



THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL NEWS

Vol:9 No:7 August 2008

August Highlights:

PAGE 16 GREEN FELLOWS

“Concern of the environment has not always been an imperative for me, but it has developed over the last two decades.”

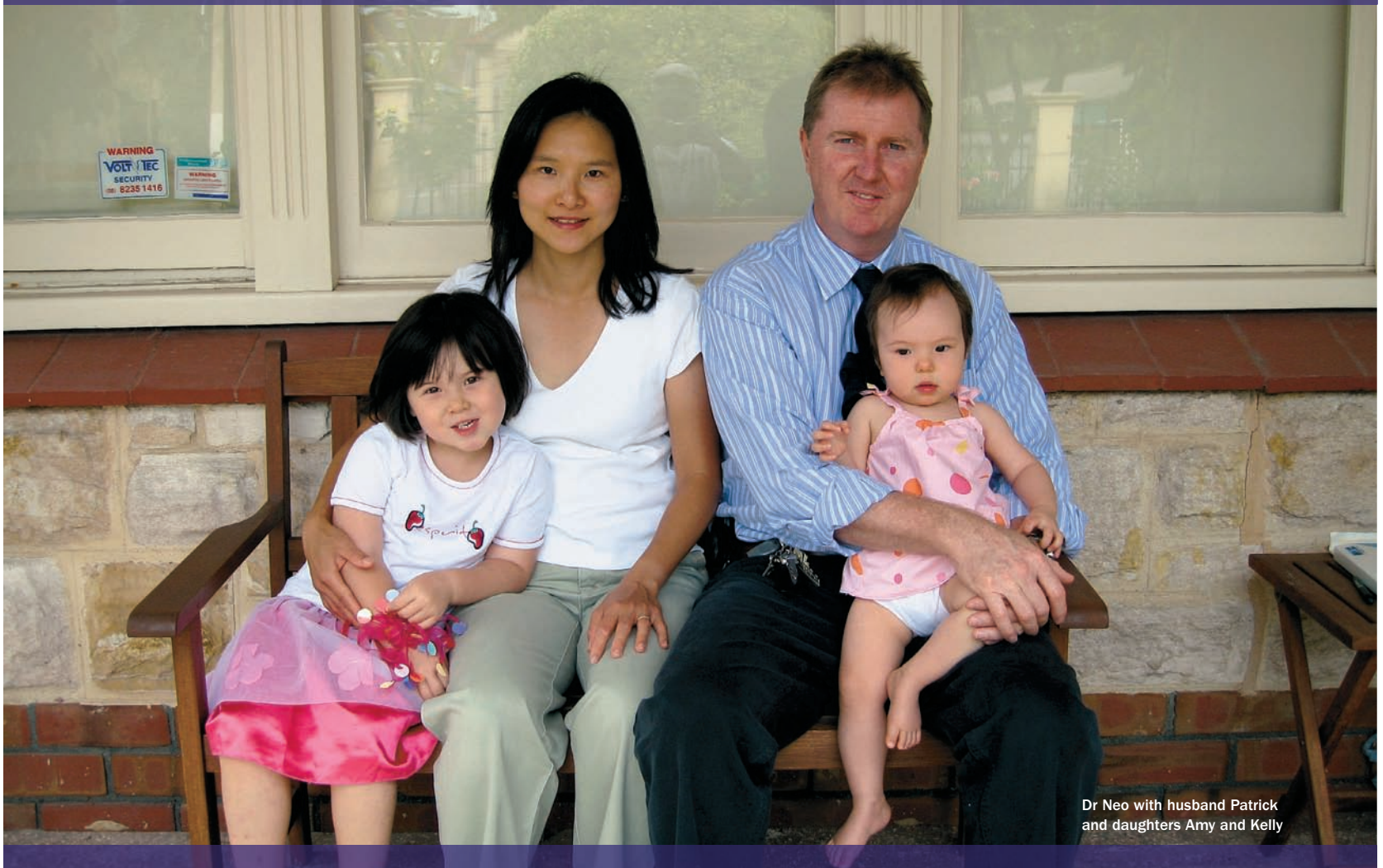
PAGE 26 MUSICAL DOCTORS

There are now more than 500 doctors and medical students on the Australian Doctors Orchestra database.

PAGE 44 CUBAN DOCTORS IN EAST TIMOR

Every year, Cuba, a third world nation of only 10 million people, sends more than 30,000 volunteer doctors and other health workers, to work in 93 countries around the world.

Part time training in South Australia, page 11



Dr Neo with husband Patrick and daughters Amy and Kelly

The College of Surgeons of Australia and New Zealand

2008 Professional Development Calendar

- QLD**
- 23 Aug – Northern Australia Surgeons Network (NASN) Videoconferences
 - 26 Sept – SAT SET, Coolum (GSA Meeting)
 - 3-5 Oct – Surgeons as Managers (SaM), Cairns
- NSW**
- 10 Sept – Mastering Intercultural Communications**, Sydney
 - 8 Sept – Mastering Professional Interactions**, Sydney
 - 2 Oct – SAT SET, Wagga Wagga (PSA Conference)
 - 10 Oct – Winding Down from Surgical Practice, Sydney
 - 23-25 Oct – Surgical Teachers Course (STC), Sydney
- VIC**
- 22-23 Aug – From the Flight Deck: Improving Team Performance, Melbourne
 - 24 Oct – SAT SET, Traralgon (Victorian ASM)
 - 8 Nov – Risk Management Foundation: Informed Consent, Melbourne
 - 15 Nov – Communication Skills for Cancer Clinicians, Melbourne
- SA**
- 19 Sept – Practice Management for Practice Managers, Adelaide
- WA**
- 23 Aug – Northern Australia Surgeons Network (NASN) Videoconferences
- TAS**
- 3 Oct – SAT SET, Hobart
- NT**
- 23 Aug – Northern Australia Surgeons Network (NASN) Videoconferences
- NZ**
- 23 August – SAT SET, Dunedin
 - 16 October – SAT SET, Palmerston North

New Workshops for 2008.

Please Note: Additional Supervisor and Trainer Courses (SAT SET) will be offered in each region; visit the PD section of the College website for more information.

Further Information

- Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org select the Fellowship and Standards menu and then click on Professional Development. Easy online registration is available for all workshops.

Surgeons as Managers workshop

Date: 3-5 October, Cairns

Cost: \$1320 (inc. GST)

CPD: 17 in Category 7

Want to inspire and lead your team and develop your management skills in the public or your private practice?

Come to the 'Surgeons as Managers' weekend retreat and gain an understanding of what it takes to be a great leader and business manager. Topics include management and leadership styles, hospital financial management, legal issues and effective practice management. It is an invaluable workshop for surgeons already working as managers or for those looking to undertake managerial positions in the future.

Previous participants have found the workshop highly beneficial to their practice:

"Excellent course ... I will make more changes to my practice following this course than after any other meeting or course I have ever attended ... thanks" (Orthopaedic Surgeon, New Zealand July 2008).

Overlooking the stunning Marlin Marina, Surgeons as Managers 2008 is being held at the Shangri-La Hotel in Cairns on 3-5 October. Partners and family are welcome. The course fee includes two night's accommodation, full attendance at the workshop and a three course dinner on Saturday night for delegates.



Winding Down From Surgical Practice

Date: 10 October, Sydney

Cost: \$187 (inc. GST)

CPD: 6 in Category 7

Thinking about retiring from surgical practice? This whole day workshop will explore issues relevant to those retired, semi-retired or contemplating retirement in an interactive discussion format. Topics will include the psychosocial implications of changing roles, implementing lifestyle change, post-operative career options and the legal and financial issues associated with closing a surgical practice, to name a few.

Proudly supported by



For further information, please call the Professional Development Department on +61 3 9249 1106 or visit www.surgeons.org then go to 'Fellowship and Standards', select 'Professional Development' and click on 'Workshops and Courses'.



Ian Gough,
President

Surgical Education and Training (SET) – 12 months on

The Australian Medical Council (AMC) reviewed the College Surgical Training program 12 months ago with the introduction of our new program – SET. As we continue to implement the new program it is appropriate to reflect on the key changes that the AMC saw and the ongoing challenges in front of us. The major changes included

- The abolition of the basic surgical training stage with a new admission process directly into one of the nine surgical training streams
- Reduced duration of training
- Progressive enhancement of curricula with identification of surgical competencies
- Enhanced in-training assessment with new assessment tools to allow improved formative and summative assessment
- Moving progressively to a competency-based training program and partial phasing out of entirely time based training
- Devolution of increased responsibilities to the specialist societies, within well defined memoranda of understanding and service agreements

Not only does SET achieve a more educationally robust program, but it also is a response to societal and regulatory factors including the increased age of medical graduates, gender and work-life balance, safe-hours requirements, workforce pressures and competition from other specialities.

Interaction with Universities

As the SET program matures and progresses, the interface with Universities and other training providers will grow in significance. Partnerships have always been important and will be more so in future. The College has already had initial discussion with Universities as to how we can assist them with streamlining of clinical content in the undergraduate curricula. The changes to a medical graduate program is producing older medical gradu-



Tasmanian surgeon Anand Dixit training the next generation of our surgeons

ates, many of whom are wanting to advance themselves earlier into specialist training. The Medical Schools increasingly look at the production of the “undifferentiated medical graduate” as more difficult to achieve.

There is no doubt that the medical student groups still desire this as an educational outcome, but the ongoing concern is how students gain the breadth and depth of knowledge in all spectrums of the medical curriculum. The earlier model of trying to reduce the clinical sciences like anatomy, pathology and physiology has not been successful for a number of the specialties. Consequently there is a lot of interest from Universities about strengthening this component of their teaching for students who have these particular interests. Advantages would include the possibility of shortening training, providing a focus for surgical academic departments and providing greater exposure to surgery for those medical undergraduates who express interest. However the views of the students need to be understood and their expectations managed. There is a role for the undifferentiated doc-

tor but the challenge will be how that outcome is achieved along with efficient training of specialists.

Attraction to Surgery

One of the more animated discussions that occur at the College is how many applicants should the College and Specialist Societies receive for each vacancy within the training program. The College is keen to train the best surgeons for the future and we need to attract the brightest and most capable candidates. With 1006 applications for the approximate 250 SET posts that will be available this year the ratio is already quite high. Despite this demand, concerns continue to get raised by supervisors that the appeal of surgery does not seem to be as attractive as it was in previous years. So it is on this reflection that various activities like active profiling into the annual convention of medical students become both more strategic and important. Similarly the stronger links into the undergraduate curricula to expose surgery perhaps by running limited skills courses needs to again be evaluated. →

President's Perspective

“The College is keen to train the best surgeons for the future and we need to attract the brightest and most capable candidates.”

Even more importantly the role modeling of surgeons is critical. International studies repeatedly demonstrate that effective career mentors are the most positive way to profile the profession. Unfortunately, students do not always view surgeons as inspiring and positive role models. It will be important to reflect on this with our next round of responsibilities for medical students and junior medical officers.

Sustainability of Surgical Training

The College has recently made further submissions to the National Health and Hospital Reform Commission. We referenced the latest (Australian) Medical Training Review Panel report with regards to increases in advanced surgical training positions. In 1997 there were 478 advanced training positions in the nine disciplines and in 2007 that had increased by 61.9 per cent to 774. The number of Fellows graduating had increased from 103 in 2001 to 155 in 2006. This is a 50.4 per cent increase. Certainly the College with the Specialist Societies has responded to the workforce issues of the 1990s.

The College is now focusing on ensuring that hospitals provide the infrastructure with regard to administrative support, paid time for supervisors and commitment to peer review and audit to ensure surgical training is recog-



Phil Truskett and Ian Gough signing the College GSA agreement

nised, rewarded and remunerated. The number of medical school graduates is now significantly increasing from 1913 in 2007 to 3400 each year from 2012. Providing opportunities of training and experiences in surgery will challenge us all.

Increased role of General Surgeons Australia (GSA) in General Surgery Training

One of the ongoing ambitions for the College is to ensure each specialty society is highly involved with delivering their train-

ing program. Under the Presidency of Dr Phil Truskett, GSA has made substantial steps in this regard and agreements have now been reached that will see GSA progressively become the lead agent with New Zealand Association of General Surgeons (NZAGS) in providing general surgery training in all parts of Australia and New Zealand. This is extremely beneficial to the role of GSA and NZAGS as well as ensuring that the College can be more fully positioned as the College of Surgical Specialties.



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Ian Dickinson,
Vice President

A long-term health reform plan for a modern Australia

The National Health and Hospitals Reform Commission (NHHRC) was established by the Rudd Government in February 2008 to develop a long-term health reform plan for a modern Australia. The commission has been tasked by cabinet to provide an interim report on a long-term health reform plan to the Commonwealth Government by the end of 2008 and a final plan in mid 2009.

The NHHRC will develop a blueprint for tackling future challenges in the Australian health system including:

- the rapidly increasing burden of chronic disease;
- the ageing of the population;
- rising health costs; and
- inefficiencies exacerbated by cost shifting and the blame game.

The College views this as a once in a generation opportunity to build on the current strengths in many components of our health system and to make substantial improvements.

As part of the commission's initial work they developed draft principles which should to a large extent, in the commission's view, shape the whole health and aged care system - public and private, hospital and community based services.

The principles were focussed in two main areas - design principles (generally what citizens and potential patients want from the system) and governance principles (generally how the health system should work).

The commission also released a report, *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Healthcare Agreements*. This document expanded on the principles and outlined 12 healthcare challenges for today. It then put forward more than 40 benchmarks by which to measure progress against the challenges.

Both the principles and *Beyond the Blame Game* can be found on the NHHRC's website - www.nhhrc.org.au.

“The College believes that preventive health initiatives need to be properly funded, but not at the expense of acute care.”

In a response to a call for submissions addressing the commission's terms of reference and the principles, the College identified 13 areas worthy of discussion in terms of the commission's review process. They are:

- service design and governance principles;
- funding accountability;
- outcome accountability;
- quality accountability;
- preventive health activities;
- indigenous health;
- respectful ethical systems;
- technology and research;
- targeted workforce;
- training;
- acute services;
- regulatory red tape; and
- clinician involvement.

A pragmatic, outcome focussed approach is required if Australia is to achieve change which will benefit the community's health and the overall health system. Our submission highlights the importance of a single funder model of healthcare to improve responsibility and accountability. The College has also stipulated far greater involvement and acknowledgement of the substantial role of the private sector.

Our submission focuses on the importance of outcome based measures in order to see definite improvements in health. It is important that responsibility for health improvement must be shared between individuals, the community and government.

The College believes that preventive health initiatives need to be properly funded, but not at the expense of acute care. For too long funding has been transferred from acute care to preventive medicine in the mistaken belief that preventive medicine will “decrease illness”.

In terms of quality, our submission highlights the College's commitment to compulsory peer review and audit and argues for sufficient government funding to ensure that this occurs appropriately.

The College argues for a review of work practices across Australia. Our submission calls for performance indicators that are matched with efficiency measures. We emphasise that while task transfer has the potential for effectively extending the delivery of health care, it must be carefully managed.

As a surgical training body the College has identified that increased training expectations will require dedicated and remunerated time with a greater skill mix in those undertaking the training and educating. In addition, increased numbers of Trainees in the future will require the private sector to be more highly involved in the training of specialist medical practitioners.

In terms of acute services, the College points out that access to acute and emergency surgery is one of the greatest health issues in Australia today. It is imperative that elective surgical services should be quarantined from acute services to provide more efficient and predictable patient outcomes.

Finally, our submission concluded by noting that if any of the commission's recommendations are to be successfully managed and implemented then clinicians must be involved.

Engaging in this sort of public policy advocacy is essential in ensuring that issues confronting surgeons and surgery are placed squarely on the agenda for policy development by the commission and the federal government.



Michael Grigg, Chair, Professional Standards

Continuing Professional Development Program

All active Fellows of the College are required to participate in the Continuing Professional Development (CPD) Program. The program aims to advance the individual surgeon's surgical knowledge and skills for the benefit of patients and provide tangible evidence of participation in and compliance with the program by the award of a certificate.

Ninety-three per cent of Fellows with a requirement participated in the CPD Program for the 2004 – 2006 triennium. Increasingly, medical registration boards, hospitals and other organisations are requiring evidence of participation in approved CPD Programs and recognise the standards set by the College. It is vitally important that the College has an effective and perceived to be effective CPD Program for Fellows.

