bowel surgeries, especially in neonates.

“In PNG parents aren’t educated about certain conditions so they often think that if a child cannot open his or her bowels for a few days it is OK as long as they are not in pain or distress, and they may ignore this as a problem until the child’s abdomen is severely distended,” said Dr Yapo.

“When they seek help at this stage it becomes a bigger problem to manage. This is about community education but it is also about access so the more of us doing this work the better.”

At Westmead Children’s Hospital, Dr Yapo had his first exposure to a number of paediatric imaging technologies, to help in making diagnosis and especially nuclear medicine studies that are not available in PNG.

“We are sometimes working on very complex cases here, and to me it is like a whole new world of medicine I had never known before. I have never had exposure to nuclear medicine studies in PNG, and while many of these procedures we still could not do at home, having this exposure will assist in helping me identify alternate ways of solving a problem.

“We are working on a lot of neonates here, which is important experience for me because at home we don’t tend to see them or have the time to understand the conditions often because they die before we get to treat them. Here however, I have been able to learn about various conditions and how best to manage them,” Dr Yapo said.

Dr Tapaua began his cardiothoracic training in 2007 at the Geelong Hospital with Mr Morteza Mohajeri. He is concentrating on coronary artery bypass graft surgery and lung cancer in 2007 and 2008. The plan is that he will do paediatric cardiac surgery in 2009. He said “with no cardiothoracic surgeons in PNG, general surgeons treated what they could (pericardectomy and some thoracic surgery). Most patients were forced to wait for treatment from Australian surgeons, who only visit once a year.”

“There is a great need in PNG at the moment because the general surgeons can only do what they can do and there is little treatment for congenital heart conditions. Because of this I am hoping to work with a paediatric cardiothoracic surgeon if there is an opportunity while in Australia because some children and adults die while they are waiting for treatment. This means that I must learn as much as possible before I go home. Rheumatic fever and valvular heart disease are also quite common,” he said.

“I see this as a breakthrough for me, to be able to learn the skills to do this surgery in PNG, and I really appreciate the support I have received in Australia.”



Another PNG surgeon, Dr Lister Lun, and anaesthetist Dr Alvin Karu are being supported by the Rowan Nicks Scholarship program to undertake cardiothoracic surgery and anaesthesia at the Cherian Institute in Chennai, India, from August 2007. Dr Tapaua, Dr Lun and Dr Karu will form the backbone of cardiothoracic services in PNG. All doctors said they were excited at the prospect of taking their new skills back to benefit their own people but that sourcing the necessary equipment could be difficult.

Dr Tapaua said that while he would be returning to the major referral hospital in Port Moresby, he would have to approach government sources for equipment. He will also be the first surgeon-educator of cardiothoracic surgery in PNG, responsible for introducing relevant modules for the specialty in university courses.

"I am looking forward to going back to impart what I have learnt here, but I am aware of how big the task is. We don't have equipment in the hospital, so I will have to find that somehow, and we don't have a teaching program for cardiothoracic surgery, so that will take some time," he said.

"But this is a start and the help and support we have received from the College and Professor Bennett will go a long way."

Dr Yapo said he too had contacted local business houses and Rotary clubs to seek funding for basic surgical instruments needed for the treatment of children. "In our theatres all the equipment are adult-oriented and some of the instruments are not workable because they are 30 to 40 years old," he said.

"Some businesses there have said they would help and I am in discussions with Rotary to help us get a paediatric operative instrument set and cystoscope, which costs a couple of thousand dollars.

"People have been incredibly helpful and supportive since I have been here so there is hope."

Dr Yapo said he was also looking forward to going home and putting his skills to use.

"I can't wait to get back and treat these kids that are very underprivileged and deserve care that is easily accessible to other people in other countries," he said.

"The plan is that as we train our doctors, we will be able to go a step forward every time so that we can phase out the Australian visits

over the next few years because we will be in a position to have local surgeons treating local children.

"We would also then be in a position to do similar visits to the Solomon Islands and other Pacific Islands and teach them to do paediatric surgery with Australian support."

According to Professor Watters, Surgeons International has been effectively making an important contribution to the training of the young doctors it has chosen to support. Professor Watters said "The funds for any one individual are limited so it is most appropriate for sponsoring travel and settling in for registrars coming to paid positions in Australia who need to be set up but not maintained long-term".

It has also been used to support some educational activities and key conference attendance for its recipients. Short-term attachments (three to six weeks) have also been funded. Other PNG surgeons who have received support include Dr John Maihua (head and neck surgery) and Dr William Kaptigau (now the country's first neurosurgeon and the first indigenous neurosurgeon). In 2001 it funded Danny Gre, a community health worker from Vanimo General Hospital in PNG who was sponsored by Ms Elizabeth Lewis to undertake an operating theatre nursing course. The criteria used to make an award from the fund include evidence of the candidate's ability and potential, confirmation that they are a bona-fide trainee with national or university endorsement, and an assessment as to how the planned activity will fit in to their entire training program.

Professor Watters said "The fund is not limited to PNG and for surgical training but is available and has been used to benefit trainees from elsewhere in the Pacific and South East Asia. The awards are made at the discretion of Professor Bennett on the recommendation of members of the International Committee".

Professor Watters said that Professor Bennett can be proud of what the Surgeons International recipients have achieved. Each recipient has the potential to make an enormous difference to health care back home.

*\*Footnote: The PNG THS Project has purchased instruments and a cystoscope for the paediatric surgeons in PNG for the above need".*

"I can't wait to get back and treat these kids that are very underprivileged and deserve care that is easily accessible to other people in other countries."



Ben Yapo



David Watters



Noah Tapaua

# From Mongolia to Australia

The scholarship provides aspiring surgeons with the opportunity to study in Australia and promotes international friendships between countries

Dr Tumennasan Magsar, from Mongolia was awarded the Rowan Nicks scholarship in 2007 and took it up in 2008. Since the establishment of the scholarships, talented surgeons, from developing countries in particular, have had the opportunity to spend time in Australia under the guidance of mentors, increasing their skills and gaining access to science and technology unavailable in their home countries.

Dr Magsar is a general paediatric surgeon and is head of the Paediatric Surgery Department in Maternal and Child Medical Research Centre in Ulaanbaatar, Mongolia. The Maternal and Child Medical Research Centre, established in 1922, is the largest medical centre in Mongolia for children's and women's health care, research and education. It has 600 beds and is the teaching hospital of the Mongolian Medical University.

For most of the Rowan Nicks scholarship he worked at the Children's Hospital in Westmead, NSW. Professor John Harvey was the supervisor of the scholarship program. According to Dr Magsar "He generously gave me opportunities to gain knowledge, engage in clinical training and operative experience. I also worked closely with widely recognised paediatric surgeon Professor Albert Shun."

"The primary goal of the scholarship was to satisfy my own expectation in a way that would improve my ability to undertake expert surgical care of my patients in Mongolia," said Dr Magsar. With the requirements in his home country and his interest, it was proposed to train on:

1. Neonatal surgery, surgical treatment of oesophageal, biliary atresia, omphalocele,



Rowan Nicks & Tumennasan Magsar at the CASC in Hong Kong

- gastroschisis and anorectal malformation etc
2. Modern surgical management in general paediatric surgery
3. Paediatric hepatobiliary surgery
4. Paediatric oncology problems, thoracic surgery, urology
5. Paediatric laparoscopic surgery

Dr Magsar had the following objectives in promoting surgery in his home country:

1. To introduce modern diagnostic and treatment methods and surgical techniques for the most common paediatric surgical disease. Thus improving the quality of care and decreasing the mortality of paediatric surgery patients.
2. To approach world standards of the treatment of neonatal and congenital defect surgery.
3. To introduce progressive methods of performing surgery on the most common paediatric tumours, thus improving the quality of life and leading to a cure.
4. To establish paediatric laparoscopic surgery.

"At the end of my scholarship I felt that my goals were achieved successfully with significant all round experience in paediatric surgery. One of the major gains from this scholarship is the clinical experience which was achieved primarily through participation in surgical

work and attendance at the outpatient clinics and ward rounds," said Dr Magsar.

"The variety of surgical work allowed me to have a good different experience in entire range of paediatric surgical conditions including day surgery cases, neonatal, chest, gastrointestinal, colorectal and hepatobiliary surgery."

