Surgical news

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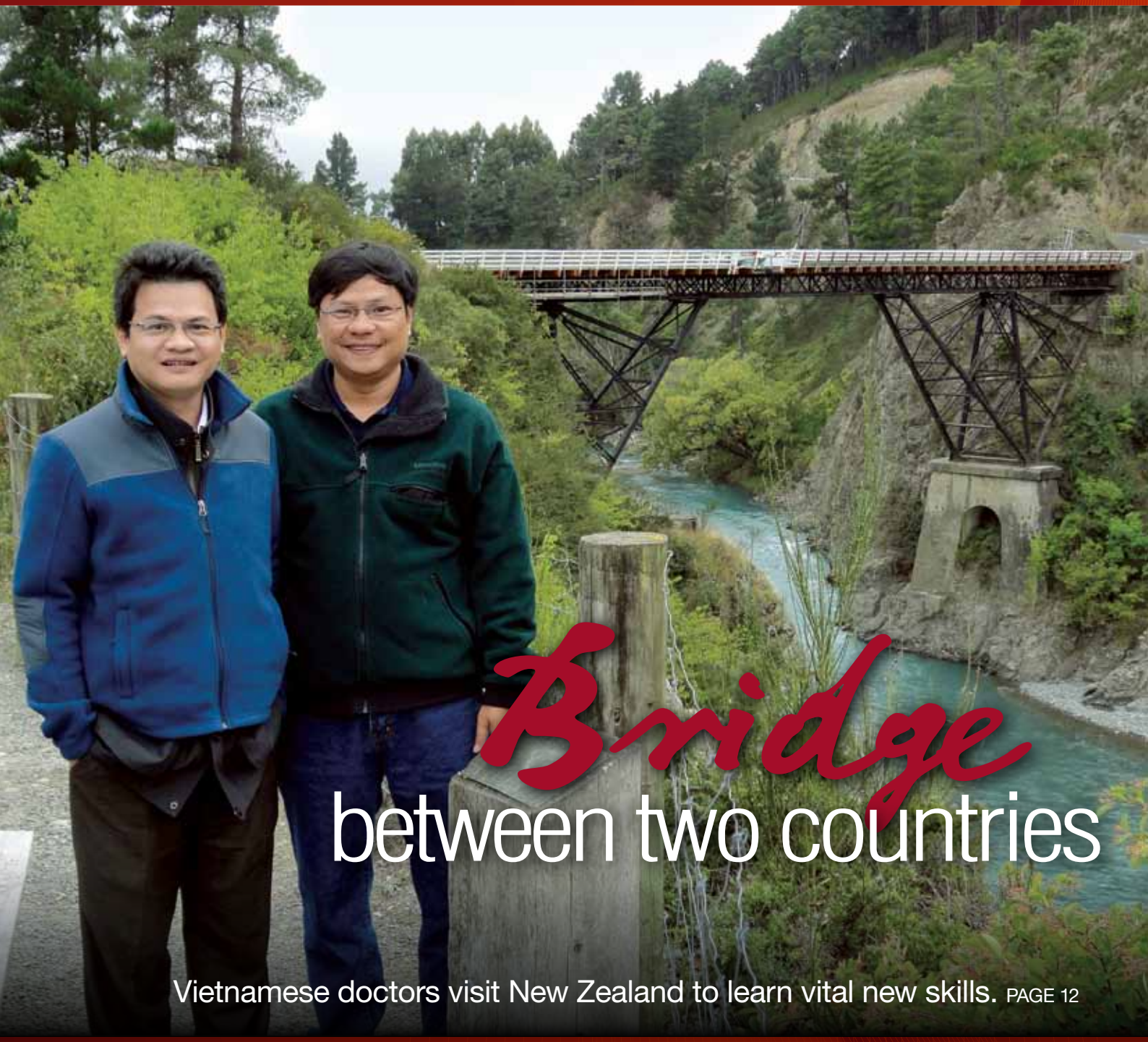
THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



Bridge between two countries

Vietnamese doctors visit New Zealand to learn vital new skills. PAGE 12

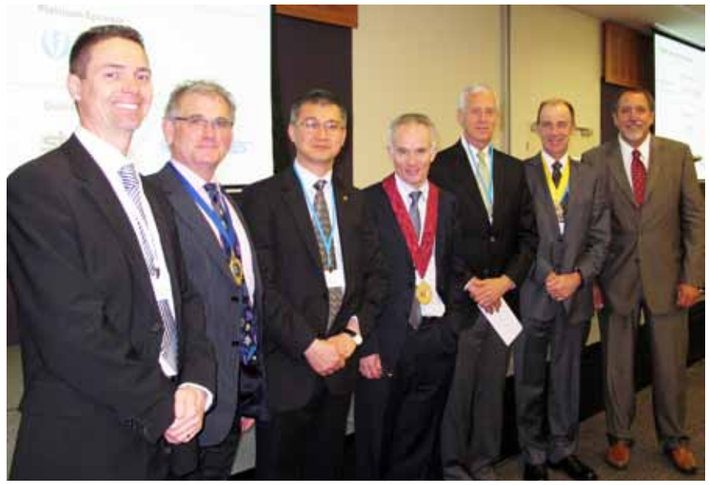
The College of Surgeons of Australia and New Zealand

ON THE COVER: Dr Nhan Phan Tran Dai and Dr Viet Vo Van at Bridge over Waiau River near Hanmer Springs. Photo provided by Allan Panting.

contents

Making our presence felt

College representatives will be engaged at specialty meetings to gain more insight on complex issues



Ian Civil, RACS President at the Opening Plenary, Plastic Surgery Congress 2011, Gold Coast, July 2011 with (from l-r) Paul Belt (Scientific Convenor), Howard Klein (President NZAPS), Swee Tan (recipient RACS Research Award), Peter Callan (President ASPS), John Persing (President Plastic Surgery Foundation USA), Phil Haeck (President AmASPS).

Ian Civil
President

This year I will be attending most of the Specialty Society Annual Scientific meetings and congresses. Recently I attended the Plastic Surgery Congress at Broadbeach in Queensland. Bringing together the Australian Society of Plastic Surgery, the New Zealand Association of Plastic Surgeons and held with the participation of the Australasian Society for Aesthetic Plastic Surgeons, the Australian Hand Surgery Society and the Australian and New Zealand Society of Ophthalmic Plastic Surgeons – the meeting reflected the complexity of surgical governance and clinical expertise in which surgical care is now delivered.

There was world leading research and in particular I was delighted to acknowledge the outstanding work of Professor Swee Tan whose contribution to understanding the genesis of vascular anomalies has provided significant improvements in treatment and outcomes. The principles are now also being applied within oncological research and other areas.

There were numerous sessions dealing with the commercial realities of the world in which we work. Aesthetic plastic surgery is particularly challenged in regard to the ethics of advertising, marketing and practice profile. Practice managers and other affiliated staff are actively involved to ensure that the appropriate cultural and ethical values can be understood and shared by all. Both ASPS and NZAPS are to be congratulated on the forthright way in which they are trying to address these issues.

Importantly the educational components were prominent. Not only the scientific sessions where the expected areas of reconstructive, plastic and aesthetic surgery were considered, but also ▸

The College stand at the recent Adelaide ASC, similar ones will be cropping up at more specialty events.

"Not only the scientific sessions where the expected areas of reconstructive, plastic and aesthetic surgery were considered, but also to issues of collegial support and the skills to be an effective educator"

to issues of collegial support and the skills to be an effective educator. RACS now provides a number of resources into all Specialty Society meetings such as the SATSET course for supervisors and also training courses for Supervisors. Currently being finalised are courses focusing on support for the trainee in difficulty (KToT) and also training around professional skills (NOTSS and TIPS). This range of courses intermeshes very effectively into all of our ongoing educational programs.

Also at the meeting was the RACS stand where College staff can explain the various activities available and provide resource material or reports that provide the foundation to our education, professional development and CPD requirements. This information and material is all available on our web site, but there is nothing like the opportunity to discuss it with your College staff to improve your understanding of the detail.

I was involved in a number of discussions around our training programs and our governance structures. RACS has now communicated clearly to the Australian Medical Council about our requirement to have more flexibility in key aspects of our training – like selection. Whilst achieving the principles of good selection practice, we need to build in parameters where the specific requirements of our nine specialties can be more fully reflected. This is now being addressed.

Separately I have had a number of discussions about possible models of improving the effectiveness of our governance structures. Having the input of Fellows through our representative methods as well as hearing directly of the concerns from the Specialty Societies and Associations is now a priority. It is really beneficial that senior Office Bearers from RACS now routinely attend the specialty meetings. This will be substantially enhanced by better integration of our leadership and representational governance approach.

More than anything else I took away from the Plastic Surgery Congress an understanding of the challenges faced by the Societies as they relate to their subspecialty groups and at the same time an appreciation of the relationship, expected by members, with the College. What I hope I left behind is encouragement to concurrently participate in subspecialty, specialty and College activities. The costs, commitment and expectations of each group are different, but together they provide a matrix of clinical, educational, and representational activities which can fulfil all of the needs of practicing surgeons and trainees. Participation in any one group alone cannot effectively meet those needs.

I look forward to the ongoing discussion around these issues in the months ahead.

The ANZ Journal of Surgery

The College's scientific journal has undergone significant changes over the past five years

Keith Mutimer
Vice President

This year marks the 80th anniversary of the *ANZ Journal of Surgery*, the College's academic publication and the pre-eminent surgical journal published in Australia, New Zealand and the South-East Asian region.

It also marks the final year of Professor John Hall's tenure as editor-in-chief, a five year period that has seen the journal undergo significant change.

In 2011, the acceptance rate for original articles is about 20 per cent, compared with an acceptance rate of 67 per cent in 2007. The product of this commitment to excellence has been a steadily rising citation rate. This is reflected in the journal's so-called Impact Factor, which is the commonly used measure of a scientific journal's average number of citations. Often used as a measure of a journal's relative importance within its field, the higher a journal's Impact Factor the more influential it is deemed to be.

In 2010 the *ANZ Journal of Surgery*'s Impact Factor was 1.344, up from .998 in 2007. In the same year, downloads of articles reached 176,000.

Dedicated to the promotion of outstanding surgical practice, and research of contemporary and international interest, the journal's readership is increasingly international, with 22 per cent of readers from Australasia, 22 per cent from the US, 20 per cent from Europe, 7 per cent from the UK, 5 per cent from China and 2 per cent from Japan. And fully 60 per cent of articles submitted for consideration come from countries other than Australia. Of those from other countries, 15 per cent come from China and 7 per cent from the UK.

There is now a much more efficient flow of manuscripts, with John leading a team of conscientious handling editors and reviewers.

Under John's leadership, the practice was initiated of issuing a media release in conjunction with the appearance of each issue of the journal. The media release publicises what is deemed the most newsworthy article of the latest issue, and this has resulted in several media interviews with contributing authors.

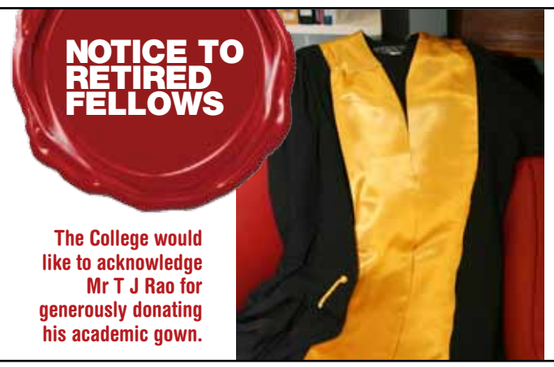
The journal's format is also more attractive and user-friendly.

But perhaps John's most lasting contribution will be the journal website – ANZJSurg.com. It is an astonishingly comprehensive website, with every article that has ever appeared in the journal since its inception now retrievable at the push of a button. As publishing becomes more electronic and less paper based, John has ensured the College's academic journal is well placed to seize future opportunities.

The Winthrop Professor of Surgery, John has for 25 years been a consultant surgeon on-call for emergencies and trauma at Royal Perth Hospital.

When recently asked what he thought his greatest achievement as editor-in-chief was, John answered "bringing the journal closer to the College". He is to be thanked and congratulated.

Throughout 2011, a transition phase has seen John working closely with his successor, Professor John Harris, the Foundation Professor of Vascular Surgery at Sydney's Royal Prince Alfred Hospital and a distinguished ▸



The College would like to acknowledge Mr T J Rao for generously donating his academic gown.

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 donations and place your name on the gown if you approve.

If you would like to donate your gown to the College, please contact Katie Fagan on +61 3 9249 1248. Alternatively you could mail the gown to Katie Fagan c/o Conferences and Events Department. Royal Australasian College of Surgeons. 250-290 Spring St, EAST MELBOURNE, VIC 3002

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"In 2010 the ANZ Journal of Surgery's Impact Factor was 1.344, up from .998 in 2007. In the same year, downloads of articles reached 176,000"

academic surgeon. His appointments have included Head, Department of Surgery, and later Associate Dean, Surgical Services, at the University of Sydney.

Widely published himself, John was formerly a regional editor of Cardiovascular Surgery and has served on the editorial board of the *ANZ Journal of Surgery* since 2004. He is currently the journal's Specialty Editor for Vascular Surgery. John Harris is eminently well placed to serve as editor-in-chief of the journal as of January next year.

Eighty years on, the *ANZ Journal of Surgery* goes from strength to strength. All those involved – members of the editorial team, contributing authors, letter writers – are to be congratulated.

Regional Annual Meetings

Another long standing College institution is the annual regional meetings held in New Zealand and most States and Territories in Australia.

Originally developed to allow Fellows to attend a scientific conference in their own region, the annual regional meetings are, in many jurisdictions, broadening in focus to encompass much more than just surgical science.

In part this is recognition that today, many Fellows receive their scientific content through comprehensive specialty scientific meetings. The regional meeting is becoming an opportunity to engage the whole Fellowship in key issues facing surgeons in their particular jurisdiction.

For example, the Queensland meeting commences with a one day forum with Queensland Health covering surgical services in regional, rural and remote Queensland. This is followed by the main ASM which this year is focussing on disaster management and the surgical response and a review of acute surgical units among other topics.

In Victoria, Fellows are meeting under the theme "Outreach Surgery, The Third World: At Home". The meeting will not only look at some of the challenges of providing surgical care in the developing world, but also within the more remote areas of Australia itself. These more general sessions will be combined with traditional scientific content with trainees presenting abstracts throughout the weekend.

In New Zealand, the 2011 theme is "Quality and Safety". The meeting organisers have approached this from an individual, an organisational and a statutory perspective. They have assembled a line-up of experienced and skilled presenters and debaters to inform and discuss issues of daily relevance to surgeons and our patients.

SA, WA and NT have combined to present a program regarding various challenges inherent to the central and west of Australia, while the ACT and Tasmania have smaller, but still vibrant meetings based around scientific content.

While Fellows would be familiar with the traditional dinner held at an annual regional meeting, many meetings are now combining a lively social and spouse program with the meeting content. Typically these programs involve taking advantage of some of the attractions in the region where the meeting is being held and include things such as winery and scenic tours.

Having attended several regional meetings during my time as Vice President, I heartily recommend these meetings to you as a way of connecting with your colleagues and having some input into issues central to the practice of surgery in your region.

The College's regional meetings for 2011 are held as follows:

ACT on 5 November. Venue to be confirmed.
New Zealand on 18 to 19 August at the Crowne Plaza, Queenstown.
Queensland & QHealth on 29 July at the Auditorium Townsville Hospital.
Queensland on 30 to 31 July at Peppers Resort Magnetic Island.
SA, WA & NT Joint ASM on 11 to 13 August at Voyages Resort, Uluru.
Tasmania on 24 September with the venue to be confirmed.
Victoria on 21 to 23 October at the Quality Inn Gateway, Wangaratta.