We encourage all surgeons to partici-

pate in the CPD Program and particularly encourage those Fellows who have outstanding returns for 2007 to make contact with the Professional Standards Department. It is important that surgeons show their ongoing commitment to professional advancement by recording the fact that they are participating in a recognised CPD Program.

The Professional Standards Department would welcome suggestions to improve the CPD Program.

CPD Online

Data collection for the 2008 Continuing Professional Development (CPD) Program is available online via the College website (www.surgeons.org). Fellows are able to access a personal CPD Online Diary using usernames and passwords to maintain CPD records in a real

time format. Fellows using the CPD Online Diary for 2008 will not be required to complete the hard copy recertification data form issued at the conclusion of 2008, however Fellows are encouraged to continue keeping evidence of CPD activities for verification purposes.

2007 CPD recertification data forms overdue

Fellows are reminded that the 2007 CPD Program recertification data forms are now overdue. Fellows who are yet to make a return for 2007 will be issued a second reminder letter in August. Please contact Maria Lynch, Department of Professional Standards, on +61 3 9249 1282 or email at cpd.college@surgeons.org if you require assistance completing your data form or CPD online training or require another copy.

In Memoriam



Information about deceased Fellows

Our condolences to the family, friends and colleagues of the following Fellows whose death has been notified over the past month:

Peter MacDonald Hewitt TAS
Kenneth George Howsam VIC
Frank Harland Mills NSW
Morgan Neelan Naidoo QLD
Peter Leslie Sender QLD
Hamilton D'arcy Sutherland SA

We would like to advise readers that it is not the practice of *Surgical News* to publish obituaries. Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website <http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/Inmemoriam/default.htm>

Informing the College

If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office. They are

ACT Eve.edwards@surgeons.org
NSW Beverley.lindley@surgeons.org
NZ Justine.peterson@surgeons.org
QLD David.watson@surgeons.org
SA Daniela.giordano@surgeons.org
TAS Dianne.cornish@surgeons.org
VIC Denice.spence@surgeons.org
WA Penny.anderson@surgeons.org
NT college.nt@surgeons.org



I.M.A Newfellow

What do all the acronyms mean?

You need to be a genius to know and understand all the acronyms associated with the College

Most readers will know what the acronym RACS stands for. But what about GSA, NZAGS, AOA, NZOA, ASPS, NZAPS, NSA, USANZ, ASCTS, AAPS, ANZSVS?

There may be a few in that cornucopia that readers recognise as being the letters of their own specialty organisation (for example ASPS is the Australian Society of Plastic Surgeons). These are the speciality societies with which the College has a Memorandum of Understanding. The more astute will have noticed that there is some doubling up - there are, for example, two orthopaedic associations - the AOA and the NZOA. In total there are nine specialities and 13 specialty societies. They are the bones of the College. They do the training of surgeons on behalf of the College. They assess IMG's (International Medical Graduates). They make the ASC (Annual Scientific Congress) what it is. Without them the College does not exist in a meaningful way.

If you did well on that list what about these: ASA, AHSS, SSA, TSANZ, AKS etc. These are a few of the 40 or so surgical subspecialty societies in Australia and New Zealand. Most of these societies hold Annual Scientific Meetings and have a governance structure and many FRACS members.

These speciality society and sub-speciality society names have become of relevance in the discussions relating to the possible recognition of post fellowship training. This is a difficult issue. When this was discussed at Council and at the Forum of Surgical Leaders, Prof. IAM Dead-Certain said that if you look from outside the College it was a "no brainer" that the main surgical body in ANZ should be very involved with post Fellowship training. (Yes, it is an unfortunate hyphenated surname for a surgeon - I believe he had an ancestor on his mother's side who was an undertaker. He also has the same Christian name initials as

Now it appears to me that if we can fix bung hips and leaking aneurysms it should not be too hard to sit down and come up with a sensible solution.

me but whereas I am quiet and retiring he is confident and articulate).

Now the "Gang of 13" as Mr. Pot Stirrer calls them does not see it quite that way. They are worried about degrading the value of the FRACS by a certificate gained after the FRACS, concerned regarding the certificate becoming a requirement for hospital accreditation and are protective of their turf from these outside bodies.

Prof. Dead-Certain however pointed out that the members of these 40 surgical organisations are our Fellows and in many cases our

mates. Some of them do not feel that they are wanted and loved by the College.

Prof. Dead-Certain also said that post Fellowship training is a reality - many new Fellows spend a year or so in an area of sub-specialisation. We can't do an ostrich act and pretend it does not exist. The AHSS, SSA and the ANZCFS want to develop further their sub-speciality training under the umbrella of the College.

However their areas cross two or three specialities and that is where the problem arises. Now it appears to me that if we can fix bung hips and leaking aneurysms it should not be too hard to sit down and come up with a sensible solution. If not we may find that the AHSS, SSA and ANZCFS and all the other XYZ's will take their BAT and BALL and B.OFF.

Well, that is not what Prof Dead-Certain thinks is the best solution. He suggests that we should all be Collegiate and instigate the true ideals of Fellowship. So there you have it - the challenge for 2008 and 2009.

Solutions to the acronyms can be found on page 49





Robert Davies, Chair WA
Regional Committee

Generational issues and the future of pro-bono work in the College



In their 2003 submission to the Australian Competition and Consumer Commission (ACCC), the College conservatively valued the pro-bono contributions by Fellows at \$230,000,000. In that same year the College collected just \$5,500,000 in fees. Pro-bono activities of Fellows represents one of our strongest assets, but at the same time is one of our biggest potential liabilities.

Currently, the College largely comprises baby boomers (born 1947-1964) and those from generation X (born 1965-1979). What can we expect as the College baton is passed to the next generation: those of generation Y (born 1980-1994)?

Baby boomers have been characterised by sociologists as workaholics who accept stress as part of the job and have become used to belt tightening and sacrifice. Their work is predicated on delayed gratification and they value titles and status symbols. Likewise, generation X tend to place more importance on career than personal life. Generation X tend to be mistrustful and suspicious of employers and have often been products of downsizing and cost cutting. As a group they have usually had

experience of many jobs, are not committed to a particular company and want immediate gratification. Together, though, baby boomers and generation X believe in paying their dues and display a total dedication to their job; just the sort of attitudes and behaviours that have sustained the College to date.

Generation Y presents a shift in outlook. As a group, they have been characterised as being unwilling to sacrifice personal life to succeed in their work. They tend not to value titles, status or experience and, importantly, they demand flexible environments and benefits. Their adult life has been characterised by an expanding job market and a shrinking workforce and this has significantly impacted upon their view of the world and their career outlook. They are ambitious, confident, demanding and impatient and are the first digitally and internet immersed generation. They may also turn out to be the first “houseless” generation, preferring a lifetime of rental to being lumbered with a mortgage. It has been said that they have no understanding of corporate behaviours and, rather cynically, that they “Can’t read, can’t spell,

can’t think, don’t care”. Even more unkindly, generation Y has been characterised as “Narcissism squared”.

It might be argued that these characteristics don’t necessarily apply to generation Y medical graduates who, by their very nature, tend to select towards altruism. Generation Y traits though can be seen to be increasingly permeating the medical workforce. For example, in a 2007 questionnaire conducted by the Association of American Medical Colleges, 52 per cent of graduating medical students agreed that a physician’s work “interfere(s) too much with other interests and pursuits”. Even more felt it interfered too much with family relations. Witness the recent industrial action of Resident Medical Officers in New Zealand over pay and conditions, leading some of their baby boomer and generation X seniors to publicly label their industrial action as unethical. This response is as much as anything a consequence of generational conflict about what constitutes acceptable corporate behaviour. Consider also Figure 1, an SMS received by the author from his Registrar. Both the form of communication and its content typify generation Y traits.

Generation Y are the most educated generation in history. As a consequence though, they are also the most debt ridden, and although it is said that they lean towards altruism, most cannot afford to be teachers. Medical students are no exception. A medical degree at Bond University for example costs around \$254,912, and current student contribution fees for a six-year undergraduate MBBS degree at the University of Western Australia amount to around \$51,000. In a study of interns at Flinders Medical Centre in 1987, 15 per cent had accrued more than \$100,000 debt by the time of their graduation. Specialist training inflicts further financial pain. The College’s surgical training fees currently amount to more than \$50,000 by the

time that a Fellowship is awarded (assuming the trainee passes the Fellowship examination at the first sitting!). (See Figure 2)

It is against this background that we have to consider the sustainability of pro-bono work in the College and to plan accordingly. Armed with their generation Y outlook on life and having sometimes accrued a financial debt at graduation equating to a small home mortgage, can we expect in the future that young surgeons will continue to be favourably predisposed to contributing to the pro-bono model that currently sustains the College? Furthermore, will generation Y attitudes towards work-life balance further erode the choice of surgery as career at all? Already we are seeing lifestyle considerations favouring the defined hours of Radiology or Emergency Medicine over the unpredictability and lifestyle intrusion of a surgical existence.

Generational issues and the consequences of the emerging expectation of a "user pays" system have important potential consequences for organisations such as the College. We must recognise, understand and respond to the social trends that are occurring around us and plan for how to incorporate "Generation Me" into a sustainable future for the College.

Hi rob had a shocking night ☹️ was on call. Need to go home for a shower. Will come to theatre a bit late if you don't mind starting HDR on your own.

Figure 1
SMS received by Consultant Surgeon from a generation Y Surgical Trainee. (HDR = high dose rate brachytherapy)

PreSET Registration	\$130
ASSET	\$2510
EMST	\$2100
CCrISP	\$1915
CLEAR	\$975
Website fee distance learning program	\$2150
Selection Processing Fee	\$500
Selection Registration Fee	\$350
Basic Science Examination (SET1)	\$4200
Clinical Examination (SET1)	\$1600
Annual training fee (\$4900 pa for 5 years)	\$24500
Fellowship Examination Fee	\$5600
Fellowship entrance fee	\$5600
TOTAL	\$52130

Figure 2 The College training fees (indicative only; individual specialties vary)

Royal Australasian College of Surgeons
Victorian Annual General Scientific & Fellowship Meeting
October 24-26, 2008
 Century Inn, Traralgon VIC

Program Includes:

- Partner Program
- Professional Development
- Workshops
- CPD Credit Points
- Networking

Social Activities:

- coal mine tour
- golf clinic
- parachuting
- air flights
- GJ Royal lecture
- Formal Dinner

Special Early Bird Registration:

For registration & further details contact the Victorian Regional manager,
 Denice Spence +61 3 9249 1254 or
denice.spence@surgeons.org

The Victorian regional committee wish to thank the sponsors for their generous support of this meeting:

- Experien Medical Finance
- AVANT
- MDA National
- Johnson & Johnson

Contact the College for application forms on
college.vsc@surgeons.org or download from the web
 on www.surgeons.org



Michael Gorton,
College Solicitor

Bed cards and privacy

Hospitals can avoid liability by adding clauses in patient privacy statements

Many hospitals use bed cards and bedside patient folders to identify inpatients awaiting treatment. However, displaying a patient's name and health information risks breaching privacy or confidentiality laws. However, by adding clauses in patient privacy statements and admission agreements to ensure that each patient expressly consents to such use of patient information, hospitals can ensure that liability is avoided.

Privacy principles

Public hospitals (and private health services with an annual turnover of less than three million) are regulated by the Health Records Act 2001 (Vic), while private hospitals are regulated by the Privacy Act 1988 (Cth). Both public and private hospitals are regulated by various privacy principles contained in their respective legislation. For example, the disclosure of a patient's name or information contained within a patient folder such as their date of birth, contact details, allergies or medical history is prohibited unless the information is disclosed for the primary purpose of treating the patient.

Bed cards and patient folders, when left slightly open or unattended, risk disclosure of patient information and may infringe privacy law.

Doctors will argue that identifying a patient by name and having quick access to further information relating to that patient are integral to the patient's treatment. The ethical concerns and safety risks associated with treating patients anonymously also lend favour to this argument. In the absence of any identifying information, hospitals could not ensure that the risk of treating the wrong patient is avoided.

While this line of reasoning is persuasive, it has not been tested in court. This means that organisations and surgeons are exposed to the possibility of breach of privacy complaints, even if the final result clears them



of liability. In the interests of avoiding costly and time-wasting litigation it is recommended that organisations specifically set out in their existing privacy policies the proposed uses of patient information, including the use of bed cards and patient folders.

Organisations can ensure a patient's consent by adding clauses in patient admission agreements setting out the specific uses of patient information and ensuring that each patient signs the admission form. Following this process, the organisation will obtain the patient's consent to use patient information on bed cards and in patient folders, protecting itself from any claims for breach of privacy.

Duty of confidentiality

Public and private hospitals and their employees are also bound by a duty not to divulge to any other personal information from which an individual receiving a health service could be identified. This duty of confidentiality is codified in legislation in several states but also arises in common law in Australia and New Zealand.

Implied consent to the disclosure of a patient's information constitutes a defence to a claimed breach of the duty of confidentiality. For instance, when a doctor refers a patient to another institution, it is assumed that the patient impliedly consents to the disclosure of their information to the relevant staff members at the new institution. Thus, while technically the duty of confidentiality has been breached, the patient's implied consent absolves the organisation of any liability for the breach.

Using bed cards contains the extra element of disclosing a patient's name not just to other practitioners but to anyone present at the hospital, including members of the general public. The calling out of the names of patients is common practice in various different health services. Because of this, the onus now probably rests with a patient to indicate that they do not wish for their name to be disclosed. Again, this is an area that remains to be clarified by the courts.

While arguments of implied consent will likely protect such use of patient information, organisations could ensure confidentiality claims are kept to a minimum by obtaining a patient's express consent upon admission as suggested above. A clause specifying all planned uses of patient information could be easily inserted into a patient's admission agreement as another clause to which the patient consents.

Under privacy and confidentiality laws in Australia, the most reliable and efficient means of avoiding liability is by obtaining a patient's written consent for all planned uses of personal and health information.

Accordingly, doctors and hospitals should ensure that their consent forms and privacy statements explicitly refer to the use of bed cards and patient health folders.

(I am grateful to Sam Szoke-Burke for assistance with this article)

Michael Gorton, Principal,
Russell Kennedy Solicitors



Eu Ling Neo

When less is best

I found the year working part time invaluable as a stepping stone from maternity leave to the full time training I am doing now

I worked at the Royal Adelaide Hospital Breast, Endocrine and Surgical Oncology unit as the part-time surgical registrar in 2007. I had returned to work after taking 10 months of maternity leave with my second daughter. My eldest daughter was three-and-a-half years old at that time. I found part-time work ideal as it gave me an opportunity to balance life as a surgical registrar as well as a mother of two young children.

I worked every Monday, Tuesday and Friday and shared weekend ward rounds with the full-time registrar on that unit. My weekly commitments included two-and-a-half sessions in theatre, two outpatient clinics and participation in the general surgical on-call roster (two or three days a month). The main workload involved breast and endocrine surgery but there was also a significant amount of exposure to melanoma and sarcoma surgery as well as emergency and trauma patients. I had a very healthy logbook – 150 major operations and 100 minor operations over the 12 month period.



Eu Ling with her daughters Amy and Kelly

I found the year working part-time invaluable as a stepping stone from maternity leave to the full-time training I am doing now. It

also could be an opportunity for someone who would like to work part-time whilst doing research or has other personal interests.

PART TIME SET POSITION SOUTH AUSTRALIA

Part time training is being sought by an increasing number of SET Trainees in General surgery. South Australia has a unique accredited training position which is available for 2009.

The position is a 12 month 'stand alone' position (i.e. not a job share) based on a 2 ½ day week and provides for six months of accredited training. The part time Trainee is employed alongside a full time Trainee and a full time Fellow.

The Breast-Endocrine and Surgical Oncology Unit is a busy unit of a major teaching hospital. The position offers a broad training experience in breast and endocrine surgery, including breast reconstruction and in general surgical oncology, encompassing melanoma and soft tissue tumour management. The Trainee will be expected to participate in rostered general surgery 'on call'.

This position provides a unique opportunity for a SET Trainee to combine accredited training with family, research or other commitments. Interstate trainees are welcome to apply and private assisting and/or research opportunities can be explored by the successful candidate.