Dr Magsar said that Professor David Croaker invited him to stay at his house and work at Canberra Hospital for ten days to share with Professor Croaker a different working environment. Working there helped him understand the differences of rural paediatric surgery services.

"I was able to have an extensive experience as I participated in many meetings. Spending some time at the Clinical School and introduction to the medical student curriculum, textbooks, lectures, and tutorials was productive to learn the teaching procedure here and compare to Mongolia. I understand the importance of the bedside teaching to medical students and their participation at department educational meetings," Dr Magsar said.

"I am proud that I had the opportunity to work at the Children's Hospital in Westmead and I understand that modern surgery is a well organised team sport and the ability to function and lead in a multidisciplinary environment will be essential.

"The visit to Australia with my family made it more enjoyable. I really appreciate the following people who supported and helped me and my family during the scholarship: Mr Rowan Nicks, Mr John Masterton and the Rowan Nicks committee, Professor Paddy Dewan, Professor John Harvey, Professor Albert Shun, Professor David Croaker, Professor Nick Smith, Professor Ralph Cohen and Dr Thomas Gordon."

One of the scholarship highlights he said was meeting Rowan Nicks. "I had the opportunity to meet Mr Rowan Nicks at the College Conjoint Annual Scientific Congress in Hong Kong. It was impressive to meet him, I enjoyed talking to him. Participation in an international meeting is almost impossible for surgeons from developing countries, and the opportunity given to Rowan Nicks scholars is unique.

See page 51 for Rowan Nicks' advertisement.





*pictured: Bruce Barraclough*

## Weary Dunlop Boon Pong Exchange Fellowship grows

A scholarship funded by the College that commemorates the bond forged between Australia and Thailand in the horrendous building of the Burma-Thai railway during World War Two is to be expanded.

Known as the Weary Dunlop Boon Pong Exchange Fellowship, the program brings young Fellows of the Royal College of Surgeons of Thailand (RCST) to Australia for four months to assist and observe under the supervision of a local mentor. So popular has the program become since its inception in 1958, the College last year decided to raise the number of exchange Fellowships available from four to six per annum. More than 60 Thai surgeons have already been funded to visit Australia under the scheme.

The co-ordinator of the Fellowship program, Professor Bruce Barraclough, said it allowed Thai surgeons to not only increase their individual skills but improve the local health care system upon their return.

"These are very well trained surgeons who are Fellows of the RCST, usually in the second or third year of their surgical practice. However, much of the work they do in Thailand is trauma and emergency medicine so they are extremely keen to experience a wider range of elective surgical procedures and get exposure to the Australian health system," he said.

"At the same time, this exchange program provides wider benefits than simply increasing the skill levels of individual surgeons. For example, there are 60 million people in Thailand with the vast majority travelling on motor cycles, yet the use of helmets was not common nor legally mandated – resulting in a significant number of head injuries.

"One of the surgeons who came to Australia via this exchange program went back and pushed local authorities to introduce such laws so the impact of this program stretches further than the individuals involved."

Under the exchange Fellowship, applica-

tions and CVs are sent to Professor Barraclough from the Thai program coordinator Professor Thongueb Uttaravichien. Professor Barraclough then approaches Australian Fellows in the relevant specialty with a request to supervise and mentor the Thai surgeons during their stay.

He said he was yet to be refused.

"This is not an insignificant ask – to bring in someone to the team for four months, to help them find accommodation, to make them feel welcome, to teach and supervise. The local surgeons involve them in their public hospital work, take them on ward rounds with other registrars, explain medical science and tests that they may be unfamiliar with and also allow them to assist in their surgery in private hospitals, he explained.

"That willingness to participate says a lot about Australian Fellows, many of whom continue to act as mentors when the Thai surgeons return home. We have surgeons from all specialties seeking this scholarship and over the years we have found them mentors across Australia.

"For their part the Thai surgeons appreciate the exposure to procedures and medical care and science not available in Thailand and the opportunity to develop those mentor relationships with senior local surgeons."

Under the Exchange Fellowship, the scholars observe and assist elective operations during the day and emergency operations at night and weekends but take no primary responsibility for patients.

The recipients are not registered for the provision of care to individual patients as prime carers, mainly because of language requirements. However, they have access to hospital libraries and participate in surgical meetings and surgical audits. Classroom training is minimal, but the scholars are encouraged to attend appropriate lectures relevant to their interests.

The scholarship consists of a \$10,000 stipend with travel allowances usually provided

from the RCST. The Weary Dunlop Boon Pong Exchange Fellowship is named after Sir Edward "Weary" Dunlop, one of Australia's greatest wartime heroes and life-long humanitarian and Boon Pong, a local Thai man who helped the prisoners of war forced to build the notorious Burma-Thailand railways by the Japanese.

After the fall of Singapore, Sir Edward Dunlop elected to stay with his unit and was taken prisoner by the Japanese for three years.

One of 13,000 prisoners, he worked on the railway during which 4500 prisoners perished and as commanding officer and surgeon, and champion of his men, earned the nickname "Weary" and the admiration of his fellow POWs.

After the two ends of the railway were joined, Sir Edward and fellow surgeon Albert Coates went on to build an 8000-bed hospital at Nakom Paton at the "Bridge on the River Kwai", near Bangkok.

Upon his return to Australia, Sir Edward was appointed Honorary Surgeon to Outpatients at the Royal Melbourne Hospital and resumed his career as a surgeon and teacher, winning wide recognition as a leader in cancer treatment and research. His frequent return visits to Java and his desire to heal the wounds of war prompted a medical exchange between Australia and Thailand, including the establishment of the College program named in his honour.

A recent exchange Fellowship recipient, Dr Winai Ungpinitpong, is now back in Thailand having spent a four-month period in Australia from September 2007.

As a colorectal surgeon, he spent his time here at the Royal Prince Alfred Hospital in Sydney. Now back working at the Surin Hospital, a 700-bed facility in the north-eastern region of Thailand near the border with Cambodia, Dr Ungpinitpong said the main problem confronting the health system was a lack of experienced doctors.

“The most important thing that I received through the exchange program was not only the experience in surgery but the chance to make friends and develop relationships with surgeons in Australia which I will never forget.”

“This (program) gave me the chance to gain and share experience with the Fellows of the College in Australia, particularly in my special interest. I have now the inspiration to set up a better system and good team in my hospital,” he said.

“The most important thing that I received through the exchange program was not only the experience in surgery but the chance to make friends and develop relationships with surgeons in Australia which I will never forget.”

Professor Barraclough, the Chair of the Board of the NSW Excellence Commission, Associate Dean at the University of Western

Sydney Medical School and President of the International Society of Quality in Health Care, has a particular interest in the scholarship because his father was one of the prisoners of war.

“Weary Dunlop was one of Australia’s great heroes, however there were many doctors who were forced to work on the Burma-Thai railway and they were all considered heroes,” he said.

“I knew a lot about this history because my father was there and I met friends of his who were also there but this exchange program has meaning in its own right. After this amount of time I would doubt that many

of the Australian mentors or Thai surgeons would know the details of this period in history, but fostering the spirit of international cooperation has its own value.

“Thailand is progressively building up its surgical workforce and while they do not yet have enough surgeons, they are trained to a high standard and doing the very best they can in the circumstances they must work in, with many more patients per surgeon than in Australia.”

Sir Edward “Weary” Dunlop died in Melbourne in 1993, with some of his ashes appropriately lying near the railway at “Hellfire Pass” in Thailand.



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## Rowan Nicks Scholar

Dr Kondwani Chalulu, a Fellow of the College of Surgeons (East Central and Southern Africa), was the 2007 recipient of the Rowan Nicks Scholarship

I was in Australia between June and October 2007 and during my stay I was under the mentorship of David Watters and Glen Guest at the Geelong Hospital. It was a whole new experience for me having to attend operations like laparoscopic banding of the stomach for treating morbid obesity when one of our biggest problems include malnutrition.

It was a wonderful and life-changing time for me. Having negotiated the problems of time difference (it took me over one week), I started enjoying life again: doing ward rounds, attend-

ing theatre sessions, x-ray sessions, multidisciplinary meetings and an occasional weekend sip of Crownies. I soon realised that my passion for the English Premier league was taking a back seat. There were no games on TV and the Australian Soccer league which had some popularity when Dwight Yorke was playing for Sydney Football Club wasn't the most popular sport.