Poison'd chalice

"Parting is such sweet sorrow"

Romeo and Juliet Act 2, scene 2

Professor U.R. Kidding

As readers of this column would know, I am passionate about Shakespeare and his insights into not only complex interpersonal issues, but also the intrigue of organisations. This stems from my choice to do English Literature and not more Latin when I was making my way through secondary education. It became a burning and consuming hobby. And although this may be politically incorrect you can write substantial analyses about sado-masochistic behaviour based on Romeo and Juliet. Just within these lines there is almost a wistful prophecy that Romeo will be killed by too much cherishing. The ongoing combination of the yin and the yang or the perverseness of pleasure and pain. This leads me remorselessly into my reactions about two recent events at my teaching hospital.

He was actually one of my better department Heads. That balance of passion for patients and the quality of their care. The irritation about the ongoing restriction of access to resources, compounded by the "stealing" of patients from his waiting list and offered to another hospital or worse, to the private sector, at a greatly inflated cost. We had endless discussions about trying to achieve consultant led services, access to additional day-time theatre sessions for emergency surgery. The sort of issues that we need to be progressing so that surgery is more available and safer.

We had shared the presentations to the Hospital Executive team and then to the department. You know what it is like; the conversation goes from the coffee shop to the board room, from the board room to the Minister's office. You actually find the suits that you only wear to "special occasions". You harness the enthusiasm of your colleagues, you get them to make commitments, and you talk about improvement in patient care... They sort of say yes. You continue on...

Then you recognise the Department of Health has "gone missing". They had previously been with you and fully supportive. Now you start to understand what it means to "stand alone".

As he put his letter of resignation on the table I was stunned. Had enough, was the "bottom line" comment. One of the better clinicians and certainly one of the more enthusiastic department heads, committed and as they say "walked the talk". However, why beat your head against the famous "brick wall" when the private hospital was offering him more operating time and the waiting time into his rooms was at least longer than mine, if not more than his other colleagues. We had a farewell dinner, great event but tinged with sorrow. He spoke about the 'sweetness' moving ahead, less futile meetings, less need for expensive suits (!) and certainly less disappointments. Why was the public hospital sector not able to retain and keep enthusiastic such important people?

That was hard enough, but in some ways expected. Clinicians are always frustrated when the obvious cannot be achieved instantaneously. What I could not understand was the next hospital executive meeting. It was not that I liked the Chief Executive... Smiled a lot, a bit too indecisive. Certainly, not surgeon like. But at least I knew she put in the hard yards and protected the hospital and the staff from the worst of the political and department interference. I had heard things were a bit more tense with the new appointments to the Board and the new Ministerial appointment as the Board Chair.

"I have decided to explore other opportunities..." What? Say that again.... Everyone at the table went into stunned mode. Apparently there have been discussions between senior levels of the department, the Minister's Office and the Board Chair and other opportunities was it...

The rest of the meeting was a blur... Julius Caesar, Romeo and Juliet, Hamlet. They all paraded in my brain. Tragedy, comedy, certainly drama...

PHOTOS PROVIDED BY DAVID MOFFAT.

Left: Peter Gregory giving a clinic at the Alola village. Top left clockwise: Village kids giving a welcome to the trekkers; Villagers with recovered guns from the site; more recoveries of Japanese armoury; Peter Gregory and General Peter Cosgrove, part of the recovery group.

A battlefield *found*

A goodwill gesture has revealed an important landmark in Australian/PNG history

For more than 60 years, the bodies of fallen Australian and Japanese troops, killed in one of the bloodiest battles of the Kokoda Campaign of 1942, lay forgotten and unidentified in some of the most impenetrable terrain on earth.

Slain during the frenzied fighting that led to one of the first Japanese retreats of WWII, the bodies of the lost were reclaimed by the jungle high upon a ridge above the Kokoda track.

Believed to be the site of Eora Creek, a fierce engagement that lasted five days and claimed the lives of 79 Australian and at least 69 Japanese soldiers, the lost battlefield lay unknown even to the thousands of trekkers who annually walk the trail below in tribute to the fallen.

Lost even to military historians, the site would have remained undiscovered were it not for a more recent death when former soldier and Kokoda trek leader Brian Freeman flew the body of local village elder Eddie Elave from Port Moresby to his remote village of Alola.

That gesture of respect, made last year in honour of the services provided by Mr Elave and the local villagers as trek porters and guides, was so warmly received, the people of Alola revealed their secret.

They told Mr Freeman of the bodies that lay in their hunting grounds whom they too believed should be returned home to their descendants.

He in turn told a select group of men who he believed capable of managing the complexities involved in securing, investigating and preserving the site.

One of these was Melbourne breast surgeon Mr Peter Gregory who knew Mr Freeman from previous trekking adventures.

Uncovering

Following that phone call, Mr Gregory, with philanthropist David Moffatt, accompanied Mr Freeman for an initial visit to the site in June last year, again with archaeologists in November and most recently in July.

"Our site mapping has now logged more than 300 weapons pits, unexploded ordnance and medical equipment believed to have come from a Japanese hospital," Mr Gregory said.

"Now the Department of Defence War Graves Unit is involved along with archaeologists, forensic anthropologists, forensic dentists and the Director of PNG's National Museum and we have now exhumed the bones of one soldier. The process of determining nationality will now occur.

"Dozens of bodies, including five Australians, were never recovered and are still listed as missing so a sample from that body has been sent to Adelaide University for DNA analysis.

"The terrain up there is so rugged; just getting there requires a half-day slog straight up from the Kokoda Track, that the body of a solider could lie 10 feet away and you would not see it.

"It would not even be possible to get there without the Alola people acting as guides because you could turn around in the dense jungle and get lost in an instant, so we are extremely grateful for their help."

Mr Gregory said the battlefield was misidentified because "popular belief" assumed the fighting took place on the second highest ridge of the area rather than the highest.

He said archaeologists now estimated that more than 800 Japanese soldiers had been based at the camp, which housed a field hospital, weapons caches and officers quarters.

"It seems that this site was first a care centre or dressing station during the Japanese advance, but then became a major battle site months later during the Japanese withdrawal," Mr Gregory said.

"The Japanese held the high ridge over the Eora Creek Gorge giving them a significant geographic advantage against the advancing Australians, but they chose to position themselves close to the only water on the ridge, neglecting the highest ground, which ultimately gave the Australians the pivotal advantage in the engagement.

"Until now we have known about the two other major battles of the Kokoda campaign – at Isurava where Australia now has an ANZAC cemetery and at Brigade Hill where 69 Australians were killed – but the largest battle was at Eora Creek.

"Despite the fact that it has remained shrouded in mystery, it was the most important battle of all because it marked the first time in the war that the Japanese fully retreated."

Now Mr Freeman, Mr Moffatt and Mr Gregory, in full consultation with the Alola people, have established a trust to raise funds for some community projects and to help develop a heritage site management plan which they hope will be key input into an application for the Kokoda Track to receive a World Heritage listing.

While the strategies and fund raising of the trust have become the province of philanthropist Mr Moffatt, the welfare of the villagers has become the focus of Mr Gregory who worked in PNG as a volunteer during his early medical training.

Just last month, he spent a week at Alola sitting around the fire with village elders to determine what they wished done to improve their lives as a thank-you for their involvement.

"There are only 75 people in Alola and life is pretty basic, no electricity, no running water except from the stream, grass huts and cooking fires and virtually no health services," Mr Gregory said.

"Yet while it is important that their village life isn't disturbed by all this, we want to assist them for giving us this gift through the provision of education and health care."

Giving Back

Mr Gregory said that upon each visit to the village he conducts a basic clinic in which he stiches wounds, drains abscesses, checks blood pressure, heart and lungs, but that plans were now unfolding to build a health clinic and primary school.

"We have now agreed to fund the secondary education of 10 village children in Port Moresby given that there is no accessible secondary schools in the region," he said.

"Then we plan to fund the training of two people of the village to undertake a basic medical course to become Health Extension Officers.

"We have also provided the initial money to build the school and clinic and while we may have to chopper in concrete, the villagers are happy to do the construction and have already begun, so hopefully both facilities will be built by the end of the year.

"At the same time, their own economic well-being should be improved by their ability to charge for their services as porters and guides to the people now visiting the lost battlefield."

Mr Gregory said he planned to make six-monthly visits to Alola in coming years with the assistance of his wife who is a nurse and midwife.

"In such tropical country as Alola, you are limited in the surgery you can do without appropriately sterile facilities because of the high infection rates," he said.

"But even so, I can treat fresh injuries or wounds and there is one fellow in the village who has a spear tip still under his skin so I think I'll treat that upon my return.

"My wife, who hasn't been there yet, will come with me on future visits which will be a great advantage because she is a very skilled nurse and will probably be of more practical use up there given the logistical limitations placed upon surgery."

With Karen Murphy

Younger Fellows

Great opportunities for Younger Fellows in 2012

Take advantage of the amazing experiences on offer

Steve Leibman
Chair, Younger Fellows Committee

The College provides some excellent professional development opportunities for Younger Fellows. It's time to start planning for 2012 to ensure you get your application in on time.

Covidien Travelling Fellowship Educational Grant, 2012

Younger Fellows face many challenges when undertaking post Fellowship studies or training. The Younger Fellows Committee in partnership with Covidien offers two Travelling Scholarships annually which can help to offset the cost of studying overseas. You are eligible to apply if you are planning to train overseas within the next 12 months, but returning to Australasia to practice. Applications will be accepted from 1 August – 30 September 2011.

Younger Fellows Leadership Exchange: AAS Academic Surgical Congress

Each year our College and the Association for Academic Surgery (AAS) in America exchange delegates as part of a leadership exchange. The purpose is two-fold; firstly to provide professional development for a Younger Fellow, particularly in relationship to leadership and secondly to promote an exchange of ideas and possible solutions for common issues affecting Younger Fellows in both organisations. The exchange also aims to identify opportunities for our Younger Fellows to access International Clinical Fellow positions in the US.

The Exchange covers airfares, accommodation, transfers and conference attendance expenses for the RACS representative. Interested Younger Fellows are encouraged to apply from 1 to 30 September 2011. The 7th Academic Surgical Congress will take place from February 14-16, 2012 at the Encore at Wynn, Las Vegas.

Younger Fellows Forum, 6-28 April 2012, Kuala Lumpur

Last but not least, I am pleased to inform all Younger Fellows that the development of the program for 2012 Younger Fellows Forum is well underway. Seema Bagia is convening the Forum which promises to provide opportunities for debating 'hot surgical topics' and a chance to relax and network with your colleagues. I am sure this unique chance to share ideas and experiences will affect your professional and personal lives. Applications are open from 1 September to 1 December 2011.

If you have any further inquires or require more information please contact the Younger Fellows Secretariat at Younger.Fellows@surgeons.org or on +61 3 9249 1122.

Russell Drysdale (1952)
A Group of Aborigines

Do you want to make a difference in Australian Indigenous Health?

Rowan Nicks Russell Drysdale Fellowship in Australian Indigenous Health and Welfare 2012

This Fellowship awards up to $60,000 (negotiable depending on qualifications and/or experience) for the 12 month period of 2012.

The Fellowship is designed to support individuals wanting to make a contribution in the area of Australian Indigenous Health and Welfare. The Fellowship particularly aims to support workers and the development of future leaders in Australian Indigenous Health & Welfare.

Australian Indigenous people are strongly encouraged to apply.

Fellowships could take the form of:
– A salary for a 12 month period at a level commensurate with the Fellow's experience and qualification OR
– A stipend and payment of course fees to undertake approved education or research

The Fellowship is open to Australian citizens or permanent residents who have appropriate prior experience and or education and wish to:
- Undertake approved programs/ activities OR
- Undertake further education OR
- Undertake a research project

Closing date: Friday 26th August, 2011

Opposite page: Watching John Dunbar as he performs surgery; Drs Viet and Nhan looking pleased having survived a scenic flight with John Dunbar; Drs Viet and Nhan, assisted by John Dunbar in the operating theatre at the old Rehabilitation Hospital.
Below: Qui Nhon. Drs Viet and Nhan looking at x-rays with Allan Panting.

Helping old friends

An ongoing bond between New Zealand and Vietnam is assisting in building skills

A cross-cultural bond forged during the tumult of the Vietnam War between local people and New Zealand medical teams sent in to help provide medical and surgical services in the midst of the violence has, decades later, resulted in a recent visit to New Zealand by two Vietnamese surgeons.

Earlier this year, Orthopaedic surgeons Dr Viet Vo Van and Dr Nhan Phan Tran Dai spent six weeks attending theatre and consultations in cities and towns across the country including Auckland, Nelson and Dunedin.

The visit by the two Vietnamese surgeons accompanied by an interpreter was supported and funded by a Surgeons International Award through the RACS Foundation for Surgery. The RACS Foundation for Surgery has agreed to fund a planned visit later in 2011 for two NZ orthopaedic surgeons to the Quy Nhon Rehabilitation and Orthopaedic Centre.

The visit was co-ordinated through the New Zealand Viet Nam Health Trust (NZVNHT), an organisation established during the 1990s to assist the re-building of health care in Binh Dinh province, Central Vietnam.

Since 1990, the Trust which until recently had been funded predominantly by NZAID, has provided equipment, support and surgical team visits to the regional town of Quy Nhon and Bong Son, where the NZ medical teams had been stationed during the war.

The team visits have covered a range of specialties including paediatrics, medicine, orthopaedics and trauma, obstetrics, cervical cancer screening, urology, general surgery, anaesthetics, nursing programs including infection control, laboratory training and the establishment of a Blood Bank service.

With the Quy Nhon Rehabilitation and Orthopaedic Centre now in the process of being rebuilt, the recent six-week exchange program was designed to give the surgeons exposure not only to complex orthopaedic procedures but also to the organisational structure and professional inter-relationships of modern western health facilities.

The trip came at the request of the Director of the Rehabilitation Centre, Dr Cuong Phan Canh, who visited NZ in 2007 and wanted the same experience for members of his surgical team.

From February to April, the two visiting surgeons were hosted and supervised by Mr John Dunbar in Dunedin, Mr Allan Panting in Nelson, and Mr David Morris in Auckland and Middlemore Hospitals.

According to a report written by the surgeons following the visit, the procedures of most interest included joint replacement surgery, anterior cruciate ligament reconstruction, arthroscopy, fracture and trauma management, particularly involving the use of intra-operative X-ray imaging, and the role of physiotherapy in rehabilitation.

As one of the few hospitals outside Ho Chi Minh City and Hanoi that provides a paediatric orthopaedic service, other than for acute trauma, the surgeons from Quy Nhon also spent time at Auckland's Starship Children's Hospital investigating Ponseti casting in the treatment of club foot, the management of developmental dysplasia of the hip, and femoral osteotomy for children with cerebral palsy.

Mr Dunbar, an orthopaedic surgeon with a paediatric subspecialty, who has visited Quy Nhon regularly in recent years to teach and operate, said the trip was of particular value given that the Rehabilitation and Orthopaedic Centre was now at the threshold of a major advance in its ability to provide care to millions of people in the provinces of central Vietnam.

He said that until now, surgeons at the Centre had been limited in what they could do by many factors including the lack of adequately sterile operating theatres, the lack of surgical equipment and intra-operative radiology and by the limitations placed upon them and allied health professionals in their ability to gain global exposure.