Any interested surgical registrars should contact Dr Nicki Bator and forward a CV for consideration to Nicki.Bator@health.sa.gov.au



Matthew Peters, Chair
RACSTA (above) & Keith
Mutimer, Honorary Treasurer

The cost of surgical training

There's a need for the transparency of Trainees fees to better understand the College's fee structure

Education is a major component of College business and is a self-funding activity supported by Trainees fees. The value for money as represented by the fees paid has been a point of much discussion and a source of contention amongst Trainees.

At the April meeting of Royal Australasian College of Surgeons Trainees Association (RACSTA), the annual fee was again the talking point after the recent increase in surgical training fees for 2008. At the invitation of RACSTA, Mr Keith Mutimer, the College Treasurer, attended the meeting to discuss Trainee concerns. The discussion and information provided has given a new level of transparency to the fee structure.

It is acknowledged that the fees represent the highest annual training fee of any of the specialty Colleges throughout Australasia. However, providing an integrated and accredited Surgical Education and Training (SET) scheme, based on a "user pays" principal that leads to an internationally recognized specialist qualification in the form of College Fellowship is costly. It should also be acknowledged that the SET activities do not create a surplus; a further outcome of the "user pays" approach. An argument could however be reasonably made for a surplus to exist, funding ongoing research and development activities to ensure the College training program remains a first class product.

So what are we paying for?

As a generalisation, most membership fee structures cover expenditure (both direct and indirect costs), and also include a margin for profit. The College does not make a profit from its training and education fees, instead they are set on a "user pays" basis in order to cover the costs associated with providing the surgical education programs.

With regard to costs, there are two aspects to consider. The first is the 'structural' compo-

nent of the fees – the 'behind the scenes' work required to run the College and its programs. The second is the direct 'education' component of fees – the training services that are visibly provided.

Sixty-one percent of the annual surgical training fee is dedicated to the day to day running of the Educational program by the College, including payments to the Specialty Societies for their training role.

This money is divided amongst College governance and education support (forty percent), specialty governance (seven percent), board executive support (ten percent), and hospital accreditation (four percent).

It should be noted Fellows are not paid for their time delivering training in the non-clinical setting or at meetings. This would otherwise have significant cost implications.

'College governance and education support' comprises:

- Education advocacy
- Representation to external stakeholders (e.g. Australian Medical Council, Health jurisdictions)
- Administration and coordination of the College governance structure as represented by College Council, the Education Board and the board of Surgical Education and Training
- Regional support
- Dean of Education
- Coordination of jurisdictional representatives
- Generic policy development
- Development of quality assurance policies and their implementation
- Development of educational modules for non-technical College competencies
- Financial management of College educational resources
- Administration of research funds/grants
- Appeals
- Administration of RACSTA
- Generic training of supervisors – SAT SET

- Development of e-logbooks
- Audits
- Publications
- Registration processes
- Information technology

'Specialty governance' comprises funds to support the running of the specialty board meetings and other governance activities.

Some specialties elect to manage their own training activities (e.g. orthopaedic surgery). Others choose to utilise existing College infrastructure in addition to conducting some of their own activities (e.g. plastic and reconstructive surgery), whilst the majority rely solely on staff managed by the College for their functioning (e.g. general surgery, cardiothoracic surgery). 'Board executive support' relates to funding operational staff to allow these specialties to function.

'Hospital accreditation' is self-explanatory. Travel and accommodation costs for fellows providing pro-bono accreditation services of training posts need to be funded by the training program.

'Training Services'

The remaining thirty-nine percent of our fees are allocated to trainee services in support of the specialty training program. This is administered by the Specialty Boards and or College. This includes:

- On-line resources
- Development of Curricula
- Training courses
- Seminars/trainee days
- Travel and accommodation for fellows providing training activities
- Maintenance of Trainee records and reports

So how do other Colleges conduct a similar level of activity without charging their Trainees a similar fee?

The College is unique in that every activity is self-funding. There is no cross-subsidisation

“Sixty-one percent of the annual surgical training fee is dedicated to the day to day running of the Educational program by the College...”

from the College’s investment fund. This means that the returns from the College investment fund are independent and NOT relied upon for funding College activities, including training. The current economic climate will more than likely see a rise in the fees of other Colleges.

Why the \$1000 price rise in 2008?

Over the past three years College Council has been implementing a “user-pays” system for the provision of all services. As such, SET Trainees pay for the running of SET. Prior to 2008 the Trainee fee structure was calculated using historical data, with cross subsidisation from other areas of College activity. The large jump in price reflects a correction to the level where training fees, based on a “user pays” system, should be.

What will happen in 2009?

The “user-pays” system for the provision of all College services will remain. Inflation will be considered and a rise in annual training fees in line with this will occur. Revenue and expenditure will be reviewed for 2008 and the training fee for 2009 will be adjusted to comply with this principle. How individual specialties will alter their fee structure is unknown.

Can anything be done to reduce the annual training fee?

Inefficiencies and unfair cost allocations are constantly being identified and addressed. This year saw the implementation of the “user-pays” system in the SET application process as well, meaning that current trainees and fellows no longer subsidise this process. Final negotiations are currently underway for hospital inspection and accreditation costs to be met by the health jurisdictions, not the College. This should provide downward pressure on future fee rises as well. As it stands SET is currently running at a deficit of \$162,000 in 2008. A greater understanding of SET’s financial position should result as the program becomes established. Other inefficiencies will present and will be acted upon.

Can anything else be modified?

Many Trainees ask why we need to have national and regional offices. Much business is conducted at the regional level, more than most trainees would be aware of. Term reports, allocation of training posts, meetings to discuss Trainee requirements, logbooks and outcomes in some specialties take place in regional offices. The services required by Fellows of the College need to be considered as well.

All in all education is expensive. The methods employed by the College to deliver world-class education to its Trainees should be applauded, not deplored. Other Colleges provide similar programs at a cheaper price but their product is not comparable and their methods in doing so may not hold well in a future of economic uncertainty. As it stands, the platform provided by the College of Surgeons ensures a strong, stable and secure future for all of its members.

I hope this article provides Trainees with the transparency they require to better understand the College’s training fee structure. Yes, as Trainees we do pay a large fee to the College annually, however this is an investment in our future that, if nurtured properly, is guaranteed to provide a satisfactory return.

Virtual Congress 2008

The Virtual Congress for the 2008 Annual Scientific Congress is now available on the web. You can view the slides of presentations alone or read the submitted abstracts. Ninety web casts from the breadth of the Congress are also available for viewing.

All posters submitted to the meeting may also be viewed.

You can access the content via the Congress website www.surgeons.org/casc2008 or via the College home page and click on ‘Conjoint Annual Scientific Congress 2008 Hong Kong’.

Click on the ‘Virtual Congress’ on the left and follow the links.

Campbell Miles
Annual Scientific Congress co-ordinator



Trainees Association



Nastasha Polites,
CASC Trainees convenor

A surgical-social event

Trainees lived it up while furthering their knowledge at the recent CASC in Hong Kong

May 2008 saw Trainees from across Australia, New Zealand and China descend upon the steamy shores of Hong Kong harbour for the College Conjoint Annual Scientific Congress (CASC). Over 200 Trainees attended the event, a record for Trainee attendance at a College ASC. With such a large group of people, an exotic location, and a social program to match, Trainees lived it up whilst updating their knowledge with cutting-edge presentations by colleagues from around the world. No wonder we were all tired when we got home!

The highlight of the Trainees Association social program was the Younger Fellows and Trainees dinner. A floating restaurant in the middle of Hong Kong Harbour was the stage. A quiet still night set the scene. Fortune tellers, calligraphy artists, noodle makers and professional cocktail waiters added spice, and younger Fellows and Trainees added some sauce. It was a huge night that was sold out long before a plane had left Aussie shores. Everyone had a great time, with sore heads full of good memories sure to remain with everyone that attended for the rest of their lives.

The academic program saw a strong Trainee presence, with both verbal and e-poster presentations allowing an unprecedented number of trainee presentations to take place. The Trainee lounge was established for the first time at an ASC, offering a common meeting place and a quiet venue in which to recline between academic sessions. Sponsor displays once again provided plenty of free coffee, a service that was well utilised by Trainees from all specialties.

So once again a precedent has been set, with huge expectations now in place for what Brisbane ASC 2009 will offer. Being the first ASC in Australia since 2006, I am certain that it will be huge. Make sure you stay tuned for updates about the Younger Fellows and Trainees dinner and everything else that RACSTA has planned for Brisbane ASC 2009. You will not be disappointed.



Xavier & Vivian Yu with
Salena Ward & Raaj Chandra

Julie Teague & Jennett Kelsall

Natasha Poiles, Jane Brooks, James
Kong & Chung-Kwong Yeung

Juliana Chen, Michael King Lok
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Green Fellows



Campbell Miles

A different kind of operation

The management skills of surgeons can be put to good use in volunteer organisations

Mount Waverley is a typical suburb of a state capital in Australia, with houses on quarter-acre blocks interspersed with occasional green spaces around sports fields. Once, this was all bushland, but that was before European settlement; the changes were wrought early with extensive land clearing for orchards and market gardens followed by the inevitable subdivisions for housing.

As the housing spread, the only bushland remnants were along the banks of creeks since these were often too steep for ready subdivision. One such area in the centre of Mount Waverley is a 1.5km length of Damper Creek. In 1968, even this was under threat of being barrel drained, the banks levelled and the land subdivided. In perhaps an unusual example of activism for the time, local residents rallied, formed an action group, successfully ran for council and stymied the developer's plans. The council even protected the area, proclaiming it Damper Creek Bushland Reserve. Having saved the land, the resident's group lapsed and the area became infested with weeds and a dumping ground for the detritus from house building. The creek was extensively damaged when the sewerage system was laid in the late 1950s and the denuded banks became prone to serious erosion.

In 1995 a new community group, Friends of Damper Creek Reserve, was formed by local citizens with a view to reversing the years of neglect. This group lobbied the local council and Melbourne Water and the two authorities provided funding for the creek bed to be stabilised using large boulders transported from central Victoria. That work is now complete and revegetation is well underway. This involves planting not just native plants but indigenous natives using seed collected from the local area. Also, it involves only planting species identified on plant lists drawn up at the end of the 1800s.

In 1984 my wife and I built our home on a



Members of the Friends of Damper Creek Reserve

block that backed on to the reserve. We watched as the creek bed was restored and planting started. One evening as I walked in the reserve and admired the work being done, a member of the friends group started a conversation on their work and asked if I had considered joining them. He was smoking a pipe so wrote down his contact details for me on his matchbox. I thought if he was committed enough to give up his matches the least I could do was join the friends group. So began my association with the Friends of Damper Creek Reserve Inc.

In those early days, my commitments to surgical practice and family prevented my attending the business meetings, but we became regular attenders at the Sunday morning working bees. I learned how to plant tube stock plants and how to identify weeds from desirable native grasses, and I met a group of committed local residents with whom I had

never previously made contact. Many of these volunteers were working and had families but still gave time to the friends group as well as other volunteer groups such as Scouts and service clubs.

When I retired from consultant practice I joined the group's executive and more recently I was elected president for a two-year term. In my first year on the executive, a block adjoining the reserve was sold to a developer who submitted plans to demolish the house and the established rear native garden on it in order to build a very inappropriate multi-unit development. This caused consternation to the friends group since the plans envisaged the block being extensively built on with mostly hard surfaces and little rear garden. In a linear reserve such as Damper Creek, the large rear gardens of adjoining blocks represent a significant extension of the reserve, especially

“It is not cheap to correct 150 years of degradation and neglect”

if the gardens are planted with native species. This led to three of us on behalf of the group successfully lobbying council to block the planned development and participating in the subsequent judicial review in front of the Victorian Civil and Administrative Tribunal.

Concern for the environment has not always been an imperative for me, but it has developed over the last two decades. In the past I have been a volunteer with Earth Sanctuaries – work that involved control of wretched serrated tussock grass at the sanctuary near Little River, outside Geelong, as well as a financial supporter of environmental groups.

Damper Creek is much closer to home than is Little River – in fact it is on my back door step. The Group used to spend six months over winter and spring planting and six months weeding. Climate change and drought has changed the balance to three months planting. We have been very successful in applying for grants from government agencies such as Melbourne Water to allow the planting schedules to continue. Over the last 12 years, \$85,000 has been raised to purchase plants. Weeding is the usual suspects – blackberry, cotoneaster, ivy and gorse. The banks of blackberry and the dense thickets of gorse, the so-called woody weeds, are now cleared so weeding now centres on weed grasses such as panic veldt, sweet vernal and Yorkshire fog. The price of liberty may be eternal vigilance; in our case it is eternal weeding. As the indigenous grasses become established, weeds are less likely to germinate but as more planting is done, it becomes less safe to use herbicides and hand weeding is essential.



Damper Creek

Replanting the banks and surrounds of Damper Creek stabilises the soil, retains moisture and slows water flow in to the creek. Unfortunately, it does little to improve water quality. The storm water coming off roads is polluted with oil and disc brake dust and rubber residues from tyres. From footpaths come dog droppings and cigarette butts. We are lobbying hard for small bio-retention basins to filter storm water at the major entry points. Work at Monash University has demonstrated the efficacy of these filters on improving water quality.

Damper Creek Bushland Reserve is now viewed as an exemplar of creek restoration, and groups from around Melbourne and Australia visit to see what can be done and how to do it. It is not cheap to correct 150 years of degradation and neglect. The creek stabilisation cost over \$150,000 and maintenance and planting must be ongoing. Authorities cannot afford to pay for hand weeding and funds for planting awarded to volunteer groups such as ours stretches our Council's resources to other areas in Waverley where there are no friends groups. The reward is the enormous increase in the number of visitors walking in the Reserve and the increase in bird life in both numbers and species. A powerful owl was photographed in the reserve a month ago – the first documented sighting in over 20 years.

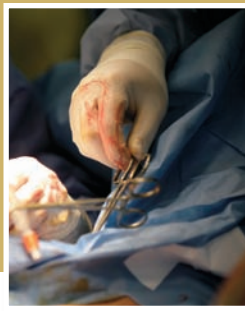
All surgeons have run successful small businesses, have spent a professional lifetime communicating clearly with colleagues and patients and have led teams. All these attributes are in demand in volunteer organisations. Of course they are not in demand from the first day one joins a volunteer organisation and leading a team is not the same as imposing one's will in the operating room. When you join a volunteer organisation you are on probation but once you have demonstrated your commitment with hard work and being a member of the team, you will find your other abilities are also in demand. The outcome is gratifying in the highest degree.

*Damper Creek Bushland Reserve:
Melways reference: 61, D10*



The College would be interested in receiving articles from Fellows who are concerned with the environment, whether it is about driving a hybrid car, involving yourself in restoration of parklands, campaigning for healthier rivers, new ideas on sustainable living or your thoughts on climate change.

Please send articles to surgical.news@surgeons.org or phone Ruth Charters, PR & Media +61 3 9276 7430



Colin Russell,
Clinical Director, VASM

Latest news from the Victorian Audit of Surgical Mortality

The Victorian Audit of Surgical Mortality (VASM) was initiated in May 2007 to promote further improvements in surgical care in Victoria. VASM started receiving cases at the beginning of 2008 and released its first annual report in July. In May 2008, VASM staff relocated to a new office space in the College headquarters. This office was purpose built to provide the privacy required under the Commonwealth Qualified Privilege scheme.

VASM has identified 126 public hospitals that perform elective surgery in Victoria. By the end of June 2008, 40 of the 126 hospitals had agreed to participate in and provide regular notification of deaths associated with surgical care. Twenty seven of these 40 hospitals are actually providing notifications of death. VASM staff continue to visit Victorian hospitals to seek their collaboration on the audit and to follow up hospitals that have agreed to participate but are not yet reporting.

In December 2007, an invitation to participate in VASM was sent to 955 Victorian surgeons. By the end of June 2008, 574 surgeons had notified VASM of their intention to participate. Of these, 537 surgeons agreed to participate in the audit, with 280 agreeing to act as first-line assessors and 303 as second-line assessors.

Only 37 surgeons intimated they would not participate; most of these have ceased clinical practice or moved interstate. Of the surgeons originally invited to participate, 381 have still not notified VASM of their intentions. Further invitations have been sent to these surgeons and VASM staff await their responses. VASM continues to seek support from all Victorian surgeons.