I was attached to a firm comprising of Mr Anthony Lawler, Mr Greg Mitchell, Mr Roger White and Mr Conrad Brandt who were all ardent Australian Football League (AFL) followers. I instantly took a liking to "The Cats" who were doing brilliantly in the league at that time, eventually (after a 30-odd year wait) winning the league in 2007. I had earlier on remarked to colleagues that it was my presence in Australia that would make Geelong win. African magic, it is called. I was not in Australia in 2008 hence the loss in the grand final after again doing well the whole year. I hope to be in Australia for the surgical conference in 2009 so watch out Hawthorn and the rest, for this September "The Cats" will emerge victors again.

Since leaving Australia, I found myself thrown into the deep end of administration. The director of our hospital had been given another post at the ministry headquarters and immediately upon my arrival I was asked to fill the vacant post in an acting capacity. I had initially thought that I would do the job for a month or two while they were looking for a replacement but ended up doing the job for eight months. Queen Elizabeth Central Hospital is a 1200 bed hospital, the biggest referral hospital in Malawi (population 13 million). It also acts as a teaching hospital for the only college of medicine in Malawi which was established in 1992.

The hospital has a joint management committee with the college of medicine with the chairmanship rotating between the college principal and the hospital director. The bulk of consultants in Malawi are from the college, hence all complicated referred patients from Malawi and beyond the borders (especially from Mozambique) are referred and treated at our hospital (the only hospital with a CT scan, and recently a magnetic resonance imaging

*“It was a whole new experience for me having to attend operations like laparoscopic banding of the stomach for treating morbid obesity when one of our biggest problems include malnutrition.”*

(MRI) scan) in Malawi. The burden of clinical work therefore is immense.

Apart from administrative duties I am also involved in teaching medical students, doing my on call duties in surgery, operating (one theatre day a week), organising audits, outpatient clinics, ward rounds, research and district outreach visits.

When I was in Australia, I was attached to a general surgical firm with interest in breast surgery. Upon my return I took over all breast work in our hospital. I started a weekly breast clinic, started auditing all breast work and dedicated one operating day to breast disease. Breast cancer patients present very late in Malawi because of various reasons and our commonest procedure is incision and drainage of abscesses from young lactating mothers.

In Geelong we were seeing very small lumps of less than two centimeter diameter with the whole multidisciplinary team of breast nurses, surgeons, oncologists, pathologists, radiologists, genetic counsellors, nutritionists, social workers being involved. In Malawi, almost all tumours that present are locally advanced breast cancers and beyond. By time of presentation there is already skin involvement and huge fixed lymph nodes (no need for sentinel nodes).

Our hospital/country has one visiting radiologist (but no mammogram), one private cytologist (most of our patients cannot afford this), no radiotherapy services at all, limited chemotherapeutic options, no histopathological service that can tell you Estrogen-Receptor-positive (ER), Progesterone-Receptor-positive (PR) or Human Epidermal growth factor Receptor 2 (HER-2) status, all these making breast cancer impossible to manage. The central medical store doesn't have Tamoxifen on its essential drug list so patients have to buy this in private pharmacies if they can afford it. Herceptin is not even known by some pharmacists and by not knowing the HER-2 status, and the expense, we don't even consider it.

With the problems highlighted (no radiological, pathological, cytological, chemoradiotherapeutic support), we cannot offer a massive screening program and we cannot treat breast cancer adequately. We do have a dedicated palliative care team already inundated by other diseases, mainly end stage HIV/AIDS and other metastatic cancers(oesophagus, cervix, Kaposi's) who take care of our advanced breast cancers.

What we usually offer breast cancer patients is a modified radical mastectomy with axillary dissection and Tamoxifen 20mg daily



Top: The Queen Elizabeth Hospital Above: Patients waiting to be seen

for life. Only two patients in the past 18 months have been sent to South Africa for chemoradiotherapy post mastectomy (both nurses).

The burden of work in our hospital has been compounded by the HIV/AIDS pandemic(14 per cent prevalence and up to 50 per cent in most medical wards), brain drain to greener pastures, staff attrition from HIV and the burden brought on by the ever increasing road traffic accidents. The effects of the credit crunch will have devastating consequences on our communities as well.

All in all the knowledge and experience gained in Australia has given me the opportunity

to appreciate how lucky I am. Delivering a service with limited resources, limited capacity in almost all areas of health ( we do get referred from the districts 300km away conditions like incarcerated hernias, bowel obstructions, insertion of drains for empyema etc, gangrenous legs for amputations, skin grafts) makes one wonder whether its worthwhile to pursue a dream of doing laparoscopic surgery or concentrate on the basics in the art of surgery. Sometimes I also wonder why I am the only Malawian surgeon in the Ministry of Health. I am sure there is a good reason. The smiles on the patients' faces after successful surgery are my main motivation to carry on.





## OTHER PROJECTS & PROGRAMS

### NUSA TENGGARA TIMUR (EAST INDONESIA)

The Nusa Tenggara Timur (NTT) project provides specialist medical services at nominated hospitals throughout NTT, East Indonesia, through the use of volunteer specialist teams. Volunteer teams assist in developing the professional skills of local surgeons, GPs and nurses.

Between 2006 and 2009, over 100 volunteers have provided over 4000 consultations and almost 1000 life changing surgical procedures, following on from work done by the Overseas Specialist Surgical Services Association of Australia (OSSAA). This has coincided with the training of over 130 local medical personnel.

### PROJECT CHINA

Project China is an exchange program between Fellows of the College and hospitals in China, designed to improve quality of training and experience while supporting the development of both countries' surgical and medical capacities.

The concept first emerged in 1988, and Project China has become one of the longest running outreach programs of the College. Since 1988, over 85 surgeons and associated specialists in 47 teams have visited 11 Chinese hospitals. Additionally, Project China has placed over 59 surgeons in Australian institutions.

Surgical visits usually last for two weeks, during which time participants give lectures, operate and conduct seminars and workshops. Chinese surgeons and associated specialists also come to Australia for visits varying from one week to one year.

### MYANMAR

In early 2009 RACS implemented the inaugural Primary Trauma Care (PTC) program in Myanmar, to address the critical need for enhanced management of primary trauma within the country.

Instructors came from Hong Kong, Timor Leste and Australia, broadening professional and personal relationships within the region, while supporting the development of Myanmar medical staff training and capacity. It is expected that follow up PTC workshops will be organised as part of an ongoing program, in 2009, 2010 and 2011.

This activity follows on in the tradition of support by orthopaedic surgeons, cardiac and plastic surgery teams to Myanmar.





## INTERNATIONAL DEVELOPMENT AND OUTREACH

### Orthopaedic Outreach

Sydney orthopaedic surgeon and educator, Professor Bill Cumming, has been awarded the College's prestigious International Medal for 2005.

“  
The aim of  
Orthopaedic  
Outreach –  
to teach local  
surgeons rather  
than simply  
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important.”

One of the highest honours given out by the College, the International Medal is bestowed on Fellows who have given a lasting contribution of an exceptional nature or through the delivery of development of surgery in underprivileged overseas communities.

Professor Cumming will officially receive the Medal in May next year for his lifetime commitment to the Orthopaedic Outreach Programme.

Orthopaedic Outreach conducts a series of educational training programs in those nations where this can be established and team service programmes to other developing neighbours.

The orthopaedic training programme began in Indonesia in the late 60s and there is now a training programme in Fiji and Papua New Guinea with new orthopaedic training programmes to be established next year in American Samoa and the Solomon Islands.

Over more than 30 years, Professor Cumming has acted as surgical educator, external examiner, coordinator and chairman of Orthopaedic Outreach while personally establishing both the Fiji and PNG orthopaedic training programmes.

Retired now from his position

as Associate Professor at the University of New South Wales at the St George Teaching Hospital he still has an active orthopaedic surgical practice at the St George Private Hospital in Sydney.

Professor Cumming said that he was “staggered but delighted” to receive the honour.

He said that while it was personally overwhelming it did serve as recognition for the great contribution made by hundreds of surgeons and nurses who had participated in the Orthopaedic Outreach programme since it began.

“Orthopaedic surgeons in Australia are enormously generous with their time and resources,” he said.

“Not only do they contribute an annual subscription to help fund this work, but they also give their time and expertise both to these programmes and the Pacific Island Project of the Royal Australasian College of Surgeons, which sends service teams to those island nations in need.”