"The standard of surgery in Vietnam is pretty good and the surgeons are very capable and resourceful, but they are limited by equipment and knowledge and in many cases have been trained by surgeons who have also had limited exposure to the developments taking place around the world," Mr Dunbar said.

"The rebuilding of the hospital gives them a great opportunity to overcome some of these problems particularly after seeing how our hospital systems work in terms of patient flow, in-patient and out-patient care, the use of diagnostic tools and post-operative care.

"That was one of the reasons that we chose to host them in Dunedin and Nelson because the hospitals here are similar in scale.

"That to me was the most significant aspect of this visit, not just transferring skills and knowledge, but giving the surgeons the opportunity to see what's possible, to give them a vision and a pathway to follow in advancing the care of patients in Vietnam."

Mr Dunbar will visit the hospital when it is fully operational next year.

He praised the efforts of Mr David Morris in setting up the Health Trust and described it as unique, in that it had not grown through government initiatives, but simply through the empathy felt by doctors for the suffering of the people of Vietnam in the now widely discredited geo-political conflict.

"There are still some older people in Quy Nhon who hold New Zealanders in high regard for the assistance offered them during the war, particularly because the New Zealand teams treated all victims equally, including members of the Viet Cong," he said.

"I think a number of people in the western countries involved in that conflict feel a degree of guilt about what happened to the people of Vietnam and it is a privilege to be in a position to help them now."

Orthopaedic skills vital

Mr Allan Panting who, along with his wife Sunny, hosted the surgeons for two weeks in Nelson in March, said that while the standard of health care in Vietnam still lagged behind that offered in western countries, the strengthening economy and greater openness to the outside world were now spurring rapid advances.

He said that while Vietnam was listed as the second most dangerous place to drive after China, the work of the new Quy Nhon Rehabilitation and Orthopaedic Centre was of great importance.

"One of the really positive aspects of this visit was the opportunity for the surgeons to see how our hospitals work while they are in the process of designing their own new hospital," he said.

> *"The program has provided equipment, support and surgical team visits to the regional town of Quy Nhon and Bong Son, where the NZ medical teams had been stationed during the war"*

"Because they work in a regional centre they have more autonomy than perhaps do those surgeons in the major metropolitan centres in Vietnam so they will be able to make changes which could then spark further change in terms of post-operative care, for example, and patient flow.

"Acknowledging that Nelson and Vietnamese hospitals differ greatly in the facilities provided and the style of practice, we considered it important that our visitors had the opportunity for wide exposure to the environment as well as orthopaedic surgery.

"Arrangements were made for the visitors to spend an unrestricted amount of time in the theatre sterilisation unit, recovery, intensive care and the emergency department where staff made them welcome and spent time discussing how each of these units functioned most effectively to support patient care. "

In the report written upon completion of the visit, Dr Viet and Dr Nhan described the experience as being of great value.

"We hope to translate most of what we have learnt in New Zealand into our practice in the clinical setting of the new hospital for the benefits of the people in central Vietnam," they wrote.

"When the new hospital goes into good operation and new equipment is available, we wish to gradually start surgeries such as head of femur, femur osteotomy, ACL reconstruction using hamstring tendon graft, external fixation and hip and knee replacements.

"This was a very valuable time because we were fortunate to experience and learn in modern and well-organised hospitals with experienced and passionate surgeons. We appreciate so much their enthusiasm in teaching us about standard, sophisticated and advanced orthopaedic techniques and procedures.

"We also greatly appreciated the opportunity to experience beautiful nature, interesting culture and to meet with the friendly people of New Zealand."

With Karen Murphy

Be involved in revealing new research

The College is reaching out, welcoming medical students and junior doctors to surgery

Comments from medical students at the 2011 DCAS course:

> Really useful experience. Has made me think about how to go about pursuing a career in surgery. Will definitely recommend other students to attend in future years.

> Great relevance to and focus on medical students. Perhaps for senior surgeons and young students/ trainees to network. Providing an environment where students/trainees can find a mentor or an opportunity to get involved in the research of one of the surgeons. Any neurosurgeons?

Richard Hanney
DCAS course Convenor

At the Adelaide ASC this year, 15 medical students from around New Zealand and Australia attended the one day "Developing a Career in Academic Surgery" (DCAS) course, having been selected for complimentary registration. The places were hotly contested, with 43 applicants, predominantly from surgical interest groups now formed among student bodies at most Australasian universities.

The 15 places were offered by the RACS Section of Academic Surgery, but the selection of the students was carried out by the Surgical Interest Network, the binational body established early last year. The response from students to this innovative offer was sufficiently keen that an additional seven paid to attend the course over and above the complimentary places. Feedback from the formal evaluation by the students has been very positive. One of the strongest messages was how satisfying it was to hear from and mix with the approachable senior academic surgeons and faculty members.

The College took this important initiative further by holding a dedicated program for the medical students on the opening day of the Congress. For a concessional registration of $100, the students were able to explore first hand their interests in a potential surgical career. Two sessions, chaired by Mark Edwards and John Collins, specifically explored the mechanisms and challenges of pursuing a career in surgery. Around 45 students attended this program. Again the feedback indicates that this was a very worthwhile initiative, important to continue and develop further at future Congresses.

The total of 83 registrants at this year's DCAS course was the highest number to date. In addition to engaging interested medical students, the Section of Academic Surgery has sought to engage the prevocational doctors, and 15 attended the 2011 DCAS course. The largest sub-group attending was from the College with a total of 26 Fellows. The presentations from the faculty from Australia, New Zealand, the US and Scotland were inspiring and this was reflected in the evaluations. Most pleasingly, all nine surgical specialties have been represented on the DCAS faculty to date.

Plans for the 2012 DCAS course are already underway. It will again be held on the day before the ASC, on Sunday, May 6, in Kuala Lumpur. While the logistics of holding the congress offshore will be a challenge, there is no doubt that the DCAS course will again be well attended, and the organisers are excited about the prospects of drawing in more local participants from Malaysia and surrounding countries.

To that end there will again be complimentary registration for interested medical students, and this opportunity will be promoted by their own Surgical Interest Network (SurgIN). For the first time, however, there will also be a complimentary airfare and accommodation provided for the medical student or pre-vocational doctor that has the most highly ranked presentation at the Surgical Research Society meeting in Adelaide on November 11, 2011. This is in addition to the number of established prizes awarded at the SRS meeting. For further information, contact academic.surgery@surgeons.org

The DCAS course has continued to evolve over the last three years, but remains committed to inspire and facilitate those interested in a career in academic surgery. The faculty line-up for the meeting in Kuala Lumpur is outstanding and the interactive sessions will provide options and practical advice. Come along to DCAS 2012 in Kuala Lumpur and be inspired. And let us know what you think by contacting the organisers on dcas@surgeons.org

Alfred Hospital General Surgery Meeting

The Department of General Surgery at The Alfred Hospital, Melbourne, is again running The Alfred General Surgery Meeting on 28 to 29 October, 2011, to be held at The Langham Hotel, Southbank, Melbourne

Jonathan Serpell
Professor/Director of General Surgery, Alfred Hospital

This meeting is a biennial one for General Surgeons and follows the previous meeting held at The Sebel Hotel in 2009 which was an outstanding success.

The meeting theme is 'Practical Updates for General Surgeons' and the target audience is therefore General Surgeons with a wide range of interests and SET trainees in General Surgery.

There are five sessions including Updates on Common Problems such as breast infections, common peri-anal problems, assessment of groin pain, management of incidental pancreatic lesions, and investigation of adrenal incidentalomas.

The second session on Emergency Surgery will cover necrotising fasciitis, large bowel obstruction, pelvic fractures-bleeding and hypotension, acute diverticulitis – when to drain, to laproscope and to observe, and severe chest trauma.

The session on Cancer Updates will include presentations on melanoma, breast cancer, carcinoids, GISTs, oesophageal cancer and papillary thyroid cancer. Session four will be Improving Outcomes and Avoiding Problems and will include anticoagulants and antiplatelet agents – when to stop and when to operate, enhanced recovery after surgery, bile duct injuries – a medicolegal perspective, and safety in surgery.

The final session on Interventional and Surgical Techniques includes presentations on management of the failed lap band, advanced colonoscopic intervention, advances in laparoscopic surgery, sutureless thyroidectomy, complicated peptic ulcers and severe pancreatitis including timing of ERCP, necrosectomy and cholecystectomy.

The invited speakers, Chris Pyke, Adrian Polglase, Robert Padbury, Paul Myles, Gregor Brown, Neil Collier and the local faculty will address these common and important problems which the General Surgeon in everyday practice will wish to deal with.

The meeting has been scheduled to enable attendance at the conference followed by a long weekend in Melbourne to take in the Derby and the Melbourne Cup. The Conference Dinner on the Friday night will be held at The Carousel at Albert Park which is a superb venue in spring. The Conference Dinner is included within the registration and a small section of the Royal Philharmonic Orchestra will provide entertainment.

This General Surgery Meeting on Practical Updates should appeal to General Surgeons in all areas and in all subspecialties and we look forward to seeing you at the meeting.

PRELIMINARY NOTICE – SURGICAL RESEARCH SOCIETY ANNUAL MEETING

The Surgical Research Society 48th Annual Scientific Meeting will be held in Adelaide on Friday 11th November 2011

This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers, scientists and medical students.

JEPSON LECTURER:
Professor Wayne Morrison
Director of the Bernard O'Brien Institute of Microsurgery and Professor of Surgery and Head of Department of Plastic and Reconstructive Surgery, St Vincent's Hospital, Melbourne.
"Tissue engineering – Regenerative surgery"

ASSOCIATION FOR ACADEMIC SURGERY GUEST SPEAKER:
Dr Justin Dimick
Director of Policy Research at the Center for Healthcare Outcomes & Policy and Assistant Professor of Surgery, University of Michigan
"Measuring surgical outcomes: Rethinking the calculus of quality"

CALL FOR ABSTRACTS:
The call for abstracts will be open on Monday 1st August 2011 and must be submitted no later than Friday 30th September 2011. Abstract forms will be available from the email address below from mid July.

CONVENOR: Professor Guy Maddern

PRESIDENT: Professor John McCall

FOR FURTHER INFORMATION CONTACT: Mrs Sue Pleass
T: +61 8 219 0900
E: academic.surgery@surgeons.org

WA Minister for Health Dr Kim Hames and WA Regional Chair Jessica Yin.

The surgeon under *siege*

Is it just me or are all surgeons feeling battered by the winds of change?

Jessica Yin
WA Regional Chair

In the past few years we have had to contend with the dissolution of surgical departments which have been absorbed into clinical units governed by body parts (e.g. cardiothoracic, gastrorenal), the introduction of the Four Hour Rule (coming to a state near you!), the Surgical Safety checklist, multiple new quality assurance procedures and, in my own public hospital, a new dress code that bans ties, watches and jewellery in any clinical areas. We now face the prospect of targets for Elective Surgery Waitlists to add to our misery.

How are we coping with all these changes?

Many of my colleagues bemoan the introduction of yet another process or check whose objective is to increase safety, but whose introduction inevitably increases inefficiency in the system. It is interesting to reflect that often the same checks are absorbed into the private hospital system with little or no change to efficiency.

An oft heard criticism is that the introduction of a new policy is not preceded by robust research to justify the change. This is particularly the case when infection control is involved. One wonders whether the recent change to dress codes has been prompted by a massive surge in patient infection rates. One would hope a randomised controlled study was carried out looking at patients managed on a ward where doctors wore ties and watches versus one where they were absent. Inevitably this is not the case and instead 'evidence' of positive swab results gets extrapolated to mean 'more infections for patients'. The hypocrisy of such a policy is that the curtains surrounding the patients have not been washed of spattered blood for decades!

Recently the burgeoning quality assurance industry came under the spotlight in an article from the AMA. It was pointed out that the growth in health care expense has been linked closely to the rise of QI administration, now a fixed feature in every hospital. What started as a small number of interested clinicians dedicated to keeping down M & M rates has now grown to full scaled departments with data collection its main aim.

The cynic in me questions whether we have had any SIGNIFICANT advance in safety to justify the expense and loss of efficiency. Needless to say the gatekeepers of data can argue their case very well. The average surgeon burdened by increasing clinic numbers, operative waitlists, training and possibly research struggles to prove his or her point.

It is particularly disconcerting when one understands that such data is also being fed upstream to health officials and eventually shaping health care policy on a wider front. As a result the core issues of patient safety as reflected by morbidity and mortality has been taken out of the hands of the surgical team.

How did we arrive at such a disenfranchised and disempowered situation?

A number of reasons have been put forward including the loss of collegiality, the competitive nature of our work, the decline of altruism, the overwhelming increase in workload overall (compounded by the shortage in surgical workforce numbers), the lack of representation on hospital boards... I could go on.

Recently (and yet again) the College has faced the issue of subspecialty separation. My own subspecialty of Urology also faced this prospect many years ago and decided (wisely, I feel) to remain with the College. It would seem to me that despite all of our differences the one thing that links us all is our common goal of excellent surgical care, no matter what the field. In facing the onslaught of imposed changes, a united front surely works to the advantage of all.

> *"Many of my colleagues bemoan the introduction of yet another process or check whose objective is to increase safety but whose introduction inevitably increases inefficiency in the system"*

As I write this monumental whinge about the system we all face, I am about to hand over the Chair Position to one of my Plastics Surgical colleagues whose own department is facing serious disruption. My two year tenure has been a whirlwind of Ministerial meetings, media interaction and constant advocacy. As hard as these two years has been, the support of my colleagues from all ranks and specialties has been a revelation. My long suffering spouse and children are eagerly anticipating my return to family life.

So how do I cope with the constant barrage? I'll tell you after I return from Ningaloo Station where we retire to haul water, fish and dig our own toilets!

History of Medicine "Tour" of Switzerland

Mr. Peter F Burke FRACS, was appointed to the Archives Committee by Sir Douglas Miller in 1979. He served on that committee for almost 20 years and was appointed Honorary Principal Curator of the College Collections following the tragic death of Mr Peter Jones in 1995. His current appointments to the College include that of Specialty Editor in Surgical History for the *ANZ Journal of Surgery.*

Peter Burke FRACS
Victorian Fellow

Twenty years ago the Victorian Branch of the Australian Medical Association arranged a "History of Medicine Tour of Europe", and the two medical consultants to this tour were well known surgeons, Peter Jones and Laurence Simpson.

The late Peter Jones served this College as a Councillor, as Honorary Principal Curator and as Honorary Librarian. His interest in history and his knowledge of Heraldry were widely recognised: the Royal Children's Hospital, The Australian College of Paediatricians, the Medical Defence Association of Victoria and the Australian Association of Surgeons each had a Coat of Arms specifically designed for them by this extraordinary man, in association with the College of Arms in England. His outstanding ability as a teacher is perpetuated in "Jones' Clinical Paediatric Surgery: Diagnosis and Management", now in its sixth edition.

Laurence Simpson was awarded the Medal of the Order of Australia in January 2011, for services to medicine as a clinician and educator: a former thoracic surgeon and now Melbourne University administrator, Laurence was a senior surgeon at several leading Melbourne hospitals and spent many years teaching surgery and medical history.

Simpson regards the period between 1958 and 1967, when he was Medical Director and thoracic surgeon at the Kwanghi Christian Hospital in South Korea, as a highlight: setting up a surgical centre in a TB sanatorium, this facility developed into a 650 bed general hospital over the next 50 years. With these two great men at the helm, a fascinating tour was guaranteed: cities visited included Heidelberg, Prague, Vienna, Budapest, Padua, Venice, Florence, Basel and Zurich. This author was unable to participate at the time; however, recently an opportunity arose to enable a visit to those sites in Switzerland, recommended those 20 years ago.