At the time of printing, VASM had received 112 notifications of death and had completed the first- and second-line assessment processes on 18 of these notifications. There are 68 cases where VASM is still

awaiting a response from the treating surgeon and 13 where the first-line assessor is yet to respond. Of the 112 cases, eight have been identified as terminal care and two as non-surgical deaths. To date, 18 cases have been reviewed by a first-line assessor. Only four of these required second-line assessments.

Victorian surgeons will note that the Victorian Surgical Consultative Council (VSCC) previously conducted a mortality audit in Victoria. While VASM has replaced the VSCC mortality audit, the VSCC still conducts an audit of surgical morbidity. In addition, the VSCC, in collaboration with VASM, will inform the surgical community about important issues arising out of the collection and analysis of the mortality audit data.

VASM would like to take this opportunity to thank all of its participating surgeons and hospitals. For further enquiries, please contact the VASM office on +61 3 9249 1132 or via email at vasm@surgeons.org

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Richard Tee

Surgeons as Educators Prize

Dr Richard Tee has been recognised for honing a method of practicing STSG skin graft harvesting

The Surgeons as Educators Committee would like to congratulate Dr Richard Tee for winning the ASC Surgeons as Educators Prize for his paper entitled *A Training Simulator for Split Skin Graft (SSG) Harvesting*.

As a surgical resident in Darwin, I was fascinated by the variety of procedures performed by the general surgeons. General surgical Trainees were expected to venture out of their comfort zones and conduct various procedures that are usually performed by sub-specialty Trainees in metropolitan hospitals. One of the procedures that I observed as a challenge to Trainees was the harvesting of Split Thickness Skin Graft (STSG). As some plastic trainees have experienced, harvesting STSGs can prove disastrous if full thickness wounds are “created” or thin fragmented sheets of useless skins harvested. I have both witnessed and personally experienced this!

Immediately after Darwin I returned to the Burns Unit at Royal Adelaide Hospital. The Director of Burns Unit, Mr John Greenwood, is a passionate burn surgeon who allows no margin of error from his residents. I was extremely impressed by Mr Greenwood and the Registrar at the burn unit as the STSGs were harvested beautifully and were thin, intermediate or thick as required! This led me to look for a model that I could practice on. I began by reviewing the literature and found three to four existing simulators. I spent a lot of time searching for the materials and many nights at the Burns Unit trying to recreate them, modify them and assess them. Eventually I narrowed it down to one that I found most practical to create.

This model consisted of a oneL saline bag core with an additional 150mls of water added. A piece of porcine skin is stapled around the saline bag (a modification of the original model by Wilson et al. 2001). This generates the “feel” that resembles a human



Dr Tee wrapped pig skin around a bag used to practice STSG harvesting to give it a human “feel”.

thigh. The use of pig skin (being most similar to human skin as compared to other animals) allows the assessment of the final product by looking at the presence of hair follicles. To see if the model would be helpful in lowering the “first-timer morbidity”, I recruited medical students with no prior knowledge of the procedure, trained them with the simulator and compared their results to a control group.

In the preliminary study, the model improved the fluency of the procedure and there was potential to reduce the morbidity generated by a “first timer”; as evident from better quality skin grafts obtained by the subjects overall after training on the simulator. However, these results need further validation.

In burn surgery, donor sites are precious and bad scarring caused by poor techniques is highly undesirable. The skill of creating different thickness of STSGs to cater for different anatomical locations and different depth of burns is often neglected by trainees. This model will serve as a

convenient teaching and learning tool for honing the skill of harvesting STSG.

I am very grateful to be awarded this prize. I thank God for being so gracious, though I am undeserving. Many thanks to Mr Greenwood for encouraging me to develop this project and pursue an academic career in surgery; to all nursing and allied health staffs at the Burns Unit, Royal Adelaide Hospital for showing me what good burn care is all about; to ANZBA for acknowledging my project by awarding the Stuart Pegg’s Prize for the earlier study; to Dr Sue Velovski and Mr Michael Kamenjarin for various good reasons; to Dr Melissa Bochner for helping me settle back into Adelaide; to Mr You Wen Yeap for his assistance in the latter part of this project; and to Miss Joyce Gong for images of the model presented at the conference.

The author is currently pursuing his Doctor of Philosophy (PhD) degree at the Bernard O’Brien Institute of Microsurgery, Melbourne.



Wanda Stelmach
Pictured: Andrew Jamieson

The need for walking speed

For Andrew Jamieson, athletics has always
come a close second to surgery

Life is golden for race-walking champion, olive grower and surgeon Andrew Jamieson. “I guess I’ve taken ‘outside of surgery’ interests to the extreme,” Jamieson muses. “I was always planning to see how far I could go. As a teenager I used to come second to Ross Haywood. I wasn’t that far behind him.”

Ross Haywood represented Australia in the 1976 Olympics in the marathon and 20km walk. But this is not the idle daydreaming of a would-be champion. Jamieson is the 2007 Australian and World Masters Athletics champion for his age group, having swept the five kilometre, 10km and 20km race walks at Riccione, Italy, and set several world records.

Jamieson is not precious about his wins. Laughing, he tells the story of how he lost all his medals then found them weeks later behind some books. Luckily, his friends took pride in his wins and presented him with a T-shirt adorned with copies of the medals.

Jamieson’s parents were missionaries in Vanuatu. His father was a medical missionary and athlete. “It’s a very strong Presbyterian background. We were living next to the hospital. I was a kid hanging around, peeking through holes in the walls at the operations. I did want to do medicine. It just seemed the natural thing to do,” he reminisces.

Jamieson boarded at Scotch College where his athletic abilities were recognised. He competed in the Australian University Athletics Championships, but, “My medical career took over. There wasn’t enough time to fit athletics in. It wasn’t a career. You did it as an amateur. You did not get paid.” He contemplates the amateur athlete’s impoverished life as he tells a story of refusing to accept a pound for running the boundary at a football match in case he lost his amateur status.

Jamieson worked in obesity surgery. Michael Long was his mentor. The irony of a slim, athletic doctor looking after morbidly



Race-walking champion – and surgeon – Andrew Jamieson

obese patients doesn’t escape him. “There was often speculation in the waiting room as to whether I had had surgery!”

Finally, needing a change, he bought a farm at Fish Creek in Victoria. “We grow olives commercially and make olive oil for others. We are the only olive oil makers in Gippsland. So we have become manufacturers as well as horticulturists.”

Jamieson practises surgery locally. “One of the greatest advantages of working in the country is that you get morning tea,” he exclaims. “You actually get scones at Leongatha and brewed coffee, sandwiches and cakes at Foster!”

Jamieson started running during the ’80s marathon craze but stopped following an injury. “At the time, near where I was working there was a group of young elite race-walking athletes. I managed to get myself into training with them. I really enjoyed it.

Although it’s competitive, it’s never nasty.”

After competing in England, where he won silver, Jamieson thought he could win gold. “So I did some more training. In Australia in 2001 I got two gold medals and I beat the bloke that I was trying to beat.”

Now 61, he trains daily, averaging 90 kilometres a week. “Unfortunately, my body’s starting to complain. I’m trying to ignore it. It’s fine if you are in the Australian Institute of Sport. You do your morning 20km then sleep for three hours. You have a massage, do a swim and another 20km. Here, I do my 20km and then work the farm. But it’s good fun! It’s good fun to win a race. It’s also good fun to just compete against everyone else.”

Jamieson is thinking about the Australian Championships in December. “I suppose I’ve still got a few goals. And, there’s one world record I haven’t got, yet.”



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Fellowship in Bariatric Surgery

The Australian Institute of Weight Control (AIWC) is pleased to announce its inaugural Fellowship Program in Bariatric Surgery. This is an outstanding opportunity for fellowship training in Bariatric surgery in Australia as part of a multi-disciplinary centre for the treatment of obesity.

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AIWC supervisors of training include:

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- **Dr. Sue Taylor**, St. John of God Hospital, Perth
- **Professor James Toouli**, Flinders Private Hospital, Adelaide
- **Dr. Lilian Kow**, Flinders Medical Centre, Adelaide
- **Dr Laurant Layani**, John Flynn Hospital, Gold Coast
- **Dr Roy Brancatisano** Baulkham Hills Hospital, Sydney

There will be 4 Bariatric fellowship positions available commencing in January 2009, for a period of 12 months. There will be opportunity to extend the position to 24 months and to spend at least 6months at another location within the network.

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Russell Gruen

Public roles of health professionals

Scientific evidence and the relationship between the medical profession, politics and the public are dynamic and inter-related

In 1848, Rudolf Virchow asserted that “medicine is a social science, and politics nothing but medicine on a grand scale”.¹ Regarded by many to be the father of modern pathology, Virchow saw clear responsibilities for doctors to engage with the broader social concerns that cause illness and harm.

A century and a half later, human health faces threats ranging in scale from terrorism and climate change to the consequences of violence, substance misuse, poverty and environmental hazards that we deal with every day in our emergency departments and our clinics. On a handful of issues, such as smoking, health care professionals have been instrumental in changing public policy. But, with many ongoing social ills, is civic action a duty of modern clinicians?

Following the September 11 terrorist attacks in the United States, the world’s leading medical journals expressed opposing views on this question. The editors of the *New England Journal of Medicine* implored doctors not to react directly to terrorism, but instead to treat injured patients, continue with medical research and ensure that the medical community is prepared for future terrorist attacks.² In response, the *Lancet*’s Richard Horton argued that anyone working in the health professions is concerned with prevention as well as healing, that medicine cannot escape politics, and to reduce the burden of harm caused by violence, doctors must address how the political determines the clinical.³ Putting aside legitimate practical concerns — after all, few doctors think they have the time or skills to be effective political agents — the real question is whether or not we should nurture interest in addressing the health of communities among health care professionals, arming them with appropriate skills and promoting opportunities for engagement.

If we examine the dual historical trajectories of scientific medicine and the place of professionals in society, we realise that this is not just a question of individual political or moral

persuasion. Instead, it is one that depends on prevailing culture and circumstances of the time. In the 19th century, for example, doctors found professional distinction difficult to attain, largely because the scientific basis of medical practice was rudimentary and their treatments were often harmful. Public health activism was one way in which doctors could achieve status and authority.

While not all doctors embraced it, public health was at least deemed to be complementary to the work of medicine.⁴

This changed rapidly early in the 20th century as scientific and clinical evidence evolved, and, in mastering this body of evidence, doctors became valuable to the public.⁵ Based on new understanding of bacteriology, germ theory and specific disease-based treatments, the biomedical model of disease triumphed. The new medical schools focused on diseases more than on people or populations, and on cures rather than on the social, behavioural and environmental forces that maintain health or produce disease. Unlike efforts to change social conditions, which were seen to be tainted by politics, advocacy and social diversity, the reductionism, objectivity and certainty of the biomedical model had great appeal. By the 1950s, the income, professional status and authority of doctors far exceeded that of public health professionals, and deep antipathies had evolved between them.

In the most recent 50 years, this relationship has become less polarised, due especially to three scientific and sociological developments. The first was the birth of modern epidemiology and multivariate analysis. They demonstrated that most major illnesses were not random occurrences and that peoples’ overall health status was not only a consequence of the care they received. We now know that they are influenced by a range of social factors, including income and social status, social support networks, education and literacy, employment and working conditions, and social and physical environments.^{6,7} Second, business

and government replaced the individual as the principal purchasers of health care, and have been increasingly interested in research that reveals disparities in health status, unequal access to treatment and variable quality of care. Managers and policymakers have challenged the view that entrenched health problems can be solved simply by more doctors, more medicines or faster discharge times. Third, fuelled by the repercussions of high-profile cases such as the Bristol Royal Infirmary⁸ and Bundaberg Hospital⁹ cases, cynicism grew about the medical profession’s ability to put aside its own interests and to self-regulate standards of performance.

In light of such developments, it is no accident that doctors have been concerned with issues of professionalism. In February 2002, a transatlantic team of physicians published a Charter of Medical Professionalism, which was a bold restatement of the responsibilities of doctors as professionals — a sort of modern Hippocratic Oath.^{10,11} From July 2003, the American Council of Graduate Medical Education and the American Board of Medical Specialties required that all American medical and specialist training programs teach and assess “professionalism” as a core competency. The concept of professionalism rapidly gained traction, and the Charter provided a road map. It offered three fundamental principles: primacy of patient welfare, patient autonomy and social justice. The first two were uncontroversial. Social justice, however, with its implied responsibilities for public roles that redress social inequalities, was greeted with some ambivalence and much confusion, and needed clarification.

With colleagues at Harvard I developed a conceptual and operational model based on our qualitative research with a range of professionals, academics, consumers and social commentators.¹² Finding the label “social justice” generally unhelpful, we preferred the term “public roles”, which we defined as advocacy for and participation in improving the aspects of communities

that affect the health of individual patients. We justified doctors' public roles on the premise that doctors and the public expect discipline-based expertise to encompass all aspects of diagnosis, prevention and treatment; patients expect the medical profession to do what it can to promote their health; and doctors can be effective advocates for societal change through changes in legislation, advertising, public awareness and so on. We set reasonable limits on these obligations, based on the strength of evidence and the feasibility of doctor-promoted change. We identified three strategies for action by busy clinicians: community participation, individual political involvement, and collective advocacy through professional organisations. We made the case that individuals could choose activities – small or large – that suit their own situation and disposition.

In the US the model generated considerable debate, became required reading for many medical training programs, and has been used in a variety of policy documents. In a survey of 1662 American doctors in six specialties, over 90 per cent rated each of community participation, political involvement and collective advocacy as important roles, although fewer than half reported being involved in such activities in the previous 3 years.¹³

Dr John Furler and his team from the University of Melbourne Department of General Practice then explored the usefulness of the model for the Royal Australian College of General Practitioners' policy on health inequalities. They conducted 80 interviews and two focus groups with a range of internal and external stakeholders.¹⁴ To some degree, Australian responses echoed the ambivalence to the concept of social justice observed in the US — public roles were supported when expressed within a familiar framework centred on care

and compassion, but contested when expressed as matters of justice and fairness, particularly if any personal sacrifice was perceived. Their findings highlighted the tensions between the dual responsibilities of professional bodies to the public and to their members, and the importance of leadership from professional organisations in promoting public engagement.

So what can we conclude? First, that both scientific evidence and the relationship between the medical profession, politics and the public are dynamic and inter-related. Second, most doctors now seem to accept that their expertise should include knowledge about social determinants of illness and access to care and that, even when they are not personally involved, it is important that the profession provides a responsible expert voice on such determinants in public debate. Third, public roles are most likely to gain traction among doctors when conceptualised as issues of care and compassion rather than as actions of justice and redistribution. Clinicians want their expertise put to good use in the public sphere in a way that complements rather than detracts from their core responsibility of being expert in the traditional doctor–patient relationship, and the rewards reaped from it. Fourth, a double challenge lies ahead because, while contemporary professional standing may partly depend on public engagement, the effectiveness of such engagement depends, in turn, on how convinced the public is that the profession has its own house in order.¹⁵ And finally, conceptual clarity, realistic expectations and good role models are needed if clinicians are to engage effectively with important public concerns. Teaching about social determinants of health alone is insufficient. To use this information and be effective political agents, future health care professionals will need skills in advocacy and public participation.

“Managers and policymakers have challenged the view that entrenched health problems can be solved simply by more doctors...”

Virchow led an extraordinarily civic-oriented life, as a participant in the 1848 Berlin uprisings and later as a Berlin city councillor, cofounder of the German Progressive Radical Party, and member of parliament. With public-spiritedness and the right tools, modern health care professionals could be both active clinicians and evidence-based advocates on important health related matters in their communities. Virchow would be pleased – medicine would once again be a social science.

Acknowledgements

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*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 (SSSSNTT) 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.

Musical Doctors

Why is there such a strong link between medicine and music?



It's not overly common to hear a surgeon answer a question with a flat out "I don't know", but ask the founder of the Australian Doctors Orchestra (ADO) why there seems to be such a strong link between medicine and music and that is exactly what he says.

And despite some prompting, plastic surgeon Mr Miklos Pohl will not budge. Is it about dexterity? Is it about precision? Is it an antidote to high-level stress?