“Many surgeons make return visits for many years and develop a great love of the people and the challenges they face while becoming and acting as mentors to the young doctors.”

Professor Cumming said the recognition provided by the

Medal also indicated the importance of the programme at a time when many trained specialists were leaving their developing nations for life in first world countries.

He said the “brain gain” to Australia was very distressing, but that the aim of Orthopaedic Outreach – to teach local surgeons rather than simply conduct surgery had proved to be prescient and profoundly important.

“When I first went to Indonesia in 1970, they had no orthopaedic surgeon – now they have 250 with another 200 in training,” Professor Cumming said.

“We understood from our Indonesian experience that making a man a teacher was the most vital contribution we could make, therefore, those volunteers who go not only take on the difficult surgical role that is required but even more importantly they create host nation surgeons who are teachers.”

“Then as the local orthopaedic surgeons mature they naturally take over the teaching of their own young people.”

“It had also been understood very early that it was vital for training to be focused on the disease and injury pathology presenting in the host developing nation.”





*Final exams for Orthopaedic trainees*



*A boy suffering from club feet about to be operated on*



*Mock arthroscopy demonstration by Professor Cumming to trainees*



*Club feet*

"All of us who have visited these nations have developed enormous respect for the host surgeons and trainees working in very limited infrastructure yet maintaining such high standards and doing such wonderful work.

"At the same time it's important to bring them to Australia to give them exposure to sophisticated orthopaedic surgery so they know what can and is being done. They should come to Australia for a short term as an essential component of their specialist training.

"It's very important to remember that these young surgeons have enormously powerful minds and a thirst for knowledge. They want to be people of the world with international knowledge and that thirst must be met.

"And in return they give us a feeling of awe and wonder when they do such terrific work with such limited facilities."

"We also have a strong team of

nurse educators who have made many visits to Fiji and now Indonesia."

Quarantined orthopaedic registrar positions are generously kept in Newcastle and other centres in Australia for this essential training.

He said that Orthopaedic Outreach continued to grow with a new training programme established in the past two years in Bali which would significantly enhance the orthopaedic services to the Balinese people.

There are now four orthopaedic surgical trainees in Bali.

"The Bali Orthopaedic Training Programme is very important," Professor Cumming said.

"Not only will it provide an upgrade in local services but it will also provide extra graduates some of whom may go to Aceh."

In July 2005 Professor Cumming and Professor Joe

Ghabrial from Newcastle went to Banda Aceh on a fact finding visit funded by AusAID.

"At the moment there is only one orthopaedic surgeon in Aceh caring for around 4.5 million people with injury presentations from both the tsunami and the civil unrest.

"We believe that hundreds of thousands of displaced people will, over time, come back to re-establish their lives there, with problems caused by untreated injuries. There are also currently more than 300 amputees to be cared for."

The giving and receipt of this Medal also highlights the important relationship between Orthopaedic Outreach and the Royal Australasian College of Surgeons.

"Now that I am older, I can see that the concept is right – that to teach and to train is even more important than a service commitment. It feels very rewarding

to know that we are on the right track in the significant past."

Professor Cumming said that Orthopaedic Outreach had been funded over the years by Australian orthopaedic surgeons, Rotary, AusAID, the College, and importantly corporate colleagues.

Funding remains a serious and pressing problem.

He said that the money donated funded not only the visits by Australian surgeons to neighbouring nations but also to bring trainees and graduates of the programmes to Australia for pre and post graduate study.

The Orthopaedic Outreach philosophy is that "if you give a man a fish you feed him for a day. If you teach him to fish you feed him for a lifetime."

"But if you teach him to be a fishing teacher, he can teach others to fish and feed his whole community."



*Pictured: Yomi (centre)  
recovering happily*

## Saving lives in West Timor

Dr Prue Keith, having already made two trips to Atambua saw a clear need for ongoing orthopaedic services



Yomi Wound Care



Dr Keith and Sr Yacinta Consulting

In May 2008, an Orthopaedic Outreach / Humanitarian Services team were on their way to the remote regional centre of Atambua in West Timor. The team had only just walked through the airport doors in transit through Kupang, when they were asked to see a severely injured young woman. Sister Yasinta, the local co-ordinator, asked Team Leader, Orthopaedic surgeon, Dr Prue Keith to assess an Oxfam worker named Yomi who had been hit and dragged by a truck while riding a motor scooter in the field. The accident had happened more than 24 hours previously, but the severely injured woman had been delayed in the back of a minivan waiting for a flight to a major medical centre in Surabaya that never eventuated.

"Yomi was very close to death by the time we saw her. She had been in transit for six hours in the back of the van with horrific injuries to her pelvis and right leg, with open fractures and gross contamination and no surgical interventions," Dr Keith said.

"I explained that the only way we could assess her effectively was to get her to a hospital immediately, to stabilise the situation. She would not have survived the flight to Surabaya particularly with the next available flight requiring another wait of 24 hours."

"I had never been to the hospital in Kupang, but within the hour we had operating rights, which is quite amazing in terms of international co-operation and we went to work with a local surgeon. It was very substantial surgery. Yomi had been dragged by the truck for 30 metres and had sustained a Grade 3C open pelvic and femoral injury with an open hip joint dislocation.

"The local surgeon and I agreed on disarticulation of the hip and amputation, as the leg was dysvascular, with no opportunity in this setting to revascularise and salvage. That initial surgery took over three hours; it was amazing that she survived given her level of contamination, time to surgery and degree of medical instability."

"We had to leave to work in Atambua the following morning and transferred her care to the local medical staff. Dr Keith had already made two previous trips to the region under the Specialist Surgical Services Support to Nusa Tenggara Timur (SSSNTT) project funded by AusAID under the ANTARA program. She saw a clear need for further surgical and medical intervention to enable people to again become productive members of their communities and to build capacity of local medical staff through on-the-job and formal training.

She was able to obtain funding for this trip through the Humanitarian Services Committee of the Australian Orthopaedic Association and Orthopaedic Outreach. She also put in her own funds to help the team get there.

"When we first began this program in 2006 there were no Orthopaedic teams working consistently in this part of West Timor. But we felt from previous experience that the people and the region were worthy of on-going care programs in surgery, particular in Orthopaedics and other areas of specialist surgery. This included a Paediatric Orthopaedic program as well as the adult service provided," she said.

The team to West Timor comprised Orthopaedic Surgeon, Dr Prue Keith, Consultant Anaesthetist, Dr John Campbell, Orthopaedic Nurse, Sr Gaye Hose and Orthopaedic Registrar, Dr Jessica Hickmott. With Sr Yasinta as guide and interpreter, the team arrived in Atambua on the 24th of May. Over the following few days the team undertook ~90 consultations and 15 major operations with some taking four hours due to surgical complexity or multiple procedures.

The surgeries covered a wide case mix including untreated fractures with non-union and mal-union, late dislocations, chronic infec-





Drs Keith and Hickmott with Local Team

tion of soft tissue and bone, tumours of bone, both benign and malignant, congenital conditions such as club foot and a series of developmental conditions especially cerebral palsy.

Dr Keith said, however, that unlike the previous visit, this time they were not accompanied by a general surgical team.

"Last year General Surgeon, Miss Meron Pitcher and her team joined us as well as a physiotherapist, Helen Burgan. Helen did not come with us although that would have been a great advantage on this particular trip because there was a very impressive young physiotherapist in Atambua who was extremely keen to learn," she said.

"Our teaching is in the clinic, ward rounds and theatre and we simply try to impart small packages of information as best we can. Last year we ran a "mini" Primary Trauma Care session, which the local staff really enjoyed, particularly our acting skills!"

Dr Keith said that while the funding was an initial difficulty, Orthopaedic companies had generously donated equipment including

small and large fragment sets with plates and screws from Smith and Nephew and battery-powered equipment from Stryker.

However, she saved her highest praise for Sr Yasinta.

"Sr Yasinta is an extraordinary woman whom I had met on my previous visits. She acted as our translator but she was much more than that, being a good negotiator with strong political intuition that I trust without question which can be very helpful on some of these visits.

"Every time I have been to West Timor Sr Yasinta has something for me to see outside the hospital such as a leprosy clinic. She was untiring in her energy to help us and an excellent source of information whenever we got confused with local custom."