In Zurich, the Ramistrasse is a magnificent boulevard in the university precinct, high above the city of Zurich. Two buildings are of immense interest to students of medical history, the University main building situated at 71 Ramistrasse, has a tower and within that tower the Institute of the History of Medicine and its library and collections are located.

Adjoining this huge building is a magnificent property at number 69: this building, which had been the site of the Physics and Physiology building of the University of Zurich in the late 19th century, was extensively renovated between 1987 and 1990 and now is the Museum of the History of Medicine of the University of Zurich.

The property has a fascinating history, including the fact that no less than five Nobel Laureates taught and undertook research in this building within a time span of 40 years: among those was Albert Einstein, who obtained his first independent academic

Left: Baroque Library Hall, Einsiedeln Abbey, Built 1738. Inset: Peter Burke outside the Pharmacy Museum of the University of Basel. **Above:** Orthopaedic extension apparatus mid 16th century; The Museum of the History of Medicine of the University of Zurich. Saints Cosmas and Damian Pharmacy, Kurrhein area, Germany, mid-18th century.

position as an Associate Professor at the University of Zurich in 1909.

The medical history collection is vast, comprising thousands of books, brochures, illustrations and other written materials, but it is fully complemented by a varied and fully displayed collection containing objects dating from the earliest times up to the present. Those objects give visual and palpable evidence of the knowledge and practices in the individual phases of the development of medicine.

The visitor who tours the permanent display in the museum truly obtains an overview of the history and evolution of medicine.

The museum collection offers a wide variety of dramatic displays which superimpose actual instruments/devices on a contemporary illustrated background, bringing the displays "to life".

Not only the museum, but the library and the archives of the Institute for the History of Medicine are also open to the public.

Just 74km from Zurich is Basel, and here are two destinations well worth a visit from anyone interested in the history of medicine. Of these, the most important, fascinating and memorable is the Pharmacy Museum of Basel, which is located in the old town of Basel and is quite difficult to locate on foot.

This extraordinary building was first mentioned as a bath house in 1296 and was occupied by many illustrious families, until finally in 1924 it became the University of Basel's Pharmacy Museum.

The pharmacist and historian Professor Josef Hafliger donated his private collection to form the Museum, which has since maintained a display style typical of the 1930s, up until the present day.

With the support of the Swiss Association of Pharmaceutical Professionals and Basel's civic authorities, this collection of ancient pharmaceutical objects has become one of the most extensive and important of its kind.

The collection is designed to emphasise the scientific, art, historical and popular aspects of the history of Pharmacy.

A most comprehensive catalogue in English details this extraordinary collection; some of the contents are recorded as: Exotic Lures, Inorganic Remedies, Amulets and Symbols, Allopathy and Homeopathy, Gods, Saints and Patrons.

This museum also presents a beautiful collection of personal pharmacy chests dating back to the 18th century; travellers always took their own miniature pharmacies with them.

The brothers Cosmas and Damian, the patron saints of doctors and pharmacists, preside over the entire collection.

The Anatomisches Museum Basel is again extraordinarily well laid out and fascinating, and this new anatomical museum was inaugurated in November 1995, following renovation of the Anatomy Institute.

Carl Gustav Jung played an important role in the reorganisation of the University in Basel and in 1824 he founded the Anatomical Museum which is divided into broad categories including, the locomotor system, digestive system, urinary and genital organs, endocrine system, and preparations of prenatal development.

Not only is the current museum totally contemporary, but it is also historical although up until the 18th century, little educational material had been acquired.

In the Institute of Anatomy, there is a skeleton estimated to be the oldest anatomical preparation of a skeleton in the world, and it was made by Andreas Vesalius in Basel in 1543.

Vesalius is generally considered to be the founder of modern anatomy, and he collected, recorded and edited his own observations and revelations concerning his preparations. They form the basis for his great work entitled "De Humani Corporis Fabrica"; reference to this wonderful book was made in the January/February edition of *Surgical News*.

For the student of anatomy, and what surgeon is not, a visit to this museum is mandatory.

Other attractions of historical interest in Switzerland include the magnificent Benedictine Abbey at Einsiedeln, which was founded in 934 AD.

The baroque chapel and library are world class and the library itself now holds 1,230 manuscripts, 1,040 incunabula, early prints and no less than 230,000 books; daily guided tours of the abbey and abbey library can be organised, excluding Sundays and Holy Days.

To visit both the chapel and library is an extraordinary experience, truly, "out of this world".

Another attraction in Switzerland, which was not visited was the Musee International de la Croix-Rouge et Du Croissant-Rouge, in Geneva. This museum is open every day except Tuesday and offers exhibitions, temporary and otherwise, as well as institutional documents, inter alia.

Visits to each and every one of these institutions are highly recommended on your next visit to Switzerland.

Websites
Museum of the History of Medicine of the University of Zurich:
www.medizin-museum.uzh.ch
Pharmacy Museum of Basel:
www.pharmaziemuseum.ch
Anatomisches Museum Basel:
www.anatomie.unibas.ch/museum
Benedictine Abbey at Einsiedeln:
www.kloster-einsiedeln.ch
Musee International de la Croix-Rouge et Du Croissant-Rouge:
www.micr.org

Nurse collaborative arrangements

Recent legislation fundamentally alters the potential relationship of doctors with nurses and midwives

Michael Gorton
College Solicitor, with Nick Williamson

The Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010 ("Amendment Act") amended both the Health Insurance Act 1973 (Cth) ("Health Insurance Act") and the National Health Act 1953 (Cth) ("National Health Act") to allow collaborative arrangements between doctors, nurse practitioners ("NPs") and midwives, leading to those NPs and midwives accessing Medicare benefits and prescribing limited medications.

The scheme is now in its second financial year. In light of this, we present an overview of collaborative arrangements, in sufficient detail for those unfamiliar with the scheme.

1 Background to the Amendment Act

The Amendment Act essentially arose due to Australia's shortage of medically trained practitioners. The Health Minister Nicola Roxon flagged the legislation early in her term, surmising "...there needs to be an incentive for doctors to eschew less complex work, and focus on the work that does require their high level skills and expertise."[1] The reforms aim to permit NPs to undertake health assessments, order tests, prescribe specific drugs and refer to specialists, akin to their role in public hospitals.[2] The UK, Canada and the US have used NPs in this manner for over 50 years.

Australia's uptake originated with a 2005 Productivity Commission Report which recommended integrating new models of care and workforce practices.[3] The 2008 Maternity Services Review further recommended expanding the role of midwives in multidisciplinary care.[4] The Amendment Act implemented these key recommendations, forming a plank in the Government's health reform agenda.

2 Mechanics: the operation of the Amendment Act

At a basic level, the Amendment Act inserted key definitions. NPs and midwives are recognised in both the Health Insurance Act and the National Health Act (providing they are authorised to practise under State laws).[5]

However, to take full advantage of the benefits (Medicare rebates and prescribing rights), NPs and midwives require endorsement and importantly, a collaborative arrangement.

2.1 Endorsement

To obtain endorsement, NPs and midwives must first be deemed eligible.

Midwives must meet the standards developed by the Nursing and Midwifery Board of Australia,[6] which require:

(a) midwifery experience equivalent to three years full-time, post registration;
(b) demonstrated competence to provide pregnancy, labour, birth and postnatal care to women and their infants;
(c) completion of an approved professional practice review program;
(d) 20 hours per year continuing professional development; and
(e) successful completion (or an undertaking to complete) an approved qualification.

Eligibility imposes more onerous conditions on midwives than NPs, who are automatically eligible (and will be until additional obligations are imposed by regulation).

To then become endorsed, NPs or eligible midwives must:

(a) engage in a collaborative arrangement;
(b) with a specified medical practitioner; and
(c) for necessary procedures or medicines.[7]

Under the Health Insurance Act, endorsed NPs and midwives are termed "participating", whereas under the National Health Act they are "authorised". The requirement for collaborative arrangements with medical practitioners is a key component of this scheme.

2.2 Collaborative Arrangements

are defined as being one of the following:[8]

(a) a NP or midwife engaged by a medical practice or one or more specified medical practitioners;
(b) a patient referred in writing to a NP or midwife by a specified medical practitioner;
(c) a NP or midwife with a written collaborative agreements with one or more specified medical practitioners (each of which may cover a number of patients); or
(d) a NP or midwife with a collaborative arrangement with one or more specified medical practitioners in regard to a particular patient (which must be documented along with the patient's consent) where the details concerning the manner of care provided to the patient are agreed in advance.

Collaborative agreements and arrangements represent the greatest shift from the existing state of affairs. We refer to "collaborative partners" and "collaborative partnerships" when referring to the above relationships.

2.2.1 Collaborative arrangements

Collaborative agreements are written agreements (contracts) between the collaborative partners.[9] Written agreements may cover one or more patients. This may encompass all patients, the medical practitioner's patients, the NP's patients, or patients with epilepsy/heart conditions (for example).

2.2.2 Collaborative arrangements

A collaborative arrangement covers just one patient, and requires the NP or midwife to keep comprehensive records as to:

(a) the collaborative partners and patient;
(b) plans for the operation of the collaborative arrangement;
(c) the scope for each collaborative partner; and
(d) the sharing of records, referrals or results.[10]

2.3 Specified Medical Practitioners

For an NP, a specified medical practitioner means all kinds of doctor. For a midwife, a specified medical practitioner means an obstetrician, a medical practitioner providing obstetric services, or a medical practitioner employed or engaged (and so authorised) by a hospital.[11]

2.4 Prescribed and necessary services

NPs and midwives are only able to access those prescribed services (pathology and diagnostics) deemed necessary in the regulations.[12] The services attracting Medicare payments for NPs and midwives are similarly prescribed.[13]

NPs and midwives are able to access prescribed medicines as marked and listed in Schedules 2, 3, 4 or 8. NPs and midwives must also obey relevant State laws when prescribing restricted or controlled medicines.[14]

3 Collaborative arrangement benefits

Consequential to the Amending Act, it was asked (and still will) whether doctors will be swamped by NPs or midwives, each promoting services and requesting participation in a collaborative agreement or arrangement? Well, the answer was and is, yes and no. It is also important to recognise collaborative arrangements can be instigated by doctors themselves, as they clearly present several benefits.

3.1 Expanded revenues and revenue streams

The ability for NPs and midwives to access Medicare benefits (and to direct others to do the same) can broaden a practice's revenue stream, without paying a full practitioner's salary. Some financial incentives are also available for employing a practice nurse, for which guidelines are available.[15]

3.2 Greater patient care

The overall time spent with patients can be increased. The delegation of tasks provides an opportunity to increase the range of services offered. Engaging a NP or midwife to provide basic medical services allows medical practitioners the ability to take more of a management role in the treatment of their patients, by spending less time on less complex work and more on the more complex, that which requires their level of skill and expertise. The dual attention also improves the management of chronic diseases, and provides both the medical practitioner and the NP or midwife an increased capacity to adapt to change as necessary.

All of which contributes to a greater sense of patient satisfaction.

3.3 Treatment access

More medical professionals usually mean greater access to medical attention. The beneficial impact of NPs in this context can be seen in the Canberra Hospital's walk-in clinic. The Clinic saw its 10,000th patient in February 2011, equating to over 1,200 patients a month from its opening in May 2009.[16] Staffed by 15 full-time-equivalent NPs, patients with minor conditions are seen on demand, without appointments or fees.[17]

These NPs act under the hospital's auspice, outside collaborative arrangements. Consequently they are limited in what they can offer. Collaborative care therefore offers NPs and midwives the opportunity to expand this service into private practice.

3.4 Broader maternal services for midwives

Midwives can become more involved in the management of women at each of the antenatal, birthing and postnatal stages. For obstetric specified medical practitioners and practices, the benefits include:

3.4.1 an expansion in the number and type of maternal services for patients;
3.4.2 more shared care models with midwives in the care of pregnant patients; and
3.4.3 providing continuity of care by offering the collaborative partners at a single location.

References

1. N Roxon (Minister for Health and Ageing), Annual Ben Chifley Memorial Light on the Hill Speech, The light on the hill: history repeating, Bathurst, 20 September 2008, viewed 17 July 2009, <http://www.asmi.com.au/documents/Roxon%20Light%20on%20The%20Hill%20Speech%20Sept%2008.pdf>
2. The Hon Nicola Roxon Mp Minister For Health And Ageing, Opening Address to Australian College Of Nurse Practitioners Conference, Marque Hotel, Canberra, 1 November 2010, <http://www.acnp.org.au/media-watch/minister-roxon-speech-acnp-conference.html>
3. Productivity Commission, Australia's Health Workforce, 22 December 2005 <http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf>
4. Improving Maternity Services in Australia: The Report of the Maternity Services Review <http://www.health.gov.au/internet/main/publishing.nsf/Content/msr-report>
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7. Health Insurance Act 1973 (Cth) s 3(1), 21; National Health Act 1953 (Cth) s 84(1)
8. Health Insurance (Midwife and Nurse Practitioner) Determination 2010 (Cth); Health Insurance Regulations 1975 (Cth) reg 2C, 2F; National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth); National Health (Collaborative arrangements for midwives) Determination 2010 (Cth)
9. Health Insurance Regulations 1975 (Cth) reg 2G; National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 6
10. Health Insurance Regulations 1975 (Cth) reg 2H; National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 7
11. Health Insurance Regulations 1975 (Cth) reg 2B; National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 4; Health (Collaborative arrangements for midwives) Determination 2010 (Cth) s 4
12. Health Insurance Regulations 1975 (Cth) reg 11A, 11B
13. Health Insurance (Midwife and Nurse Practitioner) Determination 2010 (Cth) Schedule 1
14. National Health (Listing of Pharmaceutical Benefits) Instrument 2010 (Cth)
15. Medicare Australia, Practice Incentives Program: Practice Nurse Incentive Guidelines, September 2010 <http://www.medicareaustralia.gov.au/provider/incentives/pip/files/2709-9-pn-guidelines.pdf>
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17. Media release, Katy Gallagher, Capital spending delivers $1291 million to healthcare system, 3 May 2011 http://www.chiefminister.act.gov.au/media.php?v=10668&m=52

The importance of strategic direction

The healthcare marketplace is rapidly changing and each change seems to impact on the revenues and operations of both private medical practices and public hospitals

Marianne Vonau
Chair, Professional Development

Many in private practice are being forced for maybe the first time to consider where our practice stands in the market place and what to do about its future. With the heightened competition for patients, you can no longer afford a 'business as usual' attitude, but need to decide how to position yourself in the future in order to maintain your net income and grow your practice. Developing a strategic plan helps to begin the process of addressing specific issues within your practice and implementing related solutions.

Those of us practising in hospitals may believe that strategic planning is a bureaucratic and vague process run out of a hospital administrator's office. There is usually some consultation and then the development of a few lofty commitments. Surgeons may ask, "What has hospital strategic planning got to do with me?" Too often, the answer may be, "Very little."

However, strategic planning involves some of the most important deliberations that occur in a hospital. Surgeons who are not part of the strategic planning process may find themselves isolated from the conversations and decisions that have direct and important impact on them and their patients. Remember a strategic plan is ultimately a leadership tool and a cornerstone for good management.

For several years the College has offered a range of successful workshops designed to support Fellows in their role as leaders and managers. Most recently it has partnered with the University of New England (UNE) programs to offer professional development tailored to the needs of surgeons.

The two face-to-face workshops focus on the challenges of leadership and management facing surgeons in their own business and in the broader health management context. The program is presented by highly skilled facilitators and health management subject matter experts.