"I don't know," he says. "We have discussed this question many times and no-one knows. It's not about dexterity because other medical professionals play in the orchestra not just surgeons. It is not about stress relief because preparing for a concert can in fact be quite stressful. The best that we can come up with is that it is a mind thing but what does that mean? It means there is no answer."

But the link does exist, even to such an extent that Sydney University has just established the inaugural Music and Medicine course, the first of its type in the world. Mr Pohl, a violinist and keen amateur chamber musician, set up the ADO in 1993 after attending the Summer School for Strings in the beautiful Victorian high country. While there, enjoying what he describes as his favourite week of the year, he realised he

was not the only medical professional enraptured by classical music. With the support of both professional musicians and members of the medical fraternity he organised the first ADO concert at the Melba Hall in Melbourne.

"We had 76 musicians in the orchestra for that first performance. Since then we have never had fewer than 100 members and at our 10th anniversary concert at the Sydney Town Hall in 2002 we had 170 in the orchestra which was quite ridiculous but great fun," Mr Pohl says.

"The first soloist we had was GP Bill Kimber who received a standing ovation for his performance of Beethoven's Piano Concerto No 3 in C minor."

Since then, the orchestra has even attracted professional musicians to perform as soloists including mezzo soprano Suzanne Johnston, cellist great Janis Laurs and violinist Elizabeth Wallfish.

From the outset, Christopher Martin, a former senior lecturer in strings and conducting at the University of Melbourne, took on the challenge of becoming the ADO's regular conductor and artistic director. Each year, the orchestra meets for three days of rehearsal which culminate in the annual concert which this year is to be held at Bond University on the

Gold Coast in August. The only requirement of orchestra members is that they are trained up to grade six level and are still regularly playing.

Mr Pohl says the efforts of founding conductor and now conductor laureate of ADO Christopher Martin have been largely instrumental in the success of the orchestra, efforts that have not come without some anxious moments.

"For the first ten concerts Christopher Martin chose our music and always got it right which is a pretty amazing feat in terms of satisfying so many concerned and compulsive medicos. And it hasn't been easy, especially at first rehearsals. The first rehearsal is always a bit scary, despite the fact that most of us have learnt the music that was sent out eight weeks before. It often sounds a bit ropery," he says.

"Very quickly, however, it is transformed into something really good by the Saturday afternoon when we rehearse with the soloist. Keith Crellin, our current conductor, is most patient and has a good sense of humour, which is a must when you are trying to control 110 musical medicos. Somehow we manage to satisfy him and he always seems to be smiling at the end of each performance."

Violist Keith Crellin is head of strings at the Elder Conservatorium of Music, Adelaide.



He was a founding member of their original Australian string quartet. Other musical luminaries to lend a hand include Nicolette Frailllon, conductor of the Australian Ballet Orchestra. So successful has the ADO been, that smaller ensembles have devolved out of it, with many states having their own doctor's orchestras or chamber ensembles.

"One of these was originally called Corpus Medicus until someone figured out that actually means body of a doctor so it was changed to Corpus Medicorum," Mr Pohl laughs.

"There is another called Musicus Medicus in Sydney and some of these groups are by invitation only, whereas the mother ship, the ADO, is for every medico who thinks they've got what it takes. And the wonderful thing is that the orchestra allows them to keep playing. I also established a similar orchestra when I was based in London for four years from 2002 to 2006 and that is called the European Doctors Orchestra and is going like a train."

Mr Pohl says that there are now more than 500 doctors and medical students on the database with a "hard core" of players making up about half the orchestra while other players come and go. He says the time away from medicine allows for a strong sense of camaraderie and fun.

"No hierarchy is tolerated in the orchestra, professors sit along side medical students. The ADO also has an extensive cross-section of the medical community participating as players with neurosurgeons, endocrinologists, cardiac surgeons, anaesthetist, general practitioners, psychiatrists and cardiologists all moonlighting as maestros. Yet when we get together there is so little, if any, medical talk that there are often many years of collaborative contact with fellow players before learning of their medical role," he says.

The orchestra donates all the profits from its performances to a different medical charity each year. All players pay a subscription fee and meet all their own costs including travel and accommodation which means that most of the door takings are passed onto the nominated charity.

So far the ADO has raised approximately \$300,000 all of which has been given to a variety of charities such as the Victorian District Nursing Service, the Fred Hollows Foundation, the Malcolm Sargeant Cancer Fund for Children, the Australian Craniofacial Foundation and the Glaucoma Foundation of Australia.

Mr Pohl, who was born in Budapest, Hungary, said his interest in music began early but that he decided that the life of a professional musician was not for him.

"I was singing on a tram in Budapest when a gentleman, who was a professor of music, tapped my mother on the shoulder and told her that I had a good ear and should learn music. Or that at least is what she told me, I was only four so my memory of the incident is not strong," he explains.

But his mother did take the advice and Mr Pohl was encouraged to take up the violin.

"Later, when I was about 15 I decided that I would like to be a professional musician but I am glad I didn't go through with that. It's an extremely tough life. I may have made it as a rank-and-file musician but you have to have real chops to make it as a soloist," he says.

Just recently Mr Pohl has also taken up the viola.

"I bought a new viola when I was in London which was made in Chicago," he says dreamily. It is a beautiful instrument and I am the envy of my section. It is amazing the difference that a beautifully-made instrument makes in that it allows you to make the sounds you dream of making. I have named her Lucille after Lucille Ball."

This year the ADO will be performing at the Bond University on Sunday, 24 August. Conducted by Keith Crellin, the orchestra will play Beethoven's Egmont Overture, Rachmaninov's Piano Concerto No 2 and Holst's The Planets. Next year the ADO will be performing once again in Melbourne, this time at the Melbourne Town Hall with all proceeds to go to the Victorian Cystic Fibrosis Foundation.

For further information on the up-coming concert on the Gold Coast visit the website www.ado.net.au

1. Members of Corpus on top of RMH heliport 2007 2. Libby Wallfisch ADO 10th Anniversary concert 2002 at the Sydney Town Hall 3. Martin at the Melba Hall Corpus Medicorum 2004 rehearsal 4. Mt Buller Summer School for Strings Jan 2008 L to R Anette Martin (Professional Cellist Ret.), Dr Osman Ozturk Anaesthetic Registrar and Concertmaster ADO and Corpus Medicorum, Mr Miklos Pohl/ Dr Rowan Thomas Consultant anaesthetist, Concertmaster ADO & Corpus 5. Christopher Martin, Conductor Laureate of the ADO



Pictured: Graeme Campbell

CCrISP in the Country

The benefits of rural work were highlighted when Bendigo hosted a CCrISP course

Renowned Care of the Critically Ill Surgical Patient course (CCrISP) has been held outside a state capital and in the regional Victorian town of Bendigo.

The director of the course, Mr Graeme Campbell, said the decision was common sense as there were a high number of Bendigo surgeons already involved in teaching trainees.

"We run these courses all over Australia and there is no reason why we can't do it just as well in the country as we can in the city," he said.

"The instructors for the course come from all over Australia but coincidentally half of them are based in Bendigo, and we have the Monash University Centre which is a very good facility."

The course is designed to teach young doctors who are considering a surgical career about the care of critically ill patients.

"One of my aims as a regional surgeon is to encourage young doctors to consider rural surgery as a career," said Mr Campbell

"I cannot overemphasise how much I have enjoyed working in the country; the

range of cases I see on any day has been very stimulating, the drive to work is a breeze - I highly recommend it.

"If doctors have a good experience in the country and they see that the same standard of medicine is practised here as it is anywhere else, then that makes a career in the country very attractive."

The course was supported by Monash and Latrobe Universities and Bendigo Health.

Practising surgeons and senior Trainees make ideal CCrISP instructors. If you are interested, call Rebecca Harris at the College on +61 3 9276 7421.

Tyco Healthcare Travelling Fellowship Grant

The Younger Fellows Committee in partnership with Tyco Healthcare, is pleased to offer two Travelling Scholarships to assist Younger Fellows who are travelling overseas in 2009 to further post Fellowship studies and diversify their surgical experiences.

The inaugural Tyco Healthcare Travelling Fellowship Grants were awarded in December 2006.

The applicant must be a Younger Fellow of the College (within ten years of gaining Fellowship) at the time of submitting their application, who is planning to travel overseas within the next 12 months to further post Fellowship studies prior to returning to Australasia to practice.

The Tyco Healthcare Travelling Fellowship Grants are each valued at AUD\$7,500.

For further information, please contact the Younger Fellows Secretariat, Glenda Webb, on +61 3 9249 1122 or email glenda.webb@surgeons.org

Applications close 5.00pm September 30 2008.

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Leading Gastric Surgeons from Japan and the United Kingdom, and faculty from Australia will address anatomy, pathology, resectional techniques for gastric tumours, and complication.

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- Professor Derek Alderson. Baring Chair of Surgery, University Hospital, Birmingham, UK

The symposium will be of value to all practicing Upper Gastrointestinal Surgeons, General Surgeons and Surgical Trainees. This event should not be missed.

Please visit the ANZGOSA website www.anzgos.org to download the programme for both days.



Barbara West

Hearing Aids for Australian surgeons

Intercultural communication training provides a framework for making sense of a range of human behaviours, including your own

As an intercultural communication trainer, I am often asked to supply lists of hints for working with specific populations, such as Indian nurses or elderly Italian patients. My first response to this kind of request is to ask “Wouldn’t you prefer to learn how to work with both of these kinds of people? As well as with everyone else?” “Yes!” they usually answer and thus I begin with the first lesson to be learned from this particular academic field.... Intercultural communication training is not about providing a list of etiquette rules, historical contexts, and cross-cultural hints. It is not about ‘dos and don’ts’ that the client has to go away and memorise. Without a lifetime of hands on experience, nobody can commit to memory all the cultural traits of a group of people. Instead, good intercultural training provides frameworks for making sense of a whole range of human behaviours, including your own. The most important frameworks are the ten dominant communication styles as well as understanding some central communication channels and cultural values. Training can lead to much greater efficacy when working with cultural others.

A good example of a communication style difference is between linear communication, the norm for native English speakers in most situations, and circular communication, the norm for many Arabic speakers as well as many others. The unconscious expectation amongst linear communicators is that speakers are responsible for making their point in a linear fashion; A leads to B, which leads to C. Circular communicators, however, speak and listen within a very different set of norms. For them responsibility lies not with speakers but with listeners to piece together sometimes complex symbolic stories, metaphors and contexts to understand the unstated point being made.

Neither style of communication is superior to the other. However serious problems arise when linear and circular communicators come together; both assume that the interaction will



follow their own unwritten rules and neither changes the way they hear the other. For example, the linear surgeon who tries to get informed consent from a circular patient may struggle to understand if and when the patient has understood and consented. Instead of saying “Yes, I understand and agree”, the circular patient tells a seemingly irrelevant story. The surgeon then tries again to explain the procedure and is met with an even more complex and symbolic story. Frequently at this juncture the surgeon calls for a translator, assuming a lack of understanding on the patient’s part. However the patient may feel that the problem does relate to their understanding but not to the surgeon’s. In addition to wasting time and resources, this interaction may have eroded the patient’s confidence in the surgeon; amongst circular communicators only children need to have things stated directly and in a linear fashion so the surgeon in this case may appear to have been acting like a child.

Another common problem emerges when direct speaking surgeons communicate with indirect patients, as is the case among many Aboriginal people, Vietnamese and others. In this case, the indirect patient may say ‘yes’ and sign all the relevant forms when asked if they understand a procedure and consent to it. However, afterwards it may emerge that the patient’s agreement was given out of politeness and a desire to be agree-

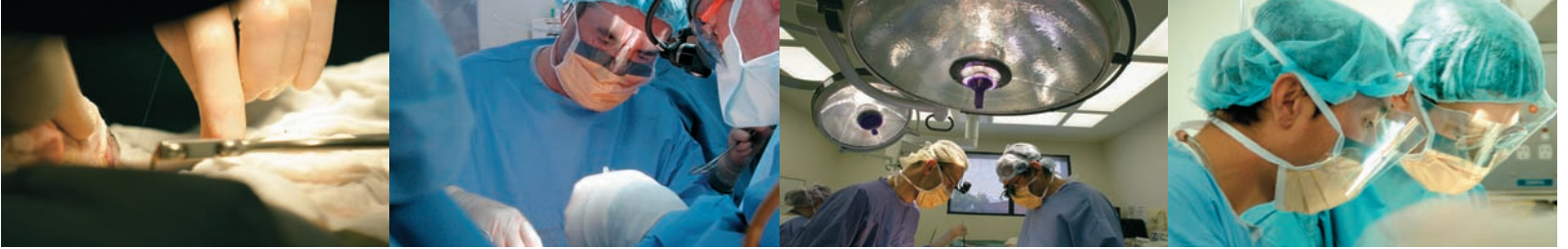
able rather than any true understanding of the procedure or surrounding circumstances. Learning to hear the indirect ‘no’ must become a part of every surgeon’s communication repertoire.

The point of intercultural communication training is usually not to change the way we speak as it generally takes years of practice to become adept at the complex storytelling and metaphor-weaving needed in circular and indirect communication. However, after just a session or two of good intercultural training, most people are able to hear and make sense of not just linear and circular communication but direct and indirect, intellectual and relational, attached and detached, and conceptual and practical communication as well. For surgeons this means that regardless of a patient’s cultural background, they can tune their ears to picking up messages that may from the vantage point of linear and direct communication be extraneous or irrelevant, aggressive or argumentative, but from the vantage point of other styles be perfectly polite and agreeable.

Barbara A West has a PhD in cultural anthropology and a breadth of experience delivering education and training in intercultural communication.

If you want to learn more about intercultural communication, Barbara is facilitating a workshop in Sydney on Wed 10 Sept, 6 – 9 pm. For more information call +61 3 9249 1106 or email PDactivities@surgeons.org.

NOMINATIONS for College Awards



Singular Awards

Award for Excellence in Surgery – Education / Research / Clinical Performance

The Awards may be given for clinical performance, for research or for education and may be made to an individual, a unit or a group.

Criteria for Awards for Excellence in Surgery are:

- The highest level of surgical achievement by world standards;
- Leadership in the field of Australasia;
- Innovation and/or advancement in the field;
- Sustained standard and sustained worth of the innovation;
- The highest standards of surgical ethics.

Companion of the College – Service to the College

The Award of Companion of the College is an honour created to recognise the contributions of a person to the College and to the community through conspicuous continued involvement in:

1. Promotion of the academic purposes of the College or facilitation of those purposes in any particular activity of the College.
2. Fostering the links between the College and other institutions within and outside Australia and New Zealand.
3. Other activities identified by Council on the recommendation of the Awards Committee as significant in the development or promotion of surgical education and/or Surgery.

The award is presented to distinguished persons, scientists and other notable persons.

Court of Honour – Service to the College

Originating in a proposal put to Council in 1973, the Court of Honour exists to both honour its members and provide advice to Council.

Members of the Court will be chosen from those who have shown continuing personal interest in the College. They may include benefactors and past officers of the College.

Sir Hugh Devine Medal – Service to the College

Approved by Council in 1972, the Sir Hugh Devine Medal is awarded for meritorious service to the College and is the highest honour the College can bestow upon a Fellow in his lifetime.

Sir Louis Barnett Medal – Education / Research / Clinical Performance

Established in 1990, the Sir Louis Barnett Medal was deemed by Council to be a signal honour, bestowed on persons who have made outstanding contributions to education, training and advancement to surgery.

Nominations must be received by the Chair of the Awards Committee 6 weeks prior to the October Awards Committee Meeting.

Nominations are called for the following College Awards for submission to the October Awards Committee Meeting 2008.

Nominations for a Singular award must be made accordance with the appropriate policy which can be found on the College website www.surgeons.org



Felix Behan

Letter from Hong Kong: Conjoint Annual Scientific Congress 2008

In the great tradition of Alistair Cooke's "Letters from America" and the more recent comment in a similar vein from our new president Ian Gough when he visited the American College of Surgeons last year, I could not resist writing my own.

I recall fondly Cooke's words on the political, economic and social developments of the day, so eloquently delivered each Sunday evening in his weekly broadcasts, as an expatriate English journalist in the United States. In this story, unlike Cooke, I will touch on some scientific aspects as well. It is interesting to note that following his death in 2004, at the age of 95, some controversy arose regarding Cooke's skeletal remains and their misappropriation.