Upon returning to Kupang the team called in to see Yomi which was a visit that Dr Keith described as "emotional," but also gave a further opportunity to participate in the woman's care. She required further debridement surgeries by the local surgeons and was eventually transferred to Surabaya. The good

news is that she has survived her accident and is currently learning to transfer and walk with crutches."

"Currently her wounds have healed reasonably well, she is standing and getting outside in her wheel chair. She is a wonderful young woman who had experienced suffering beyond imagination so it felt very rewarding to be able to help her. It seems just one of those weird things that we were in the same place when she needed us, because without doubt she would have died had she had to wait for treatment any longer."

Dr Keith said the team felt the trip to be an overwhelmingly positive one and felt encouraged by the eagerness to learn shown by the local staff and the trust built up with the local people. She said she would like to return in September if she can find sufficient funding. The Orthopaedic team and Orthopaedic Outreach would like to acknowledge the staff of Oxfam GB in West Timor and their partner Centre for Internally Displaced People's Services (CIS) for their contribution.



*Guy Maddern, Chair,  
Research, Audit &  
External Affairs & Board  
of Surgical Research*

## Building up from the bottom

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

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

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

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

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

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

"Lots of the doctors in NTT are doing operations on the appendix, ovarian cysts as well as caesarean sections. They are becoming GP surgeons out of

necessity, and it makes sense for us to help them. It is really the model, starting at the bottom and building up their skills."

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

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

"Other teams have had problems with the local staff not showing up in the morning. You have to remember that they get paid a pittance

and that they're tired. We wanted to work at a level that didn't exhaust them and left them keen to come back for more. And that's what happened." Dr Deutscher and his team made a point of having meals with the Indonesian doctors and nurses. They even took part in the hospital's Friday morning line-dancing and sports activities that kicked off at 6 am.

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

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

The closest major centre with the capacity to deal with the patients was seven hours away.

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

The College has sent a number of teams to the province since then. Dr Glenn Guest led the latest mission, in December, 2006, to Larantuka. "I saw 400 people in Larantuka and one of the first things I noticed was how advanced the pathology was that we were dealing with. You

*Nurse Susan Wilkens with a patient  
recovering after removal of a goitre*







*Draping techniques*

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

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

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

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

Dr Guest wants to keep returning to teach the local doctors. He knows one

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

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

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

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

—Amy Carmichael



*A spinal lesson*



*David Deutscher and kids*





*Ellen Smith, Herald Sun  
Photographer*

## Helping the blind see in Indonesia

A volunteer recounts her experiences with the College Eye Team during a trip to Sumba, an eastern island of Indonesia

IBU MOJU CAME in on our first day in Nusa Tenggara Timur blind in both eyes from cataracts. She was very frail, withdrawn and hunched, holding onto her walking stick.

When she returned for post-op, the day after ophthalmologist David Workman operated on one eye, she was afraid and didn't want to have her bandage off. She tentatively let David remove it and the expression on her face was one of amazement as she looked up to this big strange man in front of her and she could see him! She broke out in a huge smile and grabbed David's arm, rubbing it and

saying over and over "terimah kasih, terimah kasih" – thank you.

I've seen that happen before during clinics in East Timor, but I wasn't the only one in the room who felt a tear in their eye. We found out later that she had been blind for two years.

Ibu Moju was one of the 831 patients seen by the team of volunteer Australian eye specialists from the College who visited the eastern Indonesian island of Sumba for the first time in May/June this year. I travelled with the team as a volunteer to photograph their work.

It was the first time an Australian eye team had been to Sumba, and no one was sure how the trip would go. Fortunately we soon met the local ophthalmologist, Dr Rozalina Zulkarnain, who had been sent to Sumba's capital, Waingapu, by the Indonesian Health Department for six months. Her local knowledge and support were great assets for the team.

The team adapted quickly to local conditions and took an unforeseen set-back in stride.

When the surgical equipment had not arrived as planned, the ophthalmologists helped with the consultations and did 'A scans' on







potential surgery candidates. Theatre nurses Anne and Julie soon got a crowd of onlookers helping by telling patients what was on the chart during the visual acuity tests.

After the boxes of equipment finally arrived on Wednesday only one microscope was useable, so David came up with the idea to mount it on a trolley, enabling it to swing between the operating tables and getting the maximum use out of it – when one surgeon was finishing the other could be preparing to start.

Other highlights include:

- Our fabulous interpreters– Yan, Julianna, Daniel and Sebastian;
- The extremely hard-working local nurses Michael and NgoNgo;

- The camaraderie and enthusiasm of the team, how they all solved problems together on difficult cases and appreciated each other's work;
- A patient's mobile phone ringing mid-operation and no one initially realising where the song was coming from;
- Snacks! I could never fit in morning and afternoon tea but Peter Stewart bravely unwrapped his banana leaf parcel every day to see what treat was inside;
- The sights of Waingapu – the horses, the piles of chillies and betel nuts in the market, whole families piled onto one motorbike or a rack of chickens or maybe even a goat.

“Ibu Moju tentatively let David remove it and the expression on her face was one of amazement as she looked up to this big strange man in front of her and she could see him!”

1. The microscope mounted on the trolley enabling it to swing between the operating tables
  2. Theatre nurses Anee & Julie telling the patients what is on the chart during visual acuity test
  3. The young man the students are gathered around was in an car accident and had a penetrating eye injury from the rear vision mirror
  4. Eye testing by one of the optometrists
  5. The crowd patiently waiting
  6. Ibu Moju waiting
  7. Ibu Moju smiling because now she can see
- Photos courtesy of Ellen Smith



## Project China: Wuhan Children's Hospital

Since 1988, the Royal Australasian College of Surgeons has overseen Project China, an exchange program between Fellows of the College and surgeons from China. This program, steered by Professor Gordon Low and his wife Mrs. Rosie Low, has been responsible for a number of visits between Australian and China.

In June 2006 a trip was made to Wuhan in central China. The group who made this trip comprised Dr. John Neil, chief of obstetrics and gynaecology at Box Hill Hospital; Associate Professor John Drew, neonatal paediatrician; Ms Sandra Cocks, neonatal echocardiographer based at the Mercy Hospital; and myself, urology fellow doing subspecialty training in neurourology and continence. I was fortunate to be given the opportunity to make this visit when Dr. Helen O'Connell, urologist, was unable to make the trip herself.

Wuhan is a large town with a population of 8 million that is situated about 600km west of Shanghai on the Yangzi River. It is a mainly industrial city with a rich history of trade, both domestic and international, due to its position on the Yangzi which, in years gone by, was a major thoroughfare.

The Children's Hospital in Wuhan is a large hospital that serves the city and its surrounding areas. This hospital has recently merged with a nearby maternity hospital to form the new Women and Children's Medical Centre which was planned to open in July 2006. Our visit was arranged as part of commemoration of this merge.

The Chinese contingent was headed by Professor Jiang Zexi, a paediatric cardiac surgeon who has previously worked in Shanghai, Beijing, Toronto and Melbourne. Professor Jiang, and a number of other doctors and administrative staff helped look after our accommodation, transport and social activities.

On the first day, we gave a series of lectures to medical staff, mainly obstetricians, from Wuhan and the surrounding rural areas. Despite the language barrier, all talks were well received and ably translated by bilingual hospital staff. Professor Jiang herself translated a number of the talks. The presentations were further facilitated by translated transcripts of our lectures that had been previously forwarded. I gave a talk on stress urinary incontinence, a topic that had been requested prior to our arrival.

On the second day, we made a tour of the hospital wards and outpatient department.

The outpatient department was a three-storey building that looked more like a department store than a hospital ward. The ground floor of the Outpatients building was occupied by Pathology, Pharmacy and Cashiers. Patients took escalators to the second and third levels where there were multiple rooms on the perimeter around a large central open area. Patients waited their turn outside various rooms which housed the many outpatient services, including an Orthopaedic clinic, Physiotherapy and TENS therapy. There were also Respiratory, Gastroenterology and ENT clinics with endoscopy, and even an "atomisation" room where children received nebulised medication. Despite the large number of people, it all ran like a well-oiled machine with everybody knowing where to be and what to do. All patients waited their turn and, it would seem, all got seen and treated.

We were also given the opportunity to visit the hospital wards. Although clearly old, all the wards were clean and tidy. In the main wards parents stayed in with their children. Most rooms housed six beds and all wards were air-conditioned.