The College is very pleased that Professor Cliff Hughes AO, FRACS, CEO Clinical Excellence Commission is acting as a co-facilitator. Many of you will know that Prof Hughes has had a long and distinguished career in surgery and has undertaken a number of significant roles with the College. He also has experience in management and leadership training. Prof Hughes served as a College Councillor from 1997 to 2003 and was a member of the Professional Development and Standards Board in 2003 to 2004 as well as a Senior Examiner and Chairman of the College Ethics Committee.

Until 2005, Prof Hughes was a senior partner in a busy cardiothoracic surgical practice and for 10 years was Unit Head at the Royal Prince Alfred Hospital. In 1998, he was awarded the Order of Australia for service to cardiac surgery, international relations and the community.

Prof Hughes is very committed to developing the skills of surgeons in their role as managers and leaders and believes that "to be successful leaders, surgeons must spend as much effort on their practice, unit and team as they do in it."

The workshops provide an opportunity to interactively explore and reflect on relevant issues with your peers through discussion of the theoretical concepts in leadership and management.

Providing Strategic Direction, 9-11 September, Sydney

Planning and communicating direction and strategy is integral to achieving outcomes. In this workshop you can gain the skills and knowledge to produce and implement an organisational strategy.

The focus is on how to establish a strategic direction through an effective planning process. You can learn how to conduct an organisational/market analysis, sustaining a competitive advantage and developing strategic measurement systems. To maximise your learning, professional reading material is distributed prior to the workshop.

Sustaining Your Business, 18-20 November, Brisbane

This workshop provides the foundation for developing business plans and the various approaches to implementation in order to sustain business growth and performance. The workshop is relevant to individuals who have experience in determining the effective functioning and success of a practice or as clinical managers within health systems.

It also explores financial management; from the preparation and analysis of responsible budgetary plans, decision making, management and reporting, to the development of estimates and capital investment proposals. Professional reading material is available prior to the workshop

For more information, contact the Professional Development Department at +61 3 9249 1106 and PDactivities@surgeons.org

Professional Development WORKSHOPS

Professional development is important as it supports your life-long learning. The activities offered by the College are tailored to needs of surgeons. They enable you to acquire new skills and knowledge while providing an opportunity for reflection about how you can apply them in today's dynamic world.

>AMA Impairment Guidelines 5th Edition: Difficult Cases *NEW*

26 August, Perth

The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This full day workshop provides surgeons with a forum to review their difficult cases, the problems they encountered and the steps applied to resolve the issues.

>Process Communication Model (PCM) *NEW*

26-28 August, Sydney

Patient care is a team effort and a functioning team is based on effective communication. PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. PCM can also help to detect stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

>Providing Strategic Direction

9-11 September, Sydney

In this two and a half day workshop you can learn more about conducting an organisational/market analysis, sustaining a competitive advantage and developing strategic measurement systems. You will gain the skills and knowledge to produce and implement an organisational strategy by focusing on how to establish a strategic direction through an effective planning process.

>Building Towards Retirement

1 October, Brisbane

Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. The program covers key issues including maintaining health and well being, job opportunities after surgery, superannuation and legal advice, community involvement and building relationships and networks.

>Practice Made Perfect; successful principles in practice management

3 October, Brisbane

This whole day workshop focuses on the unique challenges of running a surgical practice. Learn more about the six principles of running a surgical practice. Practice managers, practice staff and Fellows are encouraged to join these workshops for a valuable learning experience.

>Writing Medico Legal Reports *NEW redesigned evening program**

19 October, Brisbane

This half-day (evening) workshop uses lectures, activities and practical demonstrations to help improve your skills in preparing medical reports for use in legal matters and giving evidence as a medical expert witness effectively in court. It is an opportunity to gain understanding of the legal rules covering admissibility of an expert report and how to prepare and set out an expert report to ensure compliance with court rules.

Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development.

2011 DATES:
AUG – NOVEMBER

ACT

>9 November, Canberra NEW
Keeping Trainees on Track (KToT)

NSW

>26-28 August, Sydney *NEW*
Process Communication Model

>19 October, Sydney *NEW*
Keeping Trainees on Track (KToT)

>20-22 October, Sydney
Surgical Teachers Course

NT

>16 September, Darwin *NEW*
Keeping Trainees on Track (KToT)

NZ

>18 August, Queenstown *NEW*
Keeping Trainees on Track (KToT)

>1-3 September, Auckland
Surgical Teachers Course

QLD

>5 September, Brisbane *NEW*
Keeping Trainees on Track (KToT)

>1 October, Brisbane
Building Towards Retirement

>3 October, Brisbane
Practice Made Perfect

>19 October, Brisbane *NEW*
Writing Medico Legal Reports

>18-20 November, Brisbane
Sustaining Your Business

TAS

>23 September, Hobart *NEW*
Keeping Trainees on Track (KToT)

VIC

>13 September, Melb *NEW*
Keeping Trainees on Track (KToT)

>21 October, Wangaratta *NEW*
Keeping Trainees on Track (KToT)

>12 November, Melbourne
Communication Skills for Cancer Clinicians

WA

>24 August, Perth *NEW*
AMA Impairment Guidelines 5th Edition: Difficult Cases

>21 October, Perth
Polishing Presentation Skills

Shifting the curve
promoting surgical research in training

More emphasis on surgical research in training would inspire another generation and advance our vocation

John A Windsor
Chair, Section of Academic Surgery

Surgery is a scientific discipline. The Memorandum of Association (1924) marking the birth of the Royal Australasian College of Surgeons stated that "the two most important duties of the College, are the training of surgeons and the promotion of research in surgery"[1]. These are the two pillars on which surgery stands. The delivery of high quality surgery in an increasingly complex environment and the progressive development of surgery in pursuit of better patient outcomes requires the continuing acquisition of new knowledge and skills (research) and the dissemination of these (education and training).

Since the foundation of the College, the domains of training and research have not received equal attention. Surgical training has been its primary focus and training has thrived with the attention. Fellows of the RACS are known throughout the world for their excellent surgical training. And the College continues to set high standards for our trainees and continues to innovate in surgical education and training.

The same cannot be said for surgical research, which has struggled over the years, for there has not been the same investment or attention. The reasons are several, not the least being the pressing and more immediate need to produce a competent surgical workforce.

The College's mandate to promote research was partly devalued when University Departments of Surgery and the Surgical Research Society of Australasia were strong. But that did not last, winter followed spring. Surgical research has also suffered through a lack of funding, the increasing sophistication of science, the struggle to identify, train and appoint academic surgeons, the rise of private practice and the failure of governments to adequately fund public hospitals.

The American Surgical Association commissioned a report on surgical education that contains a clear statement of concern.[1] It stated that "the future of surgery as an academic and professional discipline that will continue to contribute to the discovery and clinical translation of new knowledge, technology and surgical therapeutic innovation will depend on how high research is on the priority scale of surgical education and practice."

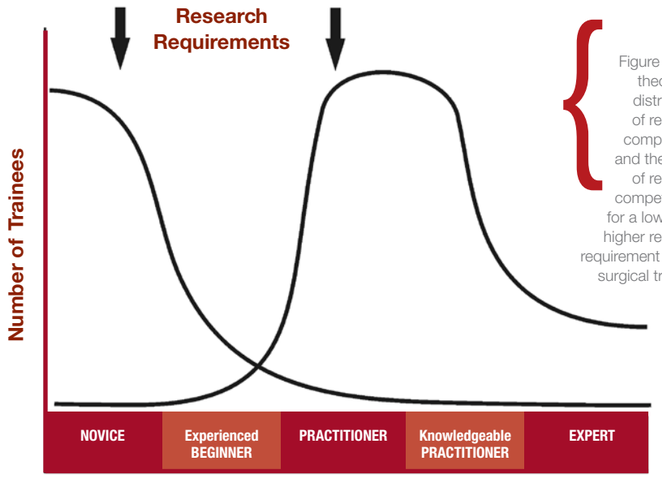

Figure 1: The theoretical distribution of research competency and the levels of research competency4 for a low and a higher research requirement during surgical training.

With a sharp tongue the report goes on to say that "research training in surgery is regarded almost as an afterthought, and the surgical profession has not placed a premium on its development and support. Further research training in surgery lacks the structure, organisation and oversight that are so well developed in clinical training." And not just in America.

There are some far reaching consequences if we do not face up to the challenge that is before us. If surgery does not promote surgical research, there will be less interest in a surgical career as students view surgeons more as technicians.

The surgeons sphere of influence will be further reduced as significant aspects of perioperative care are assumed by more expert others. There will be fewer trainees choosing academic surgery because they missed out on a compelling research experience.

The quality of surgical care will suffer for want of the appropriate and timely integration of evidence based advances into surgical care guidelines. And probably of most importance will be blunted progress in surgical science because of a diminished surgical research workforce less able to compete for research funding.

The Section of Academic Surgery has taken on two challenges under the heading of "promoting surgical research". There is the need to both 'raise the bar' and 'raise the floor'. The first challenge is the need to identify what is required for those who choose to commit to a career in academic surgery. They need more intentional, recognised and supported training pathways.

This topic will be the subject of the meeting in Adelaide (November 10-11) sponsored by the Section of Academic Surgery and the Surgical Research Society of Australasia. The second challenge is the need to revisit the research requirements during SET, which relates to the research competencies considered important for all surgeons, across all specialties.

A brief review of the current research requirements during SET for each of the specialties is striking for their variation. The requirements in Neurosurgery are for a year of full time research for all trainees. In contrast, the requirements in General Surgery can be met with a poster presentation at a local meeting.

Overall, the requirements are low, are not based on defined learning objectives, nor are they embedded in a curriculum that defines appropriate training and assessment methodology. Michelangelo once said that "the greater danger for most of us lies not in setting our aim too high and falling short; but in setting our aim too low, and hitting the mark."

Aiming too low has been the problem and the 'minimalistic' research requirements smack of tokenism, and they belie an understanding of the research competencies (knowledge, skills and attitudes) that are essential in our trainees in the world of modern surgery.

A recent article in the New England Journal of Medicine emphasised the need for scientific literacy in all graduates of medical schools,[3] and it could also be said for surgical trainees in relation to research competencies that "we should expect a higher standard from those who wish to pursue (surgery) in an era in which genomics and informatics will revolutionise biomedical science and health care. To fulfill expectations we need to foster scholastic rigor, analytical thinking, quantitative assessment and analysis of complex systems in human biology. Our goal should be to help them acquire a different, more molecularly orientated and scientifically sophisticated knowledge base."

The American Surgical Association report[2] adds another dimension by saying that "it is inherent in the education of a surgeon that he or she be exposed to a thorough understanding of basic scientific methods. It is especially important that the surgeon in training understands the appropriate methods of evaluating published material, clinical research and decision analysis." Other research competencies could be added.

Dreyfus and Dreyfus[4] have defined five levels of competency related to skill acquisition and this is helpful because it promotes a continuum of research competency, rather than a dichotomy, and there is a decision to be made about the level that we expect all of our trainees to reach.

If a theoretical distribution of research competency were plotted for our trainees it would likely be skewed to the left (Figure 1), with most trainees at the 'novice' level and some at the 'experienced beginner' level. It is suggested that this is a direct consequence of setting the research requirements at a low level. The curve would be shifted to the right if the research requirements during SET were to be lifted. This would increase the average research competency with most trainees at the 'practitioner' and 'knowledgeable practitioner' levels, there would be few trainees left at the 'novice' level, and more trainees would likely choose to reach the 'expert' level.

In considering the need to lift the research requirements during SET, so that all trainees gain a higher level of research competency, there are three options. The first is that each specialty continues to go their separate ways in defining the research requirements, even though they are essentially trying to achieve the same thing.

The second is to develop a common approach to the research requirements that draws on the best of what has already been developed within the different specialties.

The third is to start afresh by defining the learning objectives for training in research during SET, focusing on essential knowledge, skills and attitudes and how learning should be gained and demonstrated in these domains.

The Board of Surgical and Education and Training (BSET) considered these options at its recent June meeting. It was decided to establish a working party to work towards the third option, with the support of the Section of Academic Surgery and the Academy of Surgical Educators.

There will need to be recognition of the resource implications of the recommendations and a willingness to draw on external resources. It is important that all surgical specialties are represented on the working party. Any comments, criticisms or contributions from Fellows are welcomed.

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How the Fellowship examinations are organised

There are many things to consider when organising an examination of the scale today

Spencer Beasley,
Chair, Court of Examiners

Often we take things for granted – like the smooth running of the Fellowship examination.

Yet, organising the FEX is a major undertaking that has to be conducted with precision. This exam is a high stakes assessment that, despite its complexity and logistical challenges, has to be done correctly. That it runs so smoothly and efficiently is indicative of the high level of performance of the examinations department, as well as all the hard work done by the Court Registrar, Local Coordinators, Senior Examiners and Examiners – among many others.

The number of candidates now is considerably greater than when most Fellows presented. Nowadays, an examination may have to cater for up to 250 candidates, nine specialties, 150 examiners, and 380 patients for clinical vivas, spread over multiple hospitals. On top of this, arrangements have to be made for specific needs of the specialty courts, such as prosections for anatomy.

It is also necessary to organise facilities for the multiple examiner meetings (full court, executive, and specialty court meetings), taxis (for examiners and patients), buses and accommodation for the examiners. During the examination the marking sheets are collected and manually collated in preparation for the specialty court meetings and presentation to the Full Court.

The dates for the examinations are now worked out nearly two years in advance, in part to make it easier to avoid clashes with the activities of specialty societies and other RACS groups. They are held in May and September, with the written papers several weeks earlier.

Ongoing damage to the infrastructure of Christchurch – and perhaps the reluctance of candidates unused to earthquakes to want to be examined there – has meant that for the next few years Christchurch will not be used as an examination venue.

Determination of the location of future examinations has been affected by the Christchurch earthquakes, which have caused loss to much of the infrastructure in the city. Decisions on venues also have to consider whether they have the capacity to handle the increasingly large number of candidates, particularly for the Australian May examination which tends to be the largest examination.

Having said that, the next examination in Adelaide in September will have 62 General Surgery candidates, which is certainly an extraordinarily high number for a single specialty in a smaller city. The current plan for venues over the next few years is outlined in Table 1.

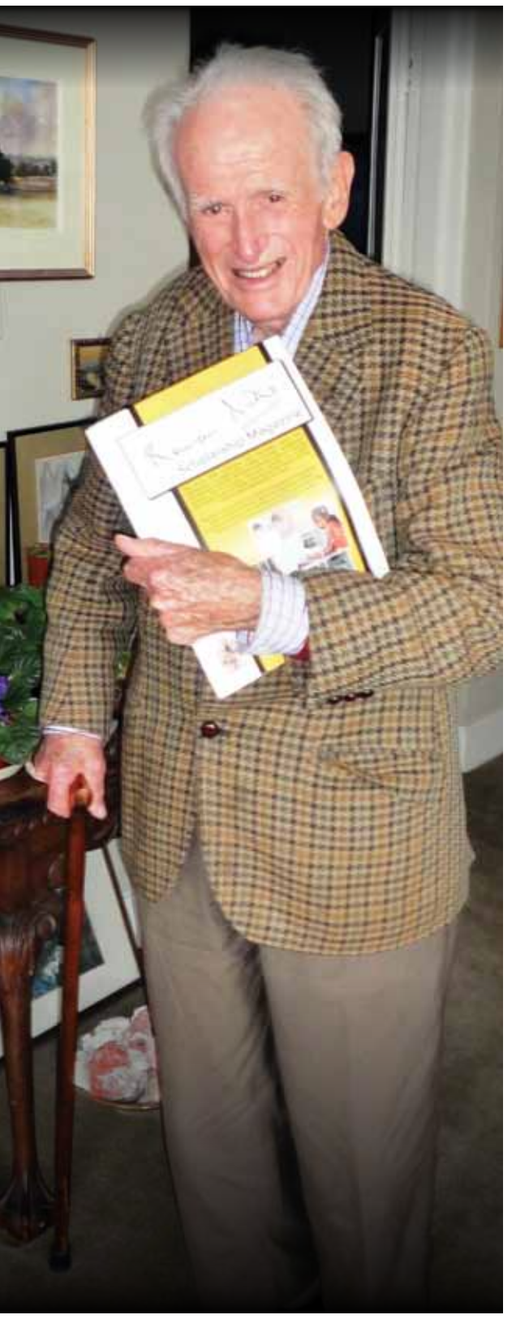
The increase in the number of candidates for the May examination in some specialties has reached the stage where the strain it puts on resources is such that from 2012, candidates applying to sit in May will indicate a preference for venue, but places will be allocated on a first in, first served basis.