The background story to this College meeting in Hong Kong is noteworthy. Political tensions had erupted 12 months earlier in relation to a political cadre of the Australian Society of Plastic Surgeons. Last May, on departing from Christchurch, Michael Leung asked me if I would be available to speak. Thanks also to our New Zealand Colleagues a resolution was found. Colin Calcinaï of Wellington, President of the New Zealand Plastic Surgical Society, brokered a trans-tasman agreement. The resultant meeting was quite memorable and the organisational input of Campbell Miles and Lindy Moffat was tremendous. Such overseas meetings should become a regular event in our surgical calendar. Campbell said to me: "Surprisingly, this is one of the best plastic surgical attendances ever." I hope the president is listening.

I arrived in Hong Kong late Saturday afternoon and was bewildered by the enormity of the new airport and by the island city's skyscrapers, which put New York's to shame. We flew into Kowloon, with a descent that wove between the buildings and gave us a view of everything, including laundry. I sought directions and was relieved to fall into the hands

of a courteous young female attendant who phoned the Renaissance Hotel, confirmed my booking and directed me to the bus transfer site. Such courtesy was a highpoint of the meeting.

It is interesting to note that the Monday was a public holiday to celebrate Buddha's birthday. I reflected on the common ground that exists between his teachings and our Western-Christian principles. How travel broadens the horizons (just read Somerset Maugham).

On Tuesday morning at the plenary session the opening ceremony featured the lion dance, a propitious happening for any significant Chinese event. At the convention centre I sat next to Tom Reeve and later spoke to Kendall Francis and Peter Grant. It was quite reassuring to see these distinguished senior personalities still attending the College meeting for its social and professional interchange.

Regarding the trade display, I particularly appreciated the Johnson & Johnson stand with their clinical video clips, which David Speakman and I watched, while queuing for and quaffing cappuccinos of Lygon Street quality. It is interesting to recall cappuccinos are named after the Capuchin monks, with a contribution no doubt from our quadrumanous ancestors the Capuchin primates.

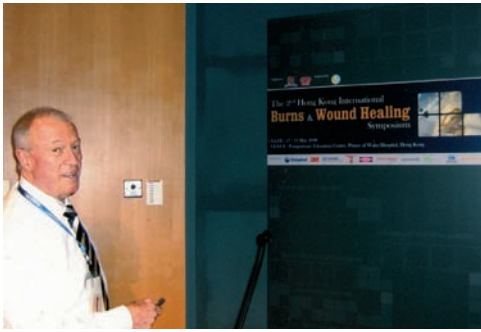
On Tuesday morning I also enjoyed listening to Professor Bill Coman give an outstanding lecture on head and neck oncology, drawing on his international work in Brisbane on the development of a vaccine for naso-pharyngeal carcinoma. Professor Coman mentioned the story of Professor John Kerr of Brisbane, the father of apoptosis or programmed cell death, a word that came from one of his classical Greek associates, Professor James Cormack of the University of Aberdeen. In their 1972 *British Journal of Cancer* publication on apoptosis, they likened the process to the Greek image of a drooping petal or a falling autumn leaf as was

"We enjoyed full silver service with fresh fruit and epicurean desserts"

noted. Since then a story has emerged about a mis-directed Nobel prize. Mark Hinds, a senior research fellow of the of the Walter & Eliza Institute, recounted to me the exact circumstances in which Horvitz, Brenner and Sulston won the 2002 Nobel Prize in Physiology/Medicine; they determined the sequence of the genome of the worm *C. elegans*, detailing the genetics of apoptosis. John Kerr's paper of 1972 preceded this Nobel recognition by 30 years. Some have said he had too few contacts on the selection committee, and coming from the Antipodes may not have helped.

On a social note, lunchtime breaks provided some of the best food at an Annual Scientific Congress I have ever experienced (even as a veteran attendee). It was on a par with New Zealand hospitality. There were no plasticised cartons of sandwiches or pre-packaged, homogenised and pasteurised drinks in cardboard cartons with plastic straws, that universally end up in garbage bins. We enjoyed full silver service with fresh fruit and epicurean desserts.

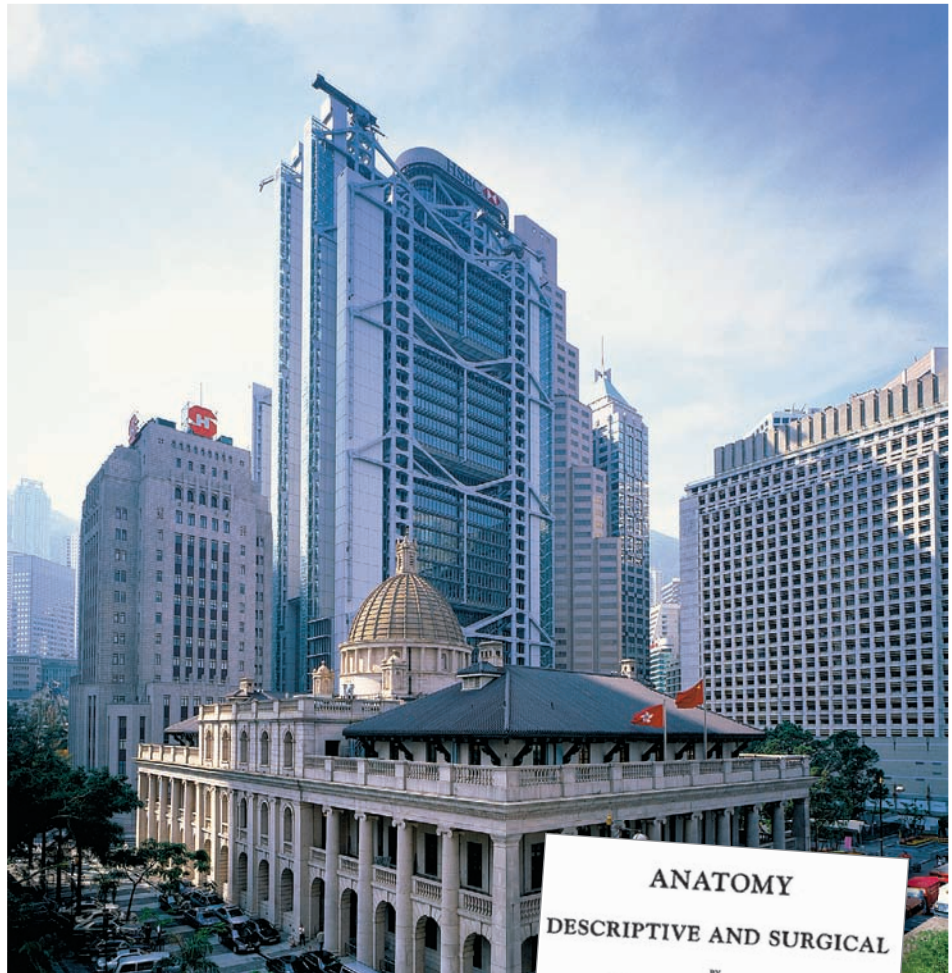
That evening, Brendan Dooley took me to the Hong Kong Club to enjoy the excellent food with some family members. This venue embodied the qualities and style of 19th century elegance, carried through into the 21st century, with red-fabric covered walls adorned with English Impressionist paintings and club chairs finishing off the setting. An interesting little episode occurred in the club when one of the guests came without a tie (as is sometimes seen in the corporate world) and in a most subtle manner one was provided to him – discreetly concealed under a napkin.



On Wednesday, Peter Choong presented a superb scientific dissertation on sarcoma for the Crouch Research lecture. I was forcibly reminded of the Osler statement of the 1890's, that "observation is the basis of all scientific advancement". Peter had observed that the growth of sarcoma in the developing long bones was impeded by the integrity of the growth plate acting as a barrier to tumour spread. He provided a dissertation about its aetiology and research. Afterwards, I spoke to Jonathon Rush and sought his opinion. His response was "Excellent, but dare I say totally over my head." And mine too. This scientific observation reminded me of the aphorism of Oliver Wendell Holmes, that "A moment's insight is sometimes worth a life's experience."

The tradition of sectional dinners is interesting; some turn out good, some bad. At the Hong Kong Jockey Club on the Wednesday evening we enjoyed an outstanding banquet with Moët Chandon and Bordeaux red for this nine-course extravaganza. Colin Calcinaï spoke about our trans-tasman collegiate interchange and the success it brings to our meetings. I spoke with Tony Penington, whose work in preparing talks as a CASC-invited speaker was quite demanding. Sean Hamilton, who also sat next to me, said it had been calculated externally that his commitment as the College's chief examiner in plastic and reconstructive surgery would amount to one-and-a-half days a week. I invited Professor Andrew Burd, the new editor of the *International Journal of Surgical Reconstruction (JPRAS)* to attend so the younger members could benefit from his experience. At the end of the meal, Michael Baldwin and Randall Sachs were still glowing from wine, food and acknowledgement, congratulations to them!

In the plenary sessions on Thursday morning (where the president's lecture, entitled The China Economic Miracle, was presented by Sir Gordon Wu) I was amazed to learn firsthand about the economic development of Hong Kong and the legacy of the 100-year British lease. Sir Gordon described the way in which the island developed and the machinations behind its progress. He mentioned an interesting vignette concerning Lee Kwan Yew, the



driving force behind the success of Singapore. As we know, Singapore is now one of the world's financial centres for sovereign funds. When talking with Chinese Premier Wan Xiao Ping once, Lee said: "We in Singapore are China's poorer relations, and look what we have done – why don't you raise your game?" The Chinese Premier's response was simply "Give us 50 years."

Later that afternoon, David Speakman chaired the Breast Symposium, and Venkat Ramakrishnan (of the UK, who formally worked with Brendan Conventry in Adelaide) gave us yet another excellent presentation on microsurgical breast reconstruction using the DIEP-(deep inferior epigastric perforator) flap. These concepts were really a continuation of his morning master class, which was chaired by Damian Grinsell.

On Friday morning we had a full house for Tony Penington's flap exposition, which was completed by my keystone presentation on melanoma. Sam Mellick talked about the history of anatomy at the University of Queensland, focusing on the importance of anatomical knowledge as the basis for surgery.

As we know, 2008 is the 150th anniversary of the first edition of *Gray's Anatomy*. In the book's frontispiece (Figure 1) the full title, it

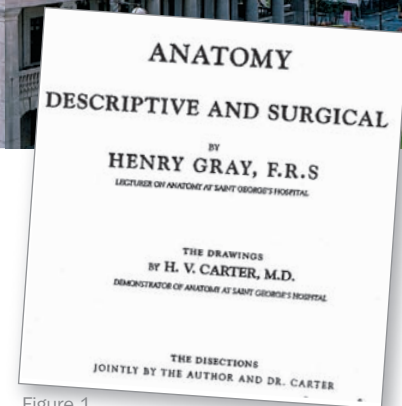


Figure 1

reads "Anatomy - Descriptive and Surgical". It was Sam who directed our attention to the apparent misspelling of "dissection". But as Simon Donahoe observed, you can bi-sect so why cant you di-sect?

On Saturday, Andrew Burd, Professor of Surgery at the University of Hong Kong, asked me to speak at his Wound Management Symposium on the use of the keystone flap. Later that afternoon, I left the new territories after an hour cab ride, barely making it in time to catch the midnight flight to Paris.

In conclusion, the College meetings must be attended for their scientific and social intermix and only our governing body can apply such benefits. The College umbrella must continue as a guide for intracollegiate activity for all specialities. It reminded me of Bruce Barraclough's comment to me in Christchurch last May "It's a great club and it's great to be a member."



Retiring from surgical practice

The range of activities embraced by surgeons in their retirement years is rich and varied

Sailing, painting, photography, travel, writing, flying, music and even competitive sport are some of the endeavours chosen to fill the time once consumed by work. But for some, the siren song of philanthropic medicine sings the loudest. Retired general surgeon Mr Janardhana Rao from Melbourne is one of this number.

Since retiring in 2005 he has taken up the honorary position of Medical Director in charge of four charity hospitals in India that treat the poorest of the poor. Since taking the two-year position last year, Mr Rao spends nine months of the year in his country of origin, with three spent in Melbourne with his children and grand children avoiding the overwhelming heat of a real Indian summer.

While there, he works mainly out of the flagship hospital of the charity group, the Sir Ivan Stedeford Hospital which was established 35 years ago and which treats thousands of patients each year. Located 25 kilometres from Chennai in the state of Tamil Nadu, the hospital was set up by the wealthy Murugappa family who donate one per cent of all the profits earned by their 23 companies to charity.

The only hospital in the region, the Sir Ivan Stedeford Hospital services a population of millions with 80,000 surgeries performed since it was established in 1966. Mr Rao said he was asked to take on the work after the position of Medical Director had been vacant for six months with the specific remit to improve facilities, staffing and medical services. With extensive experience gained over twenty years at St Vincent's hospital in Melbourne working as a trauma surgeon, Mr Rao set to work to establish a desperately needed accident and emergency department.

"Not much money had been spent on the hospital for almost a decade so there was much to be done. When I first arrived, there was no emergency out-patients service and the hospital closed its doors each day at 4.30pm even though scores of patients needed medical and surgical help from traffic accidents, fractures,

general medical emergencies," Mr Rao said.

"So my first challenge was to set up an A and E department with ten beds. The second job was to improve the Intensive Care Unit which was badly run down and poorly managed so I established a high dependency ward of eight beds with air conditioning."

To improve staff skills, Mr Rao then invited US intensivist Dr Ramakrishnan, who had previously set up a training college in the region five years previously, to return to provide Intensive Care training to the staff. Mr Rao has also begun not only training surgeons in laparoscopic surgery but has dramatically improved their pay and consequently the number of doctors working at the 200-bed multi-specialty hospital.

"When I first arrived, there was no emergency out-patients service and the hospital closed its doors each day at 4.30pm..."

"When I first took up this position there were only 38 doctors working there which was significantly less than what was needed. I spent considerable time negotiating for an increase in salaries to bring them up to the level offered at other hospitals and now we have 80 doctors and surgeons on staff," he said.

"Before we were conducting only 160 surgeries a month, but now that is up to 500 not only because of the increase in staff numbers but because I am prepared to support and encourage the surgeons to take on more complex cases than was done previously."

Mr Rao said his current project was to secure funding to construct four new theatres to replace the three run down theatres currently being used. Now that some of the most pressing issues confronting the hospital have been

dealt with, Mr Rao is seeking to develop training and research links with Australian organisations as well as asking for equipment no longer needed here but desperately required there.

"This hospital provides a very good opportunity for young Australian and New Zealand Fellows to increase their skills after training because of the variety of cases presented there. Some of these cases would never be seen in Australia in terms of advanced disease, tumours and cancers, because patients there don't go for medical care until they are very sick.

"We also have one of the busiest obstetrics and gynaecology departments in the region with up to 6000 babies born there each year but at the moment all that cord blood is thrown into the bin.

"I believe that represents a great opportunity for anyone interested in stem cell research and there is no reason why we could not set up a collaborative research project if such interest was made known to us.

"A few hospitals in Australia have also shown great generosity and provided such equipment as defibrillators and sterilising equipment.

"Now I am in search of a CT scanner and when I go back I am hoping to set up a dialysis unit. We see up to 250 diabetic patients every day but at the moment we cannot offer them dialysis. All our patients are totally poor, often they can't afford more than one meal a day and it is heart-breaking that they are simply sent home to die."

Mr Rao, who was the Victorian Honorary Consul General for India for more than 20 years, has two sons, one of whom is a urology surgeon currently training in robotic surgery at the All India Institute of Medical Sciences in New Delhi. He said that he has found the work in India, for which he receives no pay, hugely satisfying.

"The philosophy I follow is that service to humanity is service to God," he said.

"It gives me great satisfaction to help these people and is much better than sitting around in retirement with nothing to do."