In surgical ICU, we saw two babies who had recently undergone cardiac surgery. One baby had undergone repair of ventricular septal defect the previous day and was intubated.



In Neonatal ICU, there were six babies, none of whom was ventilated. The youngest neonates there were 30 weeks old. Because the hospital had only two ventilators, they were used judiciously – a far cry from the luxury we have come to expect in Australia. Common problems seen in China are hypoxic encephalopathy and meconium aspiration. Labours sometimes progress to 48 hours and the level of intervention is much lower than that we are accustomed to in Australia.

At this point, I was given the opportunity to spend some time on the Urology ward where I attended a ward round and saw two patients – one, a six year old boy with bilateral cryptorchidism two months after a road traffic accident, and the other a two year old boy with pelvi-ureteric junction obstruction who had presented with an abdominal mass.

The first boy had suffered lower limb and pelvic fractures, all of which had been internally fixed. He had also had a laparotomy to repair a bowel injury at the time of the accident. Now two months down the track, he looked to be in remarkably good spirits with all superficial wounds healed. However, the right hemiscrotum was scarred and contracted and neither testis was palpable. The left hemiscrotum was underdeveloped which raised the possibility of pre-existing cryptorchidism. Ultrasound, limited to two pictures and a report, showed the presence of a testis in the left inguinal canal. CT scan was of the pelvis only and, in contradistinction to the ultrasound, showed a testis in the region of the right external inguinal ring but no evidence of the left testis.

This case was discussed at length with a junior doctor interpreting. The final plan arrived at was to proceed to bilateral inguinal exploration and orchidopexy with the option of retroperitoneal exploration if testes were not easily found. The option of abdominal CT was discussed but, on the decision of the senior urologist, was probably going to be bypassed in order to proceed directly to exploration.

The second case of the two year old boy with the abdominal mass was more straightforward. On intravenous pyelography, there was no contrast seen on the left and there was the impression of a space-occupying mass in the left upper quadrant. The medical staff had elected to proceed to MRI and this clearly demonstrated a grossly hydronephrotic left kidney with only a sliver of residual renal parenchyma. This was a case where nephrectomy seemed appropriate but the senior urologist elected to proceed to pyeloplasty in the hope of salvage of existing renal tissue. We then discussed pyeloplasty techniques including flap techniques and laparoscopy. The Chinese are proficient laparoscopists and I had the opportunity to watch a video of laparoscopic ureteric reimplantation.

This ward session was interesting and enlightening. Despite the language barrier, exchange of ideas was still possible and, hopefully, of benefit to all involved.

There was also the chance to indulge in social activities. Lunch and dinner were elaborate affairs and each meal was like a banquet. The Chinese love a drink and most dinners were accompanied by local beer. Chinese red wine is also popular but drunk with ice and slices of lemon! We visited the local museum and East Lake, both local tourist attractions. There was a short tour of the Three Gorges area where I had the opportunity to visit the Three Gorges Dam project and had a taste of the gorges themselves with a short boat trip.

This visit was valuable for a number of reasons and I am grateful that I was able to be a part of it. Programs like Project China are essential. They allow exchange of between doctors in other parts of the world and local medical practitioners with the added advantage of improved goodwill as well. Future visits can only be beneficial, allowing further learning and the chance to build on previous visits.



*Dr Neill, Professor Jiang, Dr Drew and Sandra Cocks*



*Sandra Cocks presenting her talk with Professor Jiang interpreting*



*Urology unit medical staff*

# Primary trauma care in Myanmar

The College is helping to train instructors to allow local doctors to run future courses in primary trauma care

In the week before last year's Conjoint Annual Scientific Congress (CASC) held in Hong Kong, South East Asia was hit by the devastating Cyclone Nargis. Myanmar bore the brunt of the storm when the cyclone first made landfall there in early May. There was a lesser impact in the other Southeast Asian nations, with severe flooding and landslides across ten districts in Sri Lanka.

Now known to be the nation's worst natural disaster in its recorded history, Cyclone Nargis demolished whole towns and villages in Myanmar, killing over 140,000 people and leaving hundreds of thousands injured, homeless or without livelihoods, while 75 per cent of health facilities in the affected areas were destroyed or severely damaged, together with around 4,000 schools; an impact comparable to the Indian Ocean Tsunami in Indonesia in 2004.<sup>1</sup>

As surgeons gathered in Hong Kong from around Australasia and the world for the Hong Kong CASC, many approached Burmese-born and Hong Kong-based surgeon Mr James Kong to determine if, and what assistance could be offered to the devastated nation. After much discussion it was found that local and international relief efforts were providing immediate assistance but that sustainable engagement between the College and local medical groups could be of great value.

Following consultation with the Myanmar Medical Association (MMA), the national organisation which provides continuing medical education, Mr Kong advised the College that the most pressing medical need as listed by the MMA was for help in assisting Myanmar

establish a comprehensive trauma system including widespread education for first responders and clinicians.

Now the first phase of that engagement has been completed following a five day Primary Trauma Care (PTC) Course funded by the College and designed and delivered not only to teach primary trauma care skills but to train instructors to allow local doctors to run future courses.

From 28 March to 1 of April this year, an international team of eight instructors from Australia, Hong Kong and East Timor supervised and led the PTC program at the MMA headquarters near Kandawgyi Lake. The international team comprised Melbourne emergency physicians Dr Georgina Phillips, Course Director, and Dr Antony Chenhall, Dr Eric Vreede, an anaesthetist currently working in East Timor, and from Hong Kong Professor Sydney Chung, surgeon, Dr Anthony Ho, anaesthetist/intensivist, Dr Tsun-Woon Lee, anaesthetist, Dr Tai-Wai Wong, emergency physician, Dr James Kong, surgeon.

The five-day program was divided into an initial two-day participant course followed by a one-day instructor course which was in turn followed by two days in which those doctors who had undertaken the instructor course taught new participants under the supervision of the international faculty. In particular, the course focused on methods of triage, resuscitation, the physical movement of patients to limit further injury and the design of patient flow systems.

In her report to the College following the visit, Dr Phillips wrote that while much international aid and attention had been focussed on tackling key diseases in Myanmar such as malaria, tuberculosis and HIV/AIDS, attention to trauma had been lacking even though trauma was now emerging as a key cause of mortality and morbidity.

"The Primary Trauma Care course was developed with the support of the World Health Organisation to train health care providers to prioritise and treat severely injured patients quickly and systematically, thereby reducing death and disability," Dr Phillips wrote.

"Overseen by a not-for profit Foundation, the PTC course is run at no charge and is designed specifically for resource-poor environments; emphasising flexibility and quality early trauma care within local limitations.

"With the emphasis on a basic systematic approach and the longer term aim of devolving responsibility for co-ordinating and teaching courses to local clinicians, the PTC program was immediately attractive to the senior Myanmar doctors."

Dr Phillips reported that almost all of the teaching equipment was brought in by the visiting team with the underlying principle of the PTC course of not depleting the host country of limited resources. Large items such as airway mannequins were borrowed from hospital facilities in Hong Kong and Melbourne while the College funded the purchase of one adult airway training mannequin which was donated to the MMA as a gesture of goodwill and to help in the provision of future courses.

Smaller items and consumables such as oxygen masks, intravenous cannulae and cervical collars were left behind with the MMA for re-use in future courses. Dr Phillips reported that the program had proven very successful even though the course instructors had not met or worked together before arriving in Myanmar.

"It is a testament to the experience, professionalism and enthusiasm of all the instructors that the planning and implementation of the PTC program was smooth and uncomplicated. All instructors had extensive PTC experience in China, Vietnam and the Pacific region and in particular had rich expertise in teaching through adult learning principles and skills training," she wrote.

"Discussions within the team on the day before the PTC program began, were robust without rancour and added to the energy and success of the course and while there were some minor language issues, there are now plans to translate all of the PTC teaching material into Burmese for future courses."

In her report, Dr Phillips recommended that a second course be planned to occur before the end of this year with a further two



*“The success of this visit is not only a testament to the team of instructors but to the great enthusiasm of the local doctors.”*

courses in 2010 and 2011 to involve a mix of visiting and local instructors and to be held in a mix of major urban centres. She said future participant courses should be restricted to 20 participants, that the Myanmar clinicians be encouraged to adapt the PTC course to local environments taking into account local equipment issues and local language requirements and that secure funding be found.