The implication of this is that occasionally, if the resources of a venue are exceeded for a specific specialty, a few candidates may have to sit in the other country (most likely in New Zealand either the week before or the week after the Australian exam). In the longer term, if the candidate numbers continue to rise, it is possible that a fourth examination may have to be held.

Table 1.	Venue	2012	2013
May			
Australia (alternating)	Melbourne Brisbane	Brisbane	Melbourne
New Zealand (alternating)	Auckland Wellington	Auckland	Wellington
September			
Australia (alternating)	Adelaide Sydney	Sydney	Adelaide

Rowan Nicks – personal reflections

A great life of giving so that they can give



John Masterton

In early May 2001 in my capacity as coordinator of the College of Surgeons Annual Scientific Congress in Canberra I was sitting in a somewhat cramped little temporary office surrounded by a confusing jumble of papers and files. It was the opening day of the Congress and things were a bit hectic as they usually are at these times.

This was going to be my last Annual Scientific Congress as coordinator and yet in the back of my mind I still wanted to contribute to College affairs one way or another. My future activity was uncertain. Little did I know that in a couple of years I would be back in the job before Campbell Miles took over with all the consummate skill that he has shown over the past few years. Meantime matters were soon to take an unexpected turn.

People were coming in and out of the office in a bewildering stream when to my surprise my friend Brian Morgan came in accompanied by Rowan Nicks. While I knew of Rowan, as everyone in the College did, as the distinguished benefactor he was, I really did not know him very well. Nor did I know of his history. Our paths had seldom crossed.

Brian and Rowan wanted some help. "Would I check a document Rowan had prepared, perhaps edit it and discuss its contents?"

I may say my first task was to decipher Rowan's near illegible handwriting, but on the other hand I said 'yes'. How could one say 'no' to Rowan? This was the beginning of a wonderful association that I have had for the past 10 years.

After the editing was over I had begun to understand something about Rowan's scholarship ambitions. Shortly afterwards he asked me to join his committee. Armed with insight, I readily agreed. I was soon to learn it was difficult not to agree with Rowan.

The committee at that time was chaired by Anne Kolby who was soon to become our first female president. My knowledge of the committee was sparse. This was all to change with some measure of speed as Anne, because of her commitment as president elect, relinquished the chair and I was appointed in her place. I had to learn quickly that the Rowan Nicks Scholarships demanded a fair deal of dedication and in particular it was imperative that I got to know Rowan, his history and his philosophy. As a start, Emeritus Professor Miles Little briefed me very thoroughly on this. Miles and Rowan had worked closely together from the initiation of the Scholarships since 1987.

In 2001 Rowan was already 88-years-old. He had had a long, intensely interesting and productive life and remarkably he was still deeply involved in many things, particularly in his various scholarships. He still travelled widely. Here was a man who had had a distinguished record in the British Royal Navy in the Second World War and who had been decorated with the Order of the British Empire.

After the War he had a similarly distinguished career as a cardio-thoracic surgeon first in his native New Zealand and then in the same capacity at the Royal Prince Alfred Hospital in Sydney. Finally, after the death of his beloved wife Mary and his soon retirement from the Royal Prince Alfred Hospital he, often with his friend Sir Edward (Weary) Dunlop, travelled the world observing, working and helping people in Africa, India and Asia. All these three aspects of his life have been wonderfully described in his autobiography, The Dance of Life.

For my part in 2001, I had now entered into Rowan's life and begun to participate in his scholarship activities. It is important to realise that he had ample means inherited from his parents and now in his later years he was fulfilling his ambition to help others and encourage others to help others by means of his scholarships. His philosophy had long been 'to offer help to young surgeons from developing countries who have shown particular promise and who are destined to be leaders in their own countries'. One of his oft repeated mantras was 'to teach the teachers to teach others'.

John Masterton with Kondwani Chalulu from Malawi and Dr Anagha Zope from India, and Rowan Nicks.

Rowan Nicks and Zamzuri Zakaria

It is appropriate at this time when Rowan has died to describe his legacy, to describe the various scholarships he has established and which are handsomely endowed by his estate which has been bequeathed almost in its entirety to the Royal Australasian College of Surgeons with a subsidiary, but none the less substantial bequest to the Rowan Nicks/Russell Drysdale Fellowship Foundation of which more anon.

In 1990 Dr Godfrey Muguti, a young general surgeon from Zimbabwe was awarded the first Rowan Nicks International Scholarship. Rowan's friend Professor, now Emeritus Professor, Miles Little hosted Godfrey at Westmead Hospital in Sydney in 1991. He was a most successful inaugural scholar and has gone on to be a leader and indeed Professor of Surgery in Zimbabwe.

Since Professor Muguti's scholarship there have been many more international scholars coming from Africa, India and Asia. There have been many successes and they have contributed to the richness of our surgical culture in Australasia and more particularly have returned to their countries to enrich them.

Soon after Rowan established his international scholarships, he saw the need for a specific but similar scholarship for the small nations in the Western Pacific Rim – Fiji, Papua New Guinea, Solomon Islands and Vanuatu – all close neighbours of Australia and New Zealand.

These countries have a special need for their young surgeons to be trained and to retain them. They do not want a brain drain and they want to establish links with surgeons in Australasia. The objectives of the program have been successful and various general and specialist surgeons have had their training enhanced to the benefit of their homelands. Like the International Scholarships, the tenure of these can vary from three to 12 months.

While Rowan's most fundamental aim was always to help those less fortunate than ourselves and with fewer resources, he also had a breadth of vision encompassing surgery worldwide. He truly had an international perspective and had a sense of the need to maintain the bond between Australia and his homeland New Zealand and between Britain and Ireland. He even dreamt of an Australasian/European surgical link.

The latter was logistically too difficult to achieve, but nevertheless in 2009 we were able to award our first two Australasian and United Kingdom and Ireland Fellowships and the first Australian and New Zealand Exchange Fellowships. These are awarded to surgeons who have completed their training and are on the cusp of becoming consultant surgeons. Whereas for years surgeons from Australasia sought post-graduate experience in the US and Europe, now increasingly we have centres of excellence in our own countries that are much sought-after. Rowan's vision and legacy have made this a real possibility that supplements some scholarship facilities that already exist from other sources.

Retirement in writing only

After retirement from the Royal Prince Alfred Hospital and after the death of his wife Mary, Rowan not only travelled and worked abroad, but also within remote regions of Australia. He witnessed the medical needs of the Australian indigenous community. He was touched closely.

A man not willing to accept the status quo he linked up with the late artist Sir Russell Drysdale's estate several years ago to offer scholarships in Indigenous Health and Welfare to indigenous and even non-indigenous health workers who were working with indigenous health issues. This scheme has been highly successful. It is based in the Faculty of Medicine of Sydney University with the patronage of the Governor of New South Wales, Her Excellency Professor Marie Bashir, A.C., C.V.O., a former colleague and close friend of Rowan.

As chair of the Rowan Nicks Committee of the College, I am a member of the Rowan Nicks/Russell Drysdale Committee of the Faculty of Medicine of Sydney University. This committee has the good fortune to have Lynne Drysdale, the daughter of Sir Russell as one of its members. She and Rowan have been good friends. It is a truism to say that Rowan was a friend with everyone he encountered.

The sum of these scholarships and fellowships and the resultant annual financial outlay is no small call on the funds that Rowan has made available and will be made available from his estate. He was single-mindedly determined that his scholars – and he indeed liked to see them as his scholars – be supported. Fortunately that has proved to be the case and will be in the future.

Australia and New Zealand each have an honours system recognising their citizens' achievements. Rowan never took Australian citizenship during his many years in the country of his adoption. Consequently he missed out on an Australian award which he very richly deserved. Fortunately with appropriate lobbying this was finally achieved in his twilight year in 2010.

On 26 August, 2010, Her Excellency Professor Marie Bashir A.C., C.V.O., Governor of New South Wales and Rowan's friend, pinned the medal of the Order of Australia on Rowan at a signal day in his life. That day he returned a very happy man to his apartment, Manar in Pott's Point. In spite of failing health he had stayed in his beloved flat. As he said repeatedly to friends concerned about his welfare and who were suggesting he move to a retirement home – 'moving out is not negotiable'.

On 26 May 2011, Rowan died peacefully at home. He had been nurtured magnificently during his latter months by Kate Lehmann. A nursing sister and carer, she loved Rowan and he loved her. She sustained him. Thus ended a wonderful and fulfilled life.

The thanksgiving service in St. James Church in Sydney was wonderfully appropriate and at its conclusion when the clergy and Rowan's casket moved out into the sunshine of a beautiful winter's day in Sydney, the traffic in the street stopped as the bells of the church rang out.

His legacy will be long remembered and generations of young surgeons from around the world will benefit.

Vale Rowan Nicks, a truly great man.

Searching for a better way

Dr Deborah Wright feels most fortunate at the research opportunities that have come her way

The College's Foundation for Surgery NZ Research Fellowship has helped fund a research project that could result in a prognostic model to assist clinicians design personal treatment plans for patients with colorectal cancer.

The Fellowship was endowed upon New Zealand general surgical trainee Dr Deborah Wright in 2010 to fund the first year of her PhD research now being conducted at the University of Auckland.

Dr Wright said that while Australia and New Zealand have among the highest rates of colorectal cancer in the developed world, with treatment typically combining both surgical resection and chemotherapy, almost half of those given chemotherapy derive no benefit.

She said that while clinicians had great expertise in selecting patients who would do well with the combined treatment and those with metastasised tumours who would not, there was a large cohort of patients with Stage Two and Three colorectal cancers whose response to such treatment was less well known.

"We are now at a stage in our understanding of colorectal cancer where we need to be more precise in our knowledge of which patients and which types of tumours will do well with chemotherapy and those who do not need it either because the tumours can be treated successfully with surgical resection alone or cannot be treated at all," she said.

"Chemotherapy is expensive to provide in terms of the health system budget and expensive for patients in terms of side-effects and time away from work, so if we can determine more precise treatment plans for those patients the benefits, particularly in terms of such a relatively common disease, could be significant."

Dr Wright said that while a number of research units around the world were now working on computerised models to guide patient care, the work being done in Auckland was unique in that it did not seek to replace current knowledge, but add to it.

She said new genomic information based on the expression of messengerRNA and microRNA and the affects of various chemotherapeutic agents would be used to develop complex mathematical models to guide surgeons, pathologists and oncologists in designing personalised treatment plans.

"Clinicians already decide whether systemic chemotherapy is indicated based on disease stage – an aggregate of tumour, lymph node and metastasis status – and the individual patient's co-morbidities and functional status and we are mindful of adding to that knowledge built up over decades," she said.

"We are working instead to develop a multi-modality model which will combine the clinical and pathological data traditionally used to make treatment decisions with molecular tumour data – that is information about the expression pattern of large numbers of genes within the tumour – to achieve more accurate prognosis and prediction of treatment benefit for individual patients.

"Clinicians could then input details of a patient's gender, age and tumour stage along with molecular features and histological features and the computer could then spit out information about the likely responses to various treatment options."

Dr Wright, whose work is now being funded by the Health Research Council of New Zealand, said such a computerised treatment guide was still some years off with large patient data sets required.

Also as part of her research, Dr Wright conducted a national online survey of cancer clinicians to determine the uptake and influence of computerised prognostic models and existing molecular tests on the care of patients in New Zealand.

She said that while there are molecular modelling tests available in New Zealand and Australia for malignancies such as breast cancer, the research team was keen to learn how many clinicians used them to guide their decisions.

"The survey we conducted asked for feedback from a range of clinicians including surgeons, pathologists and haematologists and we found that such tools influence the care of many patients with cancer in New Zealand," she said.

"We were also very interested to learn that 90 per cent of clinicians predict that their frequency of use and impact on clinical decision-making will increase markedly over the next 10 years.

"All of this means that if we design a prognostic model that more accurately allows clinicians to target treatment to particular patients we should see increased patient survival and decreased patient morbidity."

Dr Wright is undertaking her PhD under the supervision of Mr Arend Merrie, Colorectal Surgeon at Auckland City Hospital and Associate Professor Cris Print of the University of Auckland.

"I had the great opportunity to undertake a science degree in Cell and Molecular Pathology at the University of Birmingham, at the same time as I was doing my medical degree, which both introduced me to research and sparked my interest in molecular biology," she said.

"When I was offered the chance to work with this amazing team as part of a wonderful research project in a world-class laboratory, I felt most fortunate.

"Then receiving the financial and professional support of the College was very meaningful to me in that you can sometimes feel overwhelmed by the scope of the research so to know that senior, knowledgeable people believe that not only is the research of value, but that you can do it is very affirming."

With Karen Murphy

The Milton Shield

A treasure from our past will now be on display once again

Mike Hollands
Treasurer

One of the College's more unusual treasures has not been seen for some time now. It used to hang in the foyer of the Great Hall, but when the old east wing was demolished to make way for the Skills Centre, no place could be found to exhibit it properly. So in recent years it has been retained in storage.

The Milton Shield was given to the College in 1968 by Conrad Blakemore, whose family had owned it for almost 100 years. There are three known examples of this Shield in Australia: one is in the Powerhouse Museum in Sydney; one belongs to the National Trust, and is on display at Rippon Lea; and one belongs to the College.

They are electrotype reproductions made by Elkington & Co of an original created by Léonard Morel-Ladeuil between 1864 and 1866, and exhibited in Paris at the Exposition Universelle of 1867. Following the sensation it caused in Paris, where it won the artist a gold medal, the British Government bought the original for the (then) enormous sum of £2000. It is now in the Victoria & Albert Museum in London.

The original is made of silver and damascened iron, and measures 880mm in height by 630mm in width. The scenes are modelled in low relief in a technique known as repoussé, where the forms are created by beating out the metal from behind.

Electrotypes are exact replicas of metal objects. The process was invented to reproduce pages of text made up in movable type, in order to cut down setting and printing time. But it was quickly applied to other objects, especially old coins. Once a mould had been made of an original object, it could be reproduced in alloy thousands of times.

Léonard Morel-Ladeuil (c1820-1888) was one of the foremost metalsmiths of his time. He was apprenticed to Morel, a manufacturer of bronzes, where he learned the techniques of chasing and finishing, and then to the silversmith Antoine Vechte, from whom he learned the art of repoussé. He found favour with the emperor Napoleon III, but this aroused the jealousy of the French guilds of goldsmiths and silversmiths, who made it difficult for him to earn a living.