Cowlshaw Symposium

SATURDAY 1 NOVEMBER 2008

THE HUGHES ROOM AT THE COLLEGE IN MELBOURNE

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SAM MELLICK, WYN BEASLEY, PHIL SHARP,
MARIUS FAHRER, GRAHAM SERPELL,
DONALD SIMPSON AND ALAN THURSTON

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VOLUNTEER CLINICAL INSTRUCTORS REQUIRED

to travel to the Northern Territory

For the last three years, the College, with funding assistance from the Australian Government, has been providing much-needed training and supervision to medical personnel in remote locations in the NT. Through the PROSPECT project (Providing Remote On Site Skills, Procedural Education and Clinical Training), the RACS supports 'clinical instructors' in visits of up to four weeks duration to hospitals in both Gove and Katherine. The focus of the training provided by the Clinical Instructors is for hospital medical officers, although a wide range of staff typically find the visits and sessions valuable, including nurses, medical students, local GPs and Aboriginal health centre staff.

A large proportion of patients in Gove and Katherine are Indigenous patients who can present with advanced morbidity. Major trauma and other life threatening emergencies need stabilisation before aerial evacuation to Darwin. The Clinical Instructors may provide assistance in such cases but focus on leaving behind the skills needed for the HMOs to cope on their own. Minor procedures, including some under general anaesthesia, are frequent and such cases are a prime focus on the training programme. Many women present in labour with co-morbid chronic illness, often having no antenatal care.

In the absence of the PROSPECT programme, local doctors carry out this demanding work with no supervision and little scope for consultation. Clinical teaching, supervision and advice provided by the clinical instructors is warmly welcomed throughout the hospitals.

Would you like to become a PROSPECT Clinical Instructor?

For further information contact the Project Officer,
Monique Whear on (+61 3) 9249 1259
or email, monique.whear@surgeons.org



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Robert Davies

Steps to learning

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

It 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



Finlay MacNeil hands out toys on a ward round



Australian surgical team



The Paediatric ward at Sa Dec Hospital



Charles Chabert demonstrates laparoscopic renal surgery



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 bureaucratized 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

Hospira - Major sponsor for provision of equipment and funding for scrub nurse
Olympus - Other major contributor

Other Contributors

Mr Andre Lalak (Storz endoscopic equipment)
Mr Howard Lau (laparoscopic equipment and trochars)
Dr Sue Chapman (percutaneous nephrolithotomy equipment)
Mr Sydney Weinstein (flexible cystoscope and light source)
The late Mr Antony Low (rigid cystoscope/resectoscope set)
Concord Repatriation General Hospital (scopes and disposables)
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)

THE GARNETT PASSE AND RODNEY WILLIAMS MEMORIAL FOUNDATION AWARDS FOR 2009

PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2009.

Project Grants are for a period of up to three years and must be conducted in an Australian or New Zealand university, teaching hospital or research institute. Individuals with a previous history of support from the Foundation are particularly encouraged to apply. Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2009, is ineligible.

The annual level of support will be up to AUD100,000 and, within this cap, grants must include the salary of the applicant and/or research assistant(s), on-costs, maintenance, equipment and all other costs. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 29 August 2008

GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2009.

Grants-In-Aid are for a period of up to two years and must be conducted in an Australian or New Zealand university, teaching hospital or research institute. Otolaryngologists or Trainees in the Specialty who are in possession of the First Part of the FRACS are eligible to apply. Please note that a current awardee whose fellowship, scholarship or grant is due to conclude after 30 June 2009, is ineligible.

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

Closing Date: 29 August 2008

Further details concerning the above awards together with the current application forms can be obtained from:-

The Secretary
The Garnett Passe and Rodney Williams Memorial Foundation
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Royal Australasian College of Surgeons

NEW ZEALAND ANNUAL SCIENTIFIC MEETING

Convention Centre, Palmerston North, New Zealand
Wednesday 27 - Friday 29 August 2008




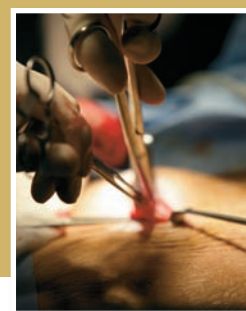
Invited Speakers Include:
James Church, Colorectal Surgeon, Cleveland Clinic, USA
Professor Bruce Mann, Surgical Oncologist, and Breast Surgeon, Sydney, Australia
Professor John Windsor, Upper GI and HPB, Auckland, NZ

Call for Abstracts:
Abstracts must be submitted online via the conference website.
Please refer to submission information on the website

Abstract Submission Deadline	16 June
Early Bird Registration by	25 July
Online Registration by	20 August

If you require any further information please contact:
Medical Industry Association of New Zealand, PO Box 8378, Symonds Street, Auckland





Hugh Bartholomeusz,
Secretary, Australian Day
Surgery Council

Australian Day Surgery Council Update

Day surgery definition -

all procedures/surgeries, excluding services normally included in an attendance (consultation) not requiring observation in a hospital bed, where the patient would be expected to leave the facility within 24 hours

Since the establishment of the Australian Day Surgery Council (ADSC) in 1980, the ADSC has continued to promote and advise on standards in day surgery in Australia. With the support of its parent bodies (the Royal Australasian College of Surgeons, the Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists) the ADSC produced *Day Surgery in Australia* (2004), currently the only publication available with definitions, guidelines and recommendations for high quality and standards for day surgery in Australia.

The ADSC believes and promotes multi disciplinary education to ensure that quality day surgery practice, professional service and patient care is kept at the highest standards. In keeping with this ideal, the membership of

the ADSC incorporates specialities, nursing groups and practice manager groups involved in day surgery. The ADSC advises day surgeries and potential day surgery operators on all challenges pertaining to day surgery.

Day surgery is often overlooked by governments, jurisdictions and accreditation agencies, who assume that problems and issues associated with day surgeries are similar to those facing hospitals. Issues including safe and quality patient care, emergency medical transport, informed consent, admission and day surgery design all pose different challenges for day surgeries.

The number of day surgeries has increased greatly since the publication of the *Day Surgery handbook*. Day surgery should prove to be one of the vital services to reduce the problem of surgical waiting lists. The potential of day surgery is enormous. The ADSC will continue to promote and advise on day surgery standards, and have an expanded role in education and advise on all aspects of day surgery in Australia.

Advances in technology and new techniques in medical care have increasingly integrated surgical and therapeutic procedures. Rapid and continuing technological and therapeutic development over the past ten to fifteen years, together with the introduction of extended (overnight)

recovery for day surgery patients, is expanding the number and range of operations which can be carried out as day surgery. It is now predicted that up to 80 per cent of all elective surgery/procedures will be carried out as day surgery and it is imperative that high standards of quality and safety of patient care in day surgery be maintained for this expanded range of operations.

To address the exciting challenges and advances in day surgery, the ADSC met in April 2008 to draft a new strategic plan which was approved by the ADSC in June 2008. The strategic plan is currently with the parent bodies for final approval. The ADSC is excited about the new strategic direction, which will position the ADSC to become a more proactive voice to government and accreditation agencies, with the support of our parent bodies.

To address the need for ongoing education in day surgery, the ADSC will also be hosting the 2009 International Congress on Ambulatory Surgery in Brisbane. We invite all Fellows involved and interested in day surgery to attend what will be an exciting and informative conference on the future and potential of day surgery.

Further information, including registration can be found at the congress website: www.iaascongress2009.org.

Notice to Retired Fellows of the College

The College maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College.

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve.

We will acknowledge your donation and place your name on the gown, if you approve. If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.

Alternatively, you could mail the gown to Jennifer C/o the Conferences & Events Department,
Royal Australasian College of Surgeons, College of Surgeons Gardens, 240 Spring Street, Melbourne 3000.

The College would like to acknowledge Dr Annabel Carney for generously donating her late father's gown, Mr Leonard Pellew

2008/2009 Rowan Nicks Australian & New Zealand (ANZ) Scholarship



RACS - The College of Surgeons of Australia and New Zealand invites suitable applicants who are citizens of New Zealand to apply for the 2008/2009 Rowan Nicks ANZ Scholarship. Rowan Nicks Scholarships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country in their chosen surgical speciality area.

The 2008/2009 Rowan Nicks ANZ Scholarship is offered to a surgeon from New Zealand to take up the scholarship in Australia. The scholarship is intended to provide an opportunity for the surgeon to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The scholarship is not only a personal award but is planned to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base. The scholarship will be awarded for any period up to a maximum of twelve months.

Applicants should be under 45 years of age and have completed the FRACS. As the scholarship is for training within Australia if the applicant has a sponsor in Australia and or wishes to work in a specific centre, this will be considered by the selection committee. Applicants must undertake to return to New Zealand on completion of the scholarship program.

APPLICATIONS MUST INCLUDE THE FOLLOWING:

1. Cover letter that outlines intended program and any sponsor in Australia if such exists (this is not obligatory)
2. CV
3. Copy of basic medical degree and Fellowship

FORWARD APPLICATION TO:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
College of Surgeons' Gardens
Spring Street Melbourne VIC 3000 Australia
Email: international.scholarships@surgeons.org
Phone: + 00 11 61 3 9249 1211
Fax: + 00 11 61 3 9276 7431



Written: Reginald Magee
Pictured: Frank Stansfield

The anatomy student's saviour

Remembering Frank Stansfield and his famously successful cramming courses

In the 1950s and 60s, many aspiring surgeons went to England to obtain a surgical qualification and experience. The first hurdle to be overcome was the Primary Fellowship examination of the Royal College of Surgeons. Although the Colleges in London and Edinburgh had organised courses, many candidates sought additional help with tutorials. In London, Frank Stansfield and David Slome conducted tutorials in anatomy and physiology, intensive cramming courses that were reputed to have 80 to 85 per cent pass rates. In their earlier years they were held in what was described as a fetid basement room near St James's Park tube station. But in later years, anatomy classes were held in St Mary Abbot's Church hall in Kensington Church Street.

Frank Stansfield was born on August 4, 1910, at Nelson, Lancashire, the only son of a successful cotton manufacturer. He was educated at Sedburgh school and then entered Downing College Cambridge as organ scholar. He read Natural Sciences and gained his BA in 1932. His medical education was at The London Hospital Medical College, graduating MA B Ch in 1936 and MB in 1937. He was senior demonstrator in anatomy at the London Hospital from 1937 to 1939.

During the war he served in the Royal Air Force as squadron leader in the medical branch. After the war he became senior lecturer in anatomy in the Institute of Basic Medical Sciences at the College of Surgeons and also Bland-Sutton lecturer, arnott demonstrator and examiner in anatomy for the Conjoint Board and for the Faculty of Dental Surgery.⁽¹⁾

At the College, Stansfield gave formal lectures and tutorials along with the other lecturers Professor Causey, Professor R. J. Last and Dr Livingstone. However, his style in the tutorials at Kensington was more relaxed. The session would start with a quick revision of the content of the previous one. He knew his students and would name themselves as he threw his questions around – Reg from Brisbane, Vernon from



Liverpool, David from Wagga Wagga, etc. His method of teaching was to use line diagrams (and there were hundreds of them) to illustrate anatomical features. He would go to the board, draw a line and say "Draw that." This would be followed by a statement such as "Anyone can draw that" or "A policeman could draw that" or "If you can't draw that, that's a pity". A couple more lines would be drawn, the labels added and there would be the triangle of Marcille. If the examination question was to describe the anatomy of the psoas muscle, the fifth lumbar vertebra or the ala of the sacrum, Stansfield would say "draw that diagram". A number of different areas would be covered in a session – the lumbo-sacral area, the root of the neck, the digastric triangle, the middle cranial fossa – all accompanied by simple line diagrams. Not only did one learn the anatomy, but also how to deal with questions that involved junctional areas such as the first rib or the twelfth rib. Other little snippets of information would be added as well, such as ossification centres, some of which were grouped together as "well-behaved secondary centres".

Stansfield also knew the examiners, their quirks and their favourite questions. "If Sir Gordon Gordon-Taylor is the examiner and asks to be shown the hypoglossal nerve, go to the body, make sure he is watching, lift up the posterior belly of the digastric muscle and demonstrate the nerve. Do that and he will smile," he would say.

Among the interests of Frank Stansfield were railways and anything to do with them.

They even entered his anatomy teaching – when talking about the brachial plexus he would refer to the branching of the trunks and cords as sets of points. If you mentioned that you wanted to go to a particular destination he would instantly tell you which station to go to, the times the train departed and which half of it to take should it divide at some point along the way. He was one of the few people who held a first class go-anywhere rail ticket.

Another interest of Stansfield's was the organ. Years after being a scholar at Cambridge he continued to play. On Sunday afternoons he would play for a service at St Mary Abbot's Church, Kensington. Following the service, he would go for a train ride.

The memory of Frank Stansfield will live forever in the minds of all those who were taught by him. For some, he was the last hope in passing anatomy for the primary fellowship examination and they are indebted to him for their success. His encyclopaedic knowledge, witticisms and sayings such as "Why do I teach this? Because it's asked" and "How much do you need to know of this? As much as I tell you" are well remembered. For answers that deviated from the facts, he would reply "That is positively grotesque" or "Uxbridge", which originated from his time in the RAF, or even "You are anticipating backwards and retrospectively the future." These sayings won't be forgotten by those who sat in his classroom. In his office, Stans had a statue (similar to the one illustrated) of an ape contemplating a human skull. One could describe it as a cynical reversal of roles in the study of anatomy.

Frank Stansfield was elected a Fellow of The Royal College of Surgeons of England in 1971. He continued his teaching until the time of his death on October 3, 1981, aged 71.

A truly great teacher.

Reference

(1) *Lives of the Fellows*. Royal College of Surgeons. Pps. 377-8



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For further information contact:
Administrator ACSC
Phone: +64 9 373 7599, ext 89304
Email: acscadmin@auckland.ac.nz

Registration
Registration is inclusive of GST & closes on 30 September 2008.
Specialist with Nurse \$2,812.50
Please contact our Administrator if you wish to attend but cannot bring your nurse with you.
A course manual, full catering and course dinner are provided.
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RECOMMENDATIONS FOR THE USE OF SENTINEL NODE BIOPSY IN EARLY BREAST CANCER

National Breast and Ovarian Cancer Centre has released Australia's first clinical practice recommendations for the use of sentinel node biopsy in early (operable) breast cancer.

Sentinel node biopsy eliminates the need for axillary clearance in the 70 per cent of women with early breast cancer who have no evidence of cancer spread to the lymph nodes, thus reducing the risk of lymphoedema in these women.

Developed by a multidisciplinary working group under the guidance of Chair Dr Neil Wetzig, the guideline is relevant for the team of health professionals involved in the treatment of women with early breast cancer. The guideline recommends that sentinel node biopsy should be offered to women whose breast cancers are 3cm or less in diameter, as an alternative to axillary clearance.

The guideline has been endorsed by The Royal Australian and New Zealand College of Radiologists (Faculty of Radiation Oncology), The Royal College of Pathologists of Australia and The Royal Australasian College of Surgeons. The guideline has also been endorsed by the peak national organisation for Australians affected by breast cancer, Breast Cancer Network Australia.

To download or order the sentinel node biopsy guideline, visit www.nbooc.org.au/resources or call 1800 624 973.

Secondary lymphoedema resources now available

National Breast and Ovarian Cancer Centre (NBOCC) has developed a suite of new resources to improve the treatment and support of all cancer patients affected by secondary lymphoedema, funded by an Australian Government grant.

It is estimated that approximately 20 per cent of survivors from breast, melanoma, gynaecological or prostate cancer will experience lymphoedema as a result of cancer surgery or radiotherapy. This equates to more than 8000 new cases each year in Australia.

Despite the prevalence of the condition, there has previously been limited evidence-based information to support people affected by secondary lymphoedema or to guide health professionals involved in the diagnosis, treatment and management of the condition.

Following a literature review and consultation process, NBOCC has released a range of evidence-based resources including:

- ▶ *The management of lymphoedema: a guide for health professionals* – to support health professionals in the assessment and management of people who may develop lymphoedema after treatment for cancer.
- ▶ *Workshop training modules* – for health professionals and Indigenous health workers, including an online learning module for rural and remote practitioners.
- ▶ *A range of consumer resources* – including an information leaflet and booklet for people at risk or diagnosed with secondary lymphoedema. The resources have been translated into Arabic, Chinese, Greek, Italian and Vietnamese and a culturally appropriate version is available for Indigenous Australians.
- ▶ *An evidence review* – on the incidence, prevention, risk factors and treatment of secondary lymphoedema.

To download or order the lymphoedema resources, visit www.nbooc.org.au/lymphoedema or call 1800 624 973.