Burmese-born surgeon Mr James Kong – who had originally been tasked by the College to liaise with the MMA to find out how the College could best help Myanmar in the wake of Cyclone Nargis - said the initial course had been a great success. He has urged the College to help source funding to continue the education program until Myanmar had enough trained trainers to continue the work themselves.

“(It is clear) that an ongoing program should be established. This program should consist of visiting international faculty who will supervise the local partners with the primary aim to establish a core of experienced local PTC instructors with the enthusiasm, skills and the leadership ability to establish a nationwide PTC Myanmar program within the coming two and a half years,” he said.

The College’s Director of External Affairs, Ms Daliah Moss, accompanied the international team during the March visit to assist with logistics and administration and as a representative of the College. She said the success of the organisation of the PTC course was due largely to James Kong. The initial PTC course visit cost \$20,000 which the College had agreed to fund out of monies overseen by the International Committee in accordance with its principles of building professional networks, capacity and improving the skills of doctors in the Asia-Pacific region.

“Given the success of this inaugural course, the College will now approach AusAid and other donors for funding for the on-going

training of local Primary Trauma Care instructors. The success of this visit is not only a testament to the team of instructors but to the great enthusiasm of the local doctors. We thought language could be a significant issue given that all the courses were presented in English but we did not need translation,” Ms Moss said.

“All the instructors simply made a point of speaking and enunciating clearly and limiting the use of jargon and this, along with the fact that they were presenting to highly skilled doctors, meant that ideas were rapidly absorbed.

“Their enthusiasm was a great highlight of the visit. Everything worked like clockwork and the local doctors showed great interest in gaining input from Australian, New Zealand and Asian doctors and surgeons.”

#### References

1. Post-Nargis Joint Assessment;” Tripartite Core Group; July 2008; UN, ASEAN, Government of Union of Myanmar

- .....
1. Daliah Moss leading the PTC class in aerobics after a strenuous morning and substantial lunch
  2. Dr TW Wong & Dr James Kong both from HK, TW demonstrating neck immobilisation on a drowsy ‘accident victim’;
  3. Professor Sydney Chung, College volunteer extra-ordinaire providing anatomical landmarks for the local candidates
  4. Dr Eric Vreede, Consultant Chief of Anesthesia, Dilli (centre) observing the Myanmar candidates practicing airway management skills on the Adult Airway Trainer -donated by the College to the Myanmar Medical Association. The Paediatric Airway Trainer (further down on the bed) has been brought on loan from Melbourne by Dr Antony Chenhall, one of the other visiting facilitators;
  5. Dr Antony Chenhall, Emergency Physician, Melbourne assisting the newly qualified local PTC instructor at the Intra-venous Access Management station using locally purchased chicken thighs to practice intra-osseous access
  6. Professor Kyaw Myint Naing, President, Myanmar Medical Association presenting the honorary membership of MMA to Dr Anthony Ho, Anesthetist, Hong Kong for his contribution to the PTC Myanmar 2009 Program





## Helping those in need

OSSAA builds trust and understanding with local people and medical counterparts in the developing countries where it works



Last year, a photograph was sent to Mr Mark Moore, an Adelaide plastic surgeon and vice-president of the Overseas Specialist Surgical Association of Australia (OSSAA). The image was of a young West Timorese woman who had severe burn contractures of the neck that had drawn her face down onto her chest. It had originally been sent to College staff by members of Oxfam asking for help.

Upon receipt of the photograph, Mr Moore showed the image to OSSAA co-ordinator Ms Ruth Boveington who felt a twinge of recognition. She hunted through old records of the service and found the woman pictured in an earlier photograph, then a child of only eight, also snapped in a plea for help because she had been born with a cleft lip and palate.

An earlier effort to bring her to Australia for treatment had failed and she had become

a recluse in her isolated village because of both the birth defect and the terrible consequences of the untreated burn.

“The picture was haunting. There was this pleading look in the father’s eyes and then to see her 15 years later still untreated and with worse physical suffering to endure was difficult,” said Mr Moore.

Now, that has changed. Mr Moore, through OSSAA and Oxfam, had the young woman, named Yanti, sent from her home in West Timor to the island of Flores where the first of many operations was conducted to treat the cleft lip and palate and then ease the severe burn contracture.

“There is a special little place on the island of Flores that was once a leprosy hospital where people with deformities can stay and be treated. The social stigma some of these people have

faced is as bad or worse in the developing world as it is here, but at St Damian Hospital they are treated with dignity and respect and some stay forever,” he said.

Mr Moore said the hospital had three new operating theatres and ward blocks and was run by the Sisters of the Holy Spirit, a world-wide order of nuns based in Europe.

“The hospital was established 40 years ago and the nun who set it up is still there. Many of the nuns undertake post-operative care and rehabilitation and show a deep commitment to the people of the community. Patients who go there for treatment are given places to stay but are also expected to work and they make shoes, splints, prosthetics, furniture and grow food,” he said.

“Hundreds of people live there, providing payment for their treatment through their work supporting the community, which



in turn gives them a sense of dignity and involvement when in some cases they had been rejected and ostracised for years by their local village community.

"It is a wonderful place, one of the most special places I've ever visited."

Mr Moore said the first operation on Yanti was done in October to repair the cleft lip and release the neck burn contracture, with another visit scheduled for June for further surgery.

"One of the best aspects of St Damian Hospital is the ongoing patient support, which means that we can do the repair in stages. Obviously, the bigger the operation the bigger the risk, a risk that is magnified when the surgeons are only visiting," Mr Moore said.

"Here, (Yanti) can stay and have physiotherapy and receive after-care until she is ready for the next procedure."

Mr Moore has been involved in OSSAA since it took over the former Australia South East Asia Rehabilitation Service, set up by the respected surgical philanthropist Mr John Hargrave when he retired in 1999.

With up to eight visits a year, he travels through East Timor, West Timor and Flores, mostly conducting plastic surgery but also providing support for general, orthopaedic and ENT surgeons. He has worked in East Timor on 22 separate trips (the last seven years supported by the College's East Timor aid program), and made 18 trips to Indonesia, working mostly in Flores.

He said the most important aspect of OSSAA's work, based on Mr Hargrave's philosophy, was that it was designed as a bottom-up aid programme rather than a top-down bureaucratic aid arrangement.

"A lot of international aid programmes involve surgeons visiting on just one or two occasions and while that is laudable it does not allow for a deep understanding of the community you are trying to help," he said.

"Without developing trust with the local people and local medical counterparts it is at times impossible to know what skills are wanted, what facilities are available, what will happen when the surgeon flies home. We have seen some work on clefts by other surgeons with very bad results, as if they go to developing countries to train."

Mr Moore said OSSAA works with local nurses or nuns or alongside young GPs sent by the Indonesian health system to remote areas for the first years of their careers.

It also sends younger Fellows of the College to West Timor or Flores to work along-

side young Indonesian surgeons.

"Surgery is expensive in Indonesia with most specialties only represented in the major cities so many people in remote areas totally miss out. You need to know what treatment is required, how to get the message to the people in need and how they will be cared for after you go," he said.

"That is what makes us different. A lot of aid programs are based on a signed agreement in Jakarta and are designed to trickle down from the top to the bottom, but that often means that the aid doesn't actually reach the people most in need. The best network in the developing world is often through religious organisations because they have a central commitment to the care of the poor."

Mr Moore said there was a high incidence of cleft lip and palate in East and West Timor because it was more common in the Asian population and it was related to malnutrition and folate deficiency during gestation.

He said that some people born with the condition were often forced to wait decades for treatment even though they were unable to eat properly and were therefore malnourished and ill, unable to attend school and unable to contribute fully to their community. However, he said untreated burns were the cause of even more suffering.

"The frequency of severe burns injuries relates to cooking with kerosene, poor quality clothing and no trauma care. They are often little people so the burns are correspondingly large and many die," he said.

"Many of those who survive and have healed without pain control, suffer severe contractures with arms fused to chests or chins to chests and some of it requires major surgery to treat."

Mr Moore said Yanti had coped well with the initial surgery and was likely to return to her village when all procedures were complete.

"She's doing pretty well and like many people from this part of the world doesn't complain about the surgery or what she has been through but when you think about what people like Yanti have endured, it is beyond our imagination."