In 1859 however, Elkington & Co. offered him a position, and he migrated to England. At first contracted for only three years, in the end he remained with Elkingtons for 23 years, in Birmingham and then in London. After retiring from working life he returned to France and settled in Boulogne, where he died of a heart attack. He was buried with much ceremony in his home town of Clermont-Ferrand.

The firm of Elkington & Co was founded in 1840 by George Richards Elkington (1801-1866) and his cousin Henry Elkington. It grew out of an old-established silversmithing business, and its great success lay in the process of electroplating. G.R. Elkington perfected and patented the process of depositing a layer of silver over a copper base using solutions of potassium cyanide. This process had been shown to him by John Wright (1808-1844), a Birmingham surgeon whose pastime was electrical experimentation.

"Following the sensation it caused in Paris, where it won the artist a gold medal, the British Government bought the original for the (then) enormous sum of £2000. It is now in the Victoria & Albert Museum in London"

It quickly superseded the traditional method of plating by hand, which was practised largely in Sheffield. Elkingtons produced a large range of household silverware, which the electroplating process had made affordable to the increasingly affluent middle classes. But they also produced electrotype reproductions of significant objects of artistic merit, such as the Milton Shield.

Conrad George Howell Blakemore MB ChM DOMS FRCSEd FRACS (1898-1976) was an eminent Sydney ophthalmic surgeon. After attending The King's School and entering the Sydney University Medical School, he enlisted on 26 July, 1917, as a sapper in the Engineering Field Companies. On his return to Australia in 1919, he continued his medical degree, graduating MB ChM in 1924. In the same year he married Una Litchfield. Their son Michael, later to become an eminent theatre director in the UK, was born in 1928.

Conrad's postgraduate work included House Surgeon at the Sydney Hospital and the Royal Westminster Ophthalmic Hospital, and Clinical Assistant at Moorfields Eye Hospital and the Edinburgh Royal Infirmary. He gained his FRACS by election on 29 September, 1930. He became Honorary Ophthalmic Surgeon at the Sydney Hospital, and was a member of the Court of Examiners. During World War II he served as Senior Consultant Ophthalmic Surgeon to the RAAF, with the rank of Group Captain.

The name of the Shield derives from the scenes on it, illustrating episodes from Paradise Lost by John Milton (1608-1674). The Shield is oval in shape, and is divided into several fields, each of which shows a different scene.

The central area is circular, and depicts the archangel Raphael telling the story of the war in Heaven to Adam and Eve in the Garden of Eden. Immediately below this is the figure of the archangel Michael trampling on the defeated Satan. At the bottom of the shield are two figures representing Sin and Death. On either side of the central circle is a kidney-shaped field, the one on the left showing the army of the rebel angels assaulting Heaven, and on the right the fall of the rebel angels. At the top of the Shield are figures of cherubim and seraphim.

The entire surface is covered in floral and animal decoration, and patterns. A cable moulding runs around the outer edge. The College's Shield is set in a heavy timber oval frame bordered with red velvet and glazed. It has a hinged foot at the back, an indication that it was intended to stand ostentatiously on a very large and elaborate Victorian-era sideboard.

The Shield will in time be put back on display in the Museum.

With Geoff Down, College Curator

Congratulations on your achievements

The RACS International Medal is awarded to Fellows who have made lasting contributions of an exceptional nature over a long period of time in the delivery or development of surgery for underprivileged communities overseas.

Mr Ian Carlisle FRACS
Award of the International Medal

The International Medal is awarded for outstanding service overseas over a sustained period.

Ian Carlisle attended Brisbane Boys' College before studying Dentistry at the University of Queensland. During his undergraduate years (1962-1966), he was a member of the UQ Rowing VIII. He practised as a dentist in London before returning to Australia to studying medicine at the University of Melbourne, graduating in 1973. Following internship, Ian trained first in General and then in Plastic Surgery. He gained experience overseas in Toronto and Harvard before establishing his career in Plastic and Facio-maxillary surgery in Melbourne. He worked for over 25 years at The Alfred Hospital and Cabrini Hospital.

Mr Carlisle has been actively involved with Interplast since its inception in 1983. He was the Chairman of its Surgical Committee (1995 to 2009) and has been a member of the Board since 2000. His international involvement has been in South East Asia and particularly in Indonesia. He has made 27 visits to Indonesia since 1986, providing specialist services and promoting education and training in plastic surgery.

Ian was also involved in the re-organisation of Burns and Reconstructive services in Bali following the catastrophic bombing in 2002. Ian Carlisle continues to promote the international work of this College and he continues to represent Interplast as an active member of the International Committee.

Mr Ian Carlisle is a most worthy recipient of the College's International medal.

Citation kindly provided by David Watters

Trauma: Lessons from the leading edge – 2011 GSA Annual Scientific Meeting

The upcoming Annual Scientific Meeting for the General Surgeons has so much to offer

A steaming hub of Australian history, culture and diverse landscapes provides the location for this year's General Surgeons Australia Annual Scientific Meeting. While Darwin is recognised for many things, from crocodiles to being the gateway to a world heritage listed site, it is also home to the internationally recognised National Critical Care and Trauma Response Centre, making Darwin a truly fitting location for the ASM – Trauma: Lessons from the Leading Edge.

The Scientific Program comprises a number of educational sessions with a highly practical focus, specifically targeted at the General Surgeon and Trainee. Contributing to the success of the program are nationally and internationally recognised guest speakers who are all leading specialists in trauma, including keynote speakers Dr Chui Ming Terk, a pioneer of Trauma Surgery in Singapore, and Dr Chris Giannou from Greece, war surgeon and former Head Surgeon for the International Committee of the Red Cross.

Incorporated again into this year's program is the well-received Trainees' Day taking place on Friday, 16 September, with the theme of Trauma Surgery. Dr Damian McMahon, Director of the Shock and Trauma Service at the Canberra Hospital, has put together an innovative and up-to-the-minute program comprising case presentations and informative lectures. Prior to this will be the Trainees' Dinner, held on Thursday, 15 September, at one of Darwin's award winning restaurants – Char.

As well as the ASM program, we are very fortunate to offer the National Critical Care and Trauma Response Centre two-day Surgical Disaster Course, which provides training for Disaster Surgery in the field. Developed to provide participants with exposure to a range of essential techniques and survival skills, this course allows Fellows the opportunity to manage successfully when deployed as part of an AusMAT. Places are limited, so to avoid disappointment get in quick and register for this fantastic opportunity.

There are also a number of valuable workshops running throughout the program, from SAT SET and Keeping Trainees on Track, to The Risks of Failed Patient Tracking and Effective Management of Adverse Events and Patient Complaints. For further information please visit www.generalsurgeons.com.au to download a copy of the Provisional Program.

Of course it's not going to be all work and no play in Darwin in September. While the weather is at its best during the dry season; blue skies, balmy nights and warm days, why not get out and about and experience what Darwin has to offer. We have endeavoured to put together a relaxed, laid back and family-friendly Social Program including a Darwin city sites tour, heritage walking tour, Adelaide River jumping crocodile cruise and Litchfield National Park tour. Also upping the ante this year is the ASM Golf Championship which sees Fellows taking on Trainees. Who will walk away with the highly sought after trophy?

The ASM also allows you the opportunity to experience some of Darwin's best and diverse restaurants, with the program incorporating a Welcome Reception at Crocosaurus Cove. Enter the world of the awesome Northern Territory Saltwater Crocodile, with some of the largest in captivity on display. As well as enjoying a relaxed and social event with your peers and colleagues, witness a member of the GSA team face her fears in the 'Cage of Death'! As always the Gala Dinner will be the event not to be missed, this year taking place at Pee Wees at the Point, along the waterfront. Nestled among the tropical palms and natural environment of East Point Nature Reserve, Pee Wees commands sweeping views across Fannie Bay to the skyline of Darwin. This social affair will include a semi-formal three course dinner and entertainment.

So why not bring your family along to experience the best that Darwin has to offer. We look forward to seeing you there!

General Surgeons Australia

For further information, email gsa.asm@surgeons.org or go to the web http://www.generalsurgeonsaustralia.com.au or call +61 3 9249 1139.

Victorian Audit of Surgical Mortality – 2010 Annual Report Release

VASM commenced auditing surgical mortality in Victorian public hospitals in January 2008. This report represents data collected to the end of June 2010.

Colin Russell
Clinical Director, VASM

Audit participation

Participation in Victorian Audit of Surgical Mortality (VASM) by Victorian Fellows has risen to 89 per cent. The return of case record forms has risen to 79 per cent. However, compliance in completing all necessary fields in the various forms can still improve.

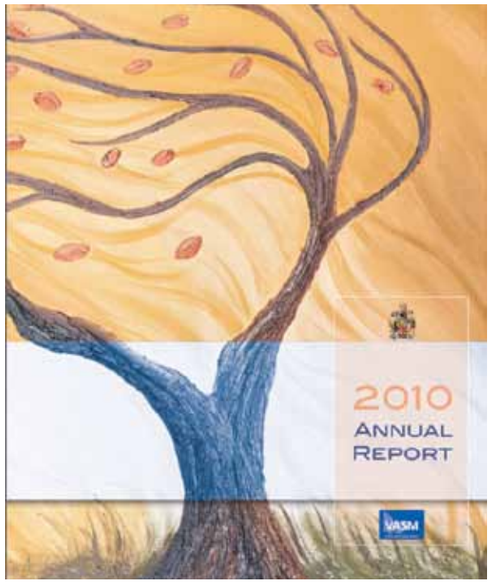
All public hospitals with relevant surgical activity are now participating. Funding has been increased to allow recruitment of Victorian private hospitals. At end of June, 2011, just over 50 per cent of eligible private hospitals have agreed to participate. The number of patients whom death has been attributed to surgery is 2,551 over the two and a half year period covered by this audit. In one year, some 352,677 patients underwent surgical procedures in the Victorian public sector. The number of deaths attributed to surgery is therefore a very small percentage.

Demographic and risk profile

Review of the demographic and risk profiles confirms the majority of surgical deaths have occurred in elderly patients with underlying health problems, admitted as an emergency with an acute life-threatening condition often requiring surgery. The actual cause of death was often linked to their pre-existing health status. Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved, not the treatment provided. The most common causes of death reported are cardiac and respiratory failure. This is congruent with the most common comorbidities in this series of patients.

Risk management

Risk management strategies for this generally elderly, sicker group of patients are especially important. The audit looks at three parameters: Venous Thromboembolism (VTE) prophylaxis, use of critical care facilities and fluid balance management.



VTE prophylaxis: Prophylaxis was provided in over two-thirds of audited deaths. A conscious decision to withhold prophylaxis due to clinical contraindication was the reason given for non-provision. Inadvertent omission of prophylaxis was rare, only occurring in 1.7 per cent of cases.

Use of critical care facilities: Close to half the patients in this audited series received critical care support during the course of their hospital stay. Assessors felt critical care support might have benefited a higher percentage of patients. The reasons why support was not provided are a recent addition to the clinical information gathered and data is not yet available for analysis.

Fluid balance during treatment: There was a perception that this may have been an issue of management in only 2.6 per cent of cases reviewed.

Operative profile

In a small percentage of patients (12.9 per cent, 144 patients) no operative intervention occurred. This was an active decision not to proceed and usually occurred in patients admitted as an emergency for an irretrievable clinical problem. A total of 1,453 separate episodes of surgery occurred in 900 patients. The most frequent operative procedures described were for trauma or acute abdominal pathology. This reflects the high percentage of patients admitted as emergencies in this series. A consultant performed the surgery in 54 per cent of instances and made the decision to proceed to surgery in 60 per cent.

There was an unplanned return to the operating room in 132 (14.7 per cent) of the 900 patients. Unexpectedly the rate of unplanned return to the operating room was significantly higher in patients admitted electively. This has occurred despite a higher percentage of elective cases being operated on by a consultant surgeon. There is no obvious explanation for this trend. This will be monitored over time.

Unplanned return to the operating room is often, but not always, necessitated by a complication of the initial procedure and is associated with increased risk of death. Consultant involvement in such cases is highly desirable. Direct consultant involvement in such cases has risen from around 30 per cent in 2007/08 to 80 per cent in 2009/10. This recognition of the need for direct consultant involvement is to be commended.

Inter-hospital transfers

Twenty-two per cent of cases required inter-hospital transfer. Issues of patient care related to transfer were raised in a third of these cases. The most common criticism was that transfer occurred inappropriately late in the course of the patient's illness.

Peer-review outcomes

Assessors involved in the audit process review and appraise the appropriateness of the clinical care provided to each case reported to VASM.

Second-line assessments (SLAs): The frequency of need for SLA could be seen as an indirect measure of quality of care. Second-line assessments are requested for cases in which the clinical care needs to be looked at more closely or the treating surgeon did not provide sufficient information to reach a conclusion. Such assessments were required in 14.3 per cent of audited cases. This rate is similar to other states. Importantly the rate has decreased from 18 per cent in 2007/08 to 8.6 per cent in 2009/10.

It is disappointing that SLA was most commonly required because the clinical information provided by the treating surgeon was inadequate.

The need for SLA was similar among surgical specialties, and metropolitan and rural hospitals.

Clinical management issues: Assessors use a standard spectrum of criticism to convey their perceptions of appropriateness of care. These are described in detail in section 2.11.3 of the annual report.

In 88 per cent of audited deaths, no, or only minor, issues of patient care, were perceived. However, in 12 per cent of cases more major issues of care were identified (areas of concern and adverse events).

Over the audit period (2007 to 2010) there has been a significant decrease in the frequency with which assessors are identifying clinical management issues. The incidence of more major criticisms of clinical care is similar among the surgical specialties. It is of some interest that in cases in which there was no operative procedure there was a significantly higher rate of areas of concern or adverse events. The available data does not tell us the reason.

It is important to remember that criticism of clinical care is not always attributable to the surgical team. A third of the issues identified were attributed to other specialty areas.

Perceived impact of identified issues on clinical outcome: There was a perception that the clinical management might have been better in 395 of the 1,113 audited deaths (35 per cent). In only 47 of these 395 patients (4 per cent of audited series) the clinical management was deemed likely to have contributed to the adverse outcome. The perceived relationship of clinical management to outcome was less clear in the remaining cases.

Frequency of specific issues of clinical management: The most common clinical issue among the 496 specific issues identified was delay in delivery of definitive care. This occurred at multiple levels in the care pathway. The underlying problem is usually delay in establishing the true diagnosis leading to late referral and delay in implementing definitive treatment. A similar pattern has been reported by the Western Australian Audit of Surgical Mortality (WAASM) and the South Australian Audit of Peri-operative Mortality (SAAPM). The recent Case Note Review Booklet published by VASM features clinical cases that exemplify this problem. Patients with the clinical risk profile demonstrated in this audited series tolerate delay in treatment very poorly.

The full report is available on the College website at http://www.surgeons.org/VASM

In Memoriam

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

>Allan Campbell,
SA General surgeon

>Ronald Todd,
QLD General surgeon

>Hugh Dudley,
UK General surgeon

>Peter Barnes,
WA Otolaryngologist

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website www.surgeons.org go to the Fellows page and click on In Memoriam.

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
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Process Communication Model

Improving the way you interact in your workplace can have many positive changes

Marianne Vonau
Chair, Professional Development Committee

The following quotes are what surgeons have said after attending a Process Communication Model course.

"I just wanted you to know that I have already received very positive feedback from one of the nurses at work about my being a lot more effective in my interactions with patients. I am not all that conscious of this change, but apparently it is very noticeable."

"I keep on thinking about the seminar a lot, if not most of the time. I am confident that what I learnt will impact positively on patient safety and team building, although it's early days. What I can tell for sure is that I feel empowered and happy to a degree way beyond my expectations. Million thanks!"