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Katherine Edyvane

Cuban doctors in East Timor

A story of the humanitarian drive of Cuba, which is their sincere desire to help those less fortunate

Few are aware that every year, Cuba, a third world nation of only 10 million people, sends more than 30,000 volunteer doctors and other health workers, to work in 93 countries around the world. Many work in Central and Latin America, the Caribbean and Africa. More recently Cuba has been sending doctors to Pakistan and the Asia-Pacific area, including over 300 to East Timor. Later this year it plans to send doctors to Papua New Guinea, and other Pacific nations.

Although I had previously met Cuban medical workers in other international medical aid situations, it was during a recent one year assignment as long term surgeon advisor to the Dili National Hospital, in the Australia Timor Leste Program of Assistance for Specialised Services (ATLASS), which is funded by AusAid and managed by the College, that I learned more about the scope and intent of Cuba's huge and ongoing medical aid effort.

In November 2007 I was fortunate in being part of a Timorese Ministry of Health team evaluating the 30-bed district hospital in the remote Timorese district of Oecussi. A district so remote that the only access route for the average Timorese is a once-a week 12 hour ferry trip from Dili. As part of our evaluation, I spoke to Cuban doctors, who were the only doctors staffing the hospital and the outlying remote clinics in the mountains. From them I heard, first-hand, of their tremendous work and extreme hardships.

I spoke to one young 25 year-old GP, who for the last two years had lived and worked in a clinic in a mountain village eight hours walk from the local hospital. The young doctor spoke of the many un-well patients he had seen. Patients, many children, suffering from malnutrition, gastroenteritis, pneumonia, TB, hepatitis, malaria, and surgical problems like hernias, appendicitis, peritonitis, and advanced malignancies such as breast cancer. While he

was able to treat many of the patients with infectious diseases, he felt helpless with those that needed in-hospital treatment or surgery.

The young doctor's living conditions were also difficult, but remarkably he did not complain. He lived in a small room attached to the clinic, with a single gas burner stove, electricity for only four hours in the evening, meaning no fan or air-conditioning for the oppressive tropical heat, no screens for insects other than a mosquito net over the bed, and no television. For transport, there was a single mini-van for the 30 Cuban doctors in the district of Oecussi.

“There can be no doubt that the Cuban doctors in Timor are more adapted to the difficult living conditions in Timor Leste than would be most Western medical missions.”

There was also the 50 year-old Cuban intensive care specialist, who worked at the Oecussi district hospital. While he had experienced similar difficult living and working conditions, his only complaints were of cultural isolation and being homesick. He lamented that in the last two years he had not gone to a good party with rum, music and dancing and feared for his sanity.

There can be no doubt that the Cuban doctors in Timor are more adapted to the difficult living conditions in Timor Leste than would be most Western medical missions. A fact, which partially reflects their own difficult living conditions back home in Cuba, where the average Cuban doctor earns only \$20-30 USD per month, and is an important motive

for why so many Cuban doctors choose to work overseas. Currently, Cuban doctors in Timor Leste are paid \$200 USD per month, by the Cuban Government, and at the completion of a standard two-year term there is also a \$4,000 USD bonus. The Government of Timor Leste contributes to the mission by way of accommodation, transportation, phone cards and food rations.

Over the years I have asked many Cuban doctors about their motives for volunteering to work in places like Timor Leste. The reasons cited are: economic, humanitarian and to gain more clinical experience. Given that thousands of Cuban doctors are trained each year in a country of only 10 million it is perhaps not surprising that most new medical graduates have had little patient contact and specialists feel the need for more clinical exposure. And whatever one may feel about the politics of the government of Cuba, the humanitarian drive, which motivates many Cuban doctor's is undeniable: I am constantly impressed by their sincere desire to help those less fortunate.

Cuba's large medical workforce

The history of Cuba's large medical workforce begins in 1959, when at the start of Fidel Castro's revolution most of its doctors fled to the USA, and by necessity it had to train a large number of it's own doctors. Since that time the government has strongly focused on developing and maintaining a first-class universal health care system and actively encouraged it's youth to pursue training in the health sciences, putting no restrictions on the number of doctors it trains per year. As a consequence Cuba now has the highest number of doctors per capita in the World: in 2005 it was one doctor for every 159 people.

With the forging of strong ties with other countries, sometimes with no pre-existing diplomatic relations, Cuba has helped many

in it's region and around the world, by sending them much-needed doctors, and by training medical students from these countries in Cuba. In 2005 there were 12,000 medical students from 83 countries studying medicine in Cuba, all on scholarships paid for by the Cuban Government, and 1,600 new doctors from overseas were graduated.

Furthermore, in the next 10 years, Cuba intends to "up scale" it's efforts and train a further 10,000 per year or 100,000 doctors. To put this into some perspective, Australia with it's current population of 21 million trains ~1500 new doctors per year.

While many of the foreign students in Cuba are from Central and South America, the Caribbean and Africa, the list also includes 60 Hispanic and African-American students from the USA, who cannot not afford the fees of the mostly private medical schools. Since 2005, Cuba has also begun training students from Pakistan (1000), East Timor (700), and the Soloman Islands (25).

According to Fidel Castro, the driving force behind Cuba's expanding international medical workforce is solely humanitarian, saying that while many other countries direct their economies at becoming military super-powers, Cuba aims to become a humanitarian medical superpower. He also denounces the "plundering" of the many doctors from poorer Third World countries, who now work in the First World.

Cuba and Timor Leste

The influence of Cuba on Timor Leste dates back to at least 1975 when Indonesia invaded Timor Leste, nine days after it proclaimed it's independence from Portugal. During the next 25 years of Indonesian occupation, the Timorese resistance movement based much of its socialist ideology and guerrilla warfare tactics on Fidel Castro's revolutionary struggle many years before. →



Dr Eries, Cuban Anaesthetist & Lucia, Cuban nurse anaesthetist with a new born



Dr Ivan, Cuban Oromaxillo facial surgeon, Katherine & Ernesto, a Timorese nurse technician, operating on a young man with an arrow to his face

Fellows in the News

“Later this year, Cuba will also be sending its first doctors to Papua New Guinea, the Soloman Islands, Vanuatu, Kirabati, Tubalu and Nauru”



Chief of Brigade, Dr Alberto Chief & plastic surgeon of Cuban Medical Brigade to Timor Leste outside the home of the Cuban doctors



Post surgery on a neonate with Hirschsprungs disease Lucia, Katherine & Armano, Timorese nurse anaesthetist

Indeed, nowhere is the influence of Cuba's revolution on Timor more apparent than in the famous photograph of Ernesto “Che” Guevara (the legendary Argentinean doctor and guerrilla fighter who fought with Castro in Cuba). His image (of a handsome bearded revolutionary wearing a beret) was, and continues to be, a symbol for the Fretilin party. Anyone travelling to Timor today will be amazed at the sheer number of murals and T-shirts of Che throughout the country.

Cuba's actual physical involvement in Timor Leste began in 2003 when President Xanana Gusmao and the then Foreign Minister Jose Ramos Horta met Fidel Castro in Kuala Lumpur (at the meeting of the Movement of Non-Aligned Nations). Faced with a critical shortage of doctors in Timor (most of the previous doctors were Indonesian) Castro offered assistance in the form of Cuban doctors and 50 scholarships for Timorese to study medicine in Cuba. Since then the number of scholarships on offer has risen to 1000, with an estimated 700-800 Timorese students presently studying in Cuba. The first medical graduates are expected to return to Timor in 2011-2012. A small number of medical

students (<50) are also being trained in Dili using the so-called “university without walls” model, a Cuban-devised community-based training program (currently there are students in years one-three).

Cuba first began sending medical teams to Timor in early 2004, culminating in its largest contingent in 2006 comprising about 300 doctors, and numerous nurses and allied health professionals. Given that more than 80 per cent of the population of Timor Leste reside outside the major cities of Dili and Baucau, by far the most important contribution the Cuban medical mission has made to Timor Leste has been in its long-term provision of medical services to the remote areas of the country. No other country sending medical aid has had the medical manpower to achieve a similar feat.

Over the last two years they also have provided essential medical services to the country's main referral hospital, the Dili National Hospital, contributing ~20 specialist doctors or ~70 per cent of the medical staff. By comparison, the Australian Government, currently contributes three doctors (two College surgeons and one anaesthetist), all

of whom work at the National Hospital. It also assists in the organising of 10 one-week visits per year by teams of volunteer-specialist surgeons. There is also an Australian Military Hospital in Dili, which serves the Australian security forces.

The future of Cubans in the Asia-Pacific region

In 2011-2012, about 700 Timorese medical graduates trained in Cuba will be returning to Timor Leste, and the government of Cuba has said that it intends to continue its medical mission to Timor for another 10 years. Later this year, Cuba will also be sending its first doctors to Papua New Guinea, the Soloman Islands, Vanuatu, Kirabati, Tubalu and Nauru. For Australia, which has long had a small but significant medical presence in these countries, the challenge will be to how it should best work with this enormous workforce of doctors.

Katherine Edyvane is a general surgeon from Fremantle, Western Australia. She has worked and visited Cuba on many occasions and worked with Cuban doctors in Pakistan and East Timor.

Thank You



photo courtesy of Ellen Smith

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AE3653_RACS 06/08



Keith Mutimer,
Honorary Treasurer

A set of lancets

The lancet has appeared in many forms throughout history, they were often often made of precious metals

The lancet, the classic venesection instrument, is one of the oldest and most basic of surgical tools. It has been in use for thousands of years in many civilisations, from Egypt to China. It has appeared in many forms throughout history, but the modern type is just a sharp point held between two tortoise-shell guards. Widely used in bloodletting (phlebotomy) for many centuries, the lancet became an essential piece of equipment, which no physician or surgeon could be without. Lancets were carried everywhere, tucked in travelling cases which though small, were often very elaborate and made of precious materials. The great period of lancet use and manufacture was the 18th century.

The set in the College's collection dates from the 18th century, and consists of six lancets in an étui, a small travelling case. Five of the lancets are original, and one is a 19th-century replacement. They are all in excellent condition. The étui is a tapering case, designed to fit in the pocket, with a hinged lid at the

broader end. This one is made of wood and covered in shagreen, or tanned sharkskin, the most favoured material for these cases in the 17th and 18th centuries. Attached to the lid is a silver plaque engraved "G. Leonard 1773".

Kenneth Cabrera FRACS was born in 1932 in Sydney. He graduated MB BS from the University of Sydney in 1956, and the set of lancets was given to him on that occasion as a graduation gift. He gained his FRCS in 1962, and was admitted a Fellow of this College in June 1964 (No.1798). In this same year he moved from Sydney to Adelaide. Having trained in general surgery, he moved on to orthopaedics, and on settling in Adelaide became Orthopaedic Registrar at the Royal Adelaide Hospital. The Clinical Skills Laboratory, part of the Orthopaedics & Trauma Department at the University of Adelaide, is named in his honour. In 2005 his wife Eleanor presented the set of lancets to the College in his memory.

Written by Geoff Down



Solutions to New to Council acronyms

From page 7

RACS The Royal Australasian College of Surgeons
GSA The General Surgeons Australia
NZAGS The New Zealand Association of General Surgeons
AOA The Australian Orthopaedic Association
NZOA The New Zealand Orthopaedic Association
ASPS The Australian Society of Plastic Surgeons
NZAPS The New Zealand Association of Plastic Surgeons
NSA The Neurosurgical Society of Australasia
USANZ The Urological Society of Australia and New Zealand
ASCTS The Australasian Society of Cardiac & Thoracic Surgeons

AAPS The Australasian Association of Paediatric Surgeons
ANZSVS The Australian and New Zealand Society for Vascular Surgery
ASA The Australian Society of Anaesthetists
AHSS The Australian Hand Surgery Society
SSA The Spine Society of Australia
TSANZ The Transplantation Society of Australia and New Zealand
AKS The Australian Knee Society
FRACS Fellow of the Royal Australasian College of Surgeons
ANZ The Australia and New Zealand
ANZCFS The ANZ Cranio-facial Society



Congratulations on your achievements

Associate Professor Peter Woodruff – Court of Honour

Associate Professor Peter Woodruff was admitted to the Court of Honour during the CASC in Hong Kong 2008 in recognition for his contribution and continuing personal interest in the College.

Peter Woodruff is a vascular surgeon in Brisbane. He is currently the serving President of The Australian and New Zealand Society of Vascular Surgery.

Peter was born in Mackay and was educated in Melbourne and Adelaide. He commenced surgery in Aberdeen, Scotland, and then had two years of additional training in Boston, USA. Peter returned to Australia and joined the Royal Brisbane Hospital as a Senior Lecturer in Surgery – a general surgeon with a special interest in vascular surgery. He then became involved with renal transplantation – an area of interest that has continued throughout his surgical career. In 1977, he moved to Princess Alexandra Hospital in Brisbane to participate in the development of a specialised vascular unit becoming Director of Vascular Surgery at that hospital in 2004.

Peter was elected to the Council of the College in 1997 having been Chairman of the Queensland State Committee and President of the Australian Association of Surgeons. He served the College as Honorary Treasurer and then Vice-President of our College. As Treasurer he instituted a number of reforms that continue to benefit the fellowship to the present day. As Vice-President he oversaw the changes to Council structure that resulted in each of the surgical specialties being represented by Councillors with full voting rights.

As a surgeon, teacher, mentor, loyal servant of the College and representative of surgeons in general, Peter Woodruff is deserving of respect and admiration for his efforts and his achievements. His admission to the Court Of Honour is entirely deserved.

Dr Randall Sach - ESR Hughes Medal

Dr Randall Sach was awarded the ESR Hughes Medal in 2008 in recognition of his distinguished contributions to surgery.

Randall Sach was admitted as a Fellow (Plastic Surgery) of the Royal Australasian College of Surgeons in 1979. He has had numerous papers published and has presented papers at various scientific conferences during his years as a surgeon.

Randall has been involved in the College and the Australian Society of Plastic Surgeons (ASPS) for over 20 years. He is the past President of the ASPS and was on the College Council for three years. He was a member of the Court of Examiners and is still active in educating trainee surgeons as a supervisor and lecturer.

One of his most notable achievements has been his involvement in the Australian Day Surgery Council (ADSC). He has been a member of the ADSC for eight years, Secretary for two years and Chair for four years. As the Chair, Randall has proved a proactive leader and successfully steered the ADSC in finalising the ADSC Charter.

As an important body for upholding the standards of day surgeries in Australia, Randall led the ADSC to finalise the publication of the Day Surgery in Australia 2004 Handbook which is currently the only standard for day surgeries in Australia.

Since the 1980s Randall has been involved in numerous voluntary surgical trips in the Pacific and South East Asia. For the past five years he has been assisting in the development of training and fellowships in Sri Lanka through Interplast.

Dr Randall Sach is a most appropriate recipient of the ESR Hughes Medal for his dedication and work in improving the education and training of surgeons.

Professor Leigh Delbridge - Award for Excellence in Surgery

Professor Leigh Delbridge received an Award for Excellence in Surgery at the CASC in 2008.

Leigh Delbridge has a significant national and international reputation in the field of endocrine surgery, particularly thyroid and parathyroid surgery. He is currently Professor of Surgery at the University of Sydney and Head of Endocrine Surgery at Royal North Shore Hospital, the pre-eminent unit in Australia.

Leigh has supervised Trainees for the College and for many years has supervised international postgraduate fellows in a program that is competitively sought after by the best young surgeons internationally.

He continues the long term audit of endocrine surgery commenced by Tom Reeve. He conducts research to the highest international standards and encourages and supports Trainees, postgraduate fellows and surgical colleagues to conduct and publish research. His unit regularly has several papers at each annual scientific meeting of the Endocrine Section at the ASC of the College. Leigh himself has over 200 scientific publications.

He is President Elect of the International Association of Endocrine Surgeons. He is a member of the editorial board of the World Journal of Surgery and has been Congress Vice-President for International Surgical Week. He was President of the Australian Chapter of the International Surgical Society for five years.

He has been the Chair of the Endocrine Section of the College and the ASC foundation visitor in Endocrine Surgery. He is a past Chair of the NSW Regional Committee of the College and has had numerous appointments to Federal and State advisory committees.

He is a deserving recipient of the Award for Excellence in Surgery.



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