1. Children who have undergone plastic & reconstructive surgery having rice & vegetables for breakfast
2. Nusa Tenggara, Timor
3. A local girl recovering after her cleft palate operation
4. Yanti before the operation
5. Yanti after her first operation, with lip repair and some neck burn contracture release
6. St Damian Cancar Flores NTT

"One of the best aspects of St Damian Hospital is the ongoing patient support, which means that we can do the repair in stages."





Robert Davies

## Steps to learning

The generosity of sponsors allows an Australian team to further the knowledge of Vietnamese Urological surgeons

That is presumably Kosher: Mr David Ende didn't flinch when it was served up to him for lunch at Tap Mui, a rural hospital in southern Vietnam. David was part of the "Australian Urologists in Vietnam Project 2008" that saw five self-funded Australian Urological Surgeons (Mr David Ende, Mr Mark Louie-Johnsun, Mr Finlay MacNeil, Mr Thomas Dean, Mr Charles Chabert and Mr Robert Davies), an Anaesthetist (Dr Lan-Hoa Le) and a scrub nurse (Bonnie La) travel to Vietnam in January 2008 to further develop the endourological skills of Urologists in several hospitals. Mr Mark Louie-Johnsun established the foundations for the project on trips to Vietnam in 2006 and 2007 and coordinated the 2008 program with Dr Nguyen Hoang Duc from the Department of Urology, University Medical Centre, Ho Chi Minh City who accompanied the Australian team.

The group was based at the provincial Dong Thap Hospital in the town of Cao Lanh, which lies on the Mekong Delta in rural southern Vietnam. The first morning was spent being presented with all of the x-rays and case histories of the 31 patients that had been selected by the local urological surgeons for surgery. An afternoon of urological lectures were delivered by the Australian group to a mixed audience of surgeons, nurses and trainees then a ward round was undertaken in a very public fashion: crowds followed the surgical team around and watched as various patients were examined, X-rays reviewed and as doctors conferred.

Over the course of the next four days all patients were operated on by the local urological surgeons guided by the Australian team with an emphasis upon endourology. Most were challenging stone cases: partial staghorn calculi, large ureteric stones and chronically obstructed renal units. The Vietnamese urologists proved particularly adept at open pyelolithotomy. The renal pelves of the Vietnamese patients all seemed to be intrarenal and the Vietnam-



A child waits outside an operating theatre for surgery

ese surgeons demonstrated to the Australians a unique parenchymal clamping technique to achieve almost bloodless renal pelvic access.

At Dong Thap Hospital Mr Charles Chabert expertly demonstrated extraperitoneal laparoscopic surgery while Mr Finlay Macneil, Mr Thomas Dean and Mr Robert Davies upskilled the local surgeons in the techniques of ureteroscopic stone treatment and in percutaneous nephrolithotomy. Anaesthetics were delivered by Vietnamese technicians who worked to empirical formulae: Dr Lan-Hoa Le contributed enormously to their continuing education in anaesthetic techniques, and improving the safety and efficacy of the agents used. Bonnie La worked tirelessly to improve nursing and sterilisation procedures. Both Lan-Hoa and Bonnie La had separately been Vietnamese boat people who had been smuggled out of Vietnam as children to be eventually accepted as refugees in Australia. Their return to Vietnam on this project completed a remarkable circle for them both.

Although most surgery was based at the Dong Thap Hospital, visits were made each day by part of the group to the outlying hospitals at Sa Dec and Tap Mui. The Vietnamese Urologist based at the hospital had, remarkably, never performed a cystoscopy since the hospital did

not possess such an instrument. Perth urological surgeon Mr Sydney Weinstein kindly donated a flexible cystoscope and light source to the project and this was left at the hospital along with rigid cystoscopic instrumentation originally owned by the late Mr Antony Low (past President of the Urological Society of Australasia). The local Vietnamese urologist was instructed in cystoscopy: probably one of the simplest but most worthwhile skills imparted over the course of the trip.

What was most striking was perhaps not so much the differences in Vietnamese Surgical practice compared to Australia but the similarities. The general standard of medical care was basic but seemed adequate and there was a genuine desire to improve care and to adopt new techniques. The quality of surgical equipment at Dong Thap Hospital was inconsistent: a mixture of Chinese produced instruments, previously donated 'scopes and one image intensifier. Due to cost considerations, disposables were invariably re-used. Hospitals in Australia had donated a variety of expired disposables and these were thankfully received. Some differences were obvious: one operating theatre at Dong Thap was used by General and Orthopaedic surgery simultaneously. After disconnection from the anaesthetic machine, thin gauze was tied over the open end





The Paediatric ward at Sa Dec Hospital



Charles Chabert demonstrates laparoscopic renal surgery



Australian surgical team



Hospital surgical staff inspect donated equipment

of the endotracheal tube to prevent inhalation of flying insects. Post-operative patients were routinely restrained to their bed in recovery by cloth straps. The hospital provides a bed and medical care but patients' relatives supplied their food and day to day care. Mothers of paediatric patients slept in the bed with their children and patients had to buy their investigations. Unlike bureaucratised public hospitals in Australia, Dong Thap provided an elegant sit down lunch to their surgical staff every day, even if this sometimes included some rather unidentifiable animal body parts (or, in Mr David Ende's case, rat!)

After a week in Dong Thap, the team travelled back to Ho Chi Minh City where we attended the University Hospital and Mr Thomas Dean and Mr Charles Chabert delivered lectures at a meeting convened for local Urologists. A visit was made to Cho-Ray Hospital in Ho Chi Minh where the breadth of urological conditions represented was impressive: everything from renal transplantation and AV fistulae to trauma. Until recently the Urologists there had also looked after hemodialysis. Cho-Ray hospital has 16 operating theatres and 32 operating tables with different operations routinely happening simultaneously side-by-side. There were some extraordinary contradictions: the neurosurgery theatre housed a new Stealth neurosurgical localisation machine and fairly advanced laparoscopic urology was being performed whereas the hospital did not possess a flexible cystoscope or a simple optical lithotrite.

The Australian team was shown enormous hospitality by their Vietnamese hosts. We shared a number of somewhat riotous dinners that variously involved extraordinary local delicacies, Vietnamese Karaoke, and copious shots of vodka downed to the Vietnamese toast of "Yo!" The Vietnamese rivalled the Japanese for the most ridiculous renditions of English songs and at one dinner in Cao Lanh we were serenaded by the Saigon University Surgeon singing us "Jingle Bells". In Ho Chi Minh City several of the Australian team also took the opportunity to visit the harrowing War Remnants Museum along with the remarkable Viet Kong built Cu Chi tunnels.

The trip built upon the previous Australian-Vietnamese urological relationships developed by Mr Mark Louie-Johnsun. He deserves special recognition for his role in instigating and coordinating the whole project, made all the more impressive by the fact that this was done as a Registrar during completion of his Australasian Urological Fellowship. In the future, consideration should be given to how Trainees might benefit further from the relationships that have been established. An exchange of Registrars, for example, would allow Australian Trainees to be exposed to an extraordinary range of pathologies and depth of open operating experience and for a Vietnamese trainee to hone endoscopic and minimally invasive surgical skills that could be taken back to their own country.

It is a project that we plan to continue. One of the biggest challenges is to change the focus

of the local Vietnamese from that of visiting surgeons operating on difficult cases for them to that of giving local surgeons the skills to do this themselves, particularly using minimally invasive techniques. To effect such change takes patience and aid groups such as ours need to adopt the philosophy of Antoine De Saint-Exupery who wrote that "What saves a man is to take a step. Then another step."

#### **Australian Urologists in Vietnam Project 2008 – Acknowledgements**

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Liverpool Hospital (disposables)  
St John of God Hospital Subiaco (disposables)  
Sir Charles Gairdner Hospital Perth (disposables)  
ACMI GYRUS (loan nephroscope)  
Vietnam Airlines (excess baggage allowances)  
Malaysia Airline (excess baggage allowances)



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Through the RACS International Scholarships Program, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from 2 weeks to 12 months.

Due to the short term nature of these visits, it is often difficult to find suitable accommodation for visiting scholars. The International Scholarships Department is seeking expressions of interest from those willing and able to provide accommodation for our visiting scholars. If you have a spare room and are interested in learning about another culture's language, customs and traditions please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a nominal stipend.

If you would like to help or require further information, please contact the International Scholarships Secretariat on the following details:

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East Melbourne Victoria 3002  
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