"PCM has opened my eyes to this mysterious line of communication signals, giving me power beyond belief. It's like I have learnt a new language and can now talk to people so they understand."

In 1971, Dr Taibi Kahler observed a process by which people interacted with one another both in positive and negative ways. He discovered that human behaviour could be identified objectively as being either productive (communication) or non-productive (miscommunication). He believed that both patterns were sequential, measurable and predictable.

In 1978, NASA used this theory to develop Process Communication Model (PCM) in the selection, placement and training of astronauts. PCM has since been modified to provide a tool which helps people to understand, motivate and communicate more effectively with others. More recently it has been used in medical settings in the US as well as Australia and New Zealand.

In July, the American Society for Quality (AQS) published a book Establishing a Culture of Patient Safety: Improving Communication, Building Relationships and Using Quality

Tools, providing a road map to help healthcare professionals establish a 'culture of patient safety' by applying the concepts of PCM.

The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the six different personality types; each person represents a combination of these types, but usually one is dominant. If these needs are met positively, individuals are happier, healthier and more productive. If the needs are not met positively, individuals exhibit signs of 'distress' and do things consciously or subconsciously to get their needs met negatively. In summary, PCM:

- Provides the tools to help identify personality types
- Assesses character strengths
- Reflects preferred management styles and choice of best communication 'channels'
- Identifies an individual's psychological and motivational needs
- Predicts potential management/interaction success or failure patterns under stress
- Provides intervention points for failure patterns
- Offers ways of reinforcing positive, productive behaviours
- Provides the tools to make interaction between individuals more effective

The College piloted and evaluated the PCM course in 2010 with 24 participants; 15 Fellows and nine Trainees. The aim of the evaluation was to assess the potential impact, value and utility of PCM as a training curriculum for surgeons. Participants were asked to complete the same survey on three occasions: at the start and end of the course and again 3-4 weeks post completion of the course.

The participant responses were collated and analysed by Next Element LLC, a US-based company specialising in evidence-based skills development. The results of the post course outcomes confirm the positive impact that PCM training had in the short term:

- The pre-course self-assessment of participant social-emotional skills (self-efficacy: openness, resourcefulness, persistence) showed, in comparison with reference data:
  (i) Values at the lower end of a normal distribution in the areas of 'At home' and 'In private practice'.
  (ii) Significantly low values in the area of 'Working with admin staff in public health'.
- The magnitude of change ('effect sizes') achieved across all areas by the PCM training was seen by Next Element, in comparison with reference data, as 'dramatic' and beyond expectations.
- The most significant change was in the surgeons' assessment of their ability to more effectively deal with admin and management reps of their hospital in the future.
- The ratings for the item 'My ability to help reduce complaints, lawsuits, mistakes and other unintended outcomes' went up slightly between the immediate post evaluation and the follow-up evaluation a few weeks later.

I have been so impressed with the evaluation results that I am attending a PCM workshop.

See you there!

For more information, contact the Professional Development Department at +61 3 9249 1106 and PDactivities@surgeons.org or visit www.surgeons.org

AccessSurgery

a new media-rich resource

Online content will greatly enhance the Libraries learning capabilities

Cathy Ferguson,
Chair Fellowship Services Committee

Over the next six months, the RACS Online Library will be expanding resources in all the surgical specialties. Along with new journal titles and e-books, the new resources will include streaming videos, multi-media and interactive formats designed to support the information needs of trainees and surgeons in their learning and practice.

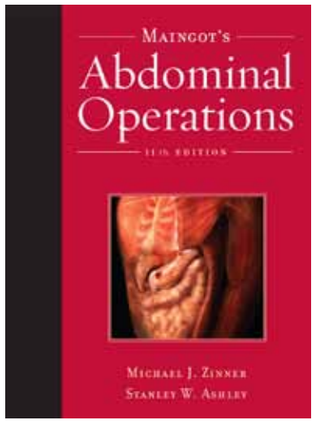
One of the first new products is AccessSurgery from McGraw-Hill who have a very credible reputation in the medical publishing industry. AccessSurgery combines leading McGraw-Hill references with surgical videos and animations. Over 165 videos demonstrate a wide range of surgical procedures and techniques. The range of e-books includes:

>Schwartz's Principles of Surgery, 9thed
>Current Diagnosis & Treatment: Surgery, 13thed
>Maingot's Abdominal Operations, 11thed
>Trauma, 6thed
>Principles of Critical Care, 3rded
>Kuerer's Breast Surgical Oncology
>Adult Chest Surgery
>McGraw-Hill Manual Colorectal Surgery
>McGraw-Hill Manual Endocrine Surgery
>Robotic Surgery
>Obesity Surgery: Principles and Practice
>Current Diagnosis & Treatment in Otolaryngology – Head & Neck Surgery, 2nded
>Smith's General Urology, 17thed
>Current Procedures: Surgery
>Zollinger's Atlas of Surgical Operations, 8thed
>Skandalakis' Surgical Anatomy

Surgeons can tailor their searches to find just videos or images, or they can search the full site. AccessSurgery delivers continually updated chapters, editor's journal reviews, and video podcasts that highlight key surgical techniques. This fully integrated resource also includes a comprehensive drug database updated in real-time, one-click access to related government guidelines, a differential diagnosis tool with over 100 symptoms and diseases, and detailed cancer staging tables.

AccessSurgery supports lifelong learning and assists Trainees in their preparation for examinations by providing over 1,400 questions and answers across the broad range of curriculum along with the ability to track and report scores.

AccessSurgery is available from the College Online Library. You can find it highlighted at the top of the Library's main page. If you have any questions or feedback on AccessSurgery, or would like to recommend resources in your area of specialty, please don't hesitate to contact the Library on +61 3 9249 1271 or email College.Library@surgeons.org



Just one of the e-books now available.

Michael Fink FRACS and Chair of the Clinical Examination Committee has noted, "I think AccessSurgery is a fantastic resource for trainees and surgeons. I particularly like the fact that it is searchable, accessing all relevant chapter sections and multimedia resources."

LOANS FOR TRAVELLING FELLOWS

The Royal Australasian College of Surgeons provides a number of interest free loans to Fellows who plan to undertake approved studies outside Australia and New Zealand.

To be eligible to apply for a loan, an applicant must:
> Be a financial member of the College.
> Demonstrate financial need.
> Be assessed as undertaking appropriate research and/or training.
> Not have an application pending, nor have received, a RACS Scholarship or Fellowship co-incidental with this loan.
> Not receive more than one loan every five years.

Applications can be submitted at anytime with assessment being undertaken upon receipt. Loans will not exceed A$20,000 each and will be subject to the availability of funding.These loans are interest free for a period of up to two years.

Please refer to the College Website for further information: www.surgeons.org/racs/fellows/resources-for-surgeons/loans-for-travelling-fellows

For information on applying for a loan, please contact: T: +61 3 9249 1220 E: travel@surgeons.org

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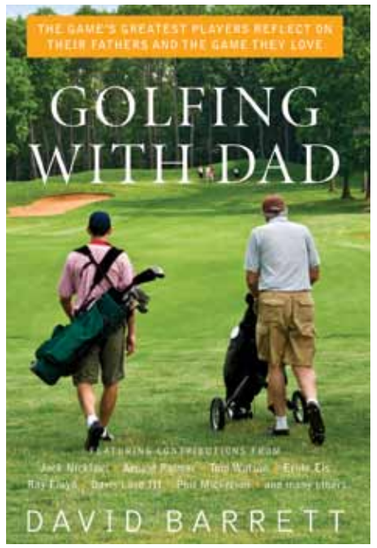

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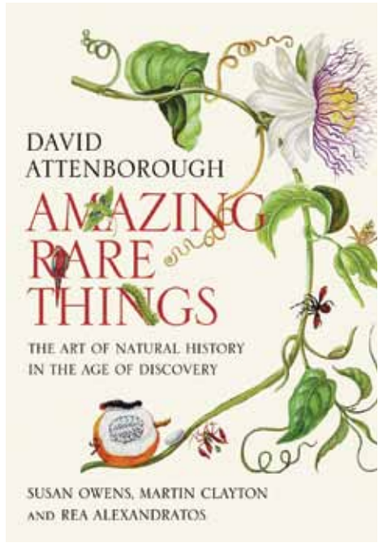

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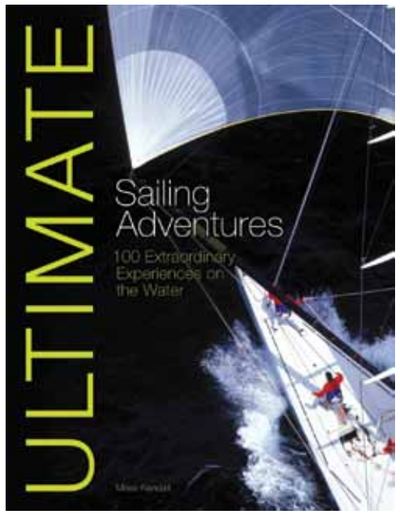

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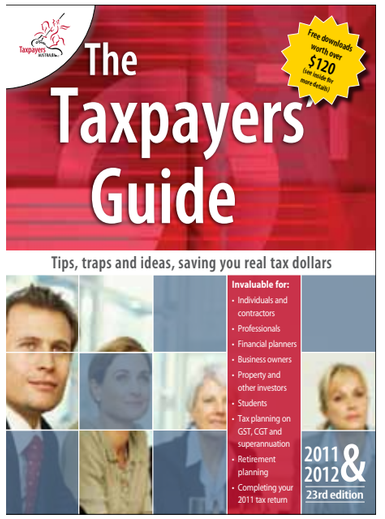

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iPad 2 Fully Loaded

Alan Hess
9781118093191 | Pbk | 304 pages | June 2011
~~AU$32.95~~ **/ AU$28.00**

A hip, straightforward guide to squeezing every bit of functionality from the iPad 2

Apple's new iPad 2 offers new functionality, WiFi or 3G connectivity, a choice of data plans, and a new and more powerful iOS 4 operating system in a thinner, lighter device. This book shows how to get the most from every feature. It covers the two front- and rear-facing cameras, advice on using the multitouch display, and the pros and cons of WiFi vs. 3G. Then it explores video chatting with FaceTime, streaming music and movies to your HDTV, tips on shooting HD video, how to sync the iPad to your computer and transfer content, and much more.

- With its advanced iOS 4 operating system, the iPad 2 offers new functionality, two cameras, WiFi and 3G connectivity, and the availability of thousands of apps
- This book explains how to evaluate and choose a data plan as well as how to set up your iPad 2 with iTunes, transfer content, and sync the iPad with your computer

Golfing with Dad: The Game's Greatest Players Reflect on Their Fathers and the Game They Love

David Barrett
9781616082536 | Hbk | 192 pages | May 2011, Norton
~~AU$24.95~~ **/ AU$18.71**

Golfing With Dad is a heartwarming collection of golf's best players' favourite memories of their fathers and how those memories shaped them not only as players, but the people they are today. Many professional golfers have been greatly influenced by their fathers, and some

of the very best have contributed interviews to this special book, edited by longtime Golf magazine editor David Barrett, the author of Miracle at Merion.

Contributors include Brad Adamonis, Jonathan Byrd, Fred Couples, Ben Crenshaw, Ben Curtis, Ernie Els. Ray Floyd, Jim Furyk, Tim Herron, Zach Johnson, Nancy Lopez, Davis Love III, Graeme McDowell, Phil Mickelson, Johnny Miller, Ryan Moore, Jack Nicklaus, Geoff Ogilvy, Arnold Palmer, Kenny Perry, D J Trahan and Tom Watson.

Amazing Rare Things: The Art of Natural History in the Age of Discovery

David Attenborough with Susan Owens, Martin Clayton, Rea Alexandratos
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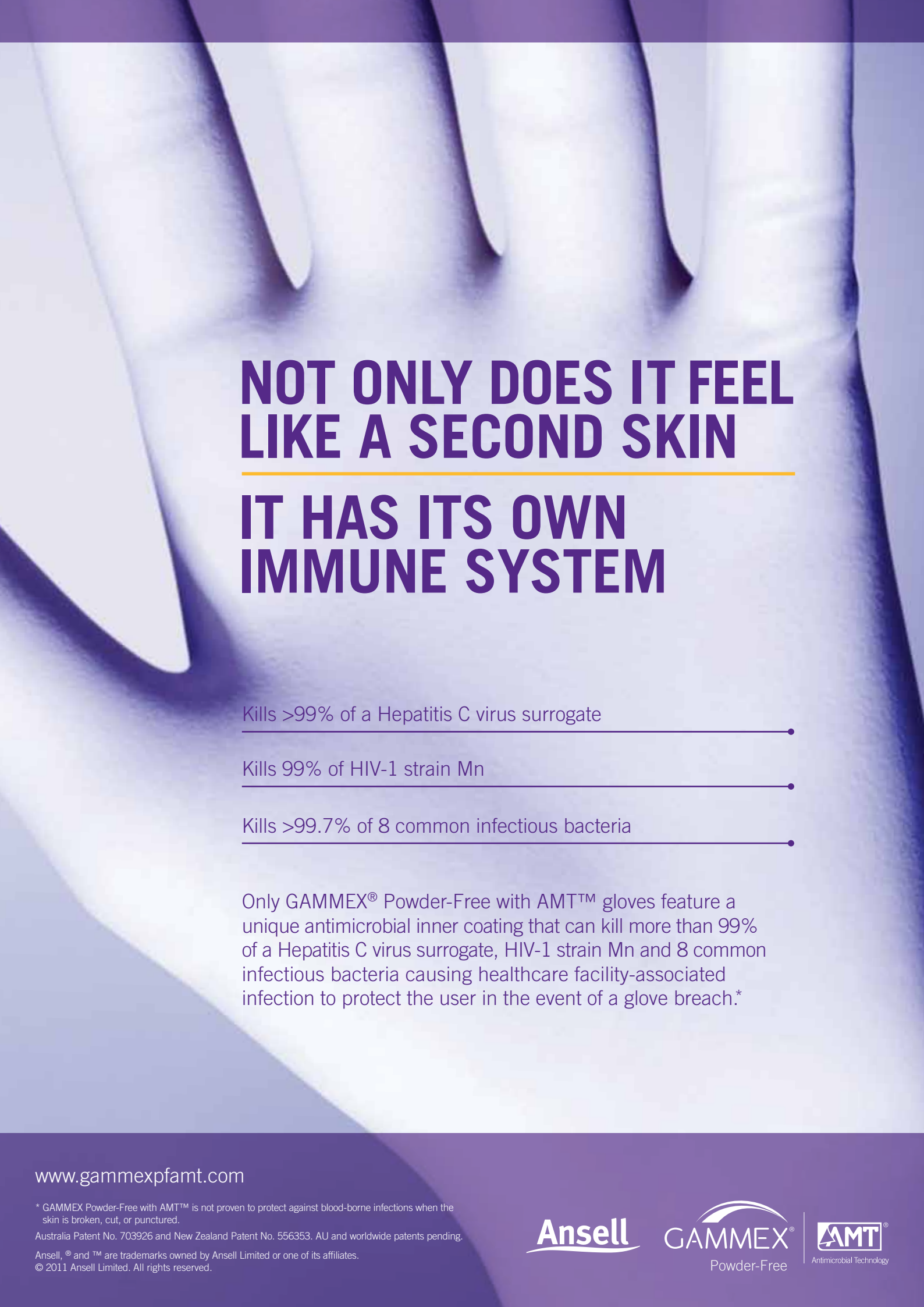

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