Pub: CMC TOTS
Date: 27-JUL-2009
Page: 1
Plate:CMYK

SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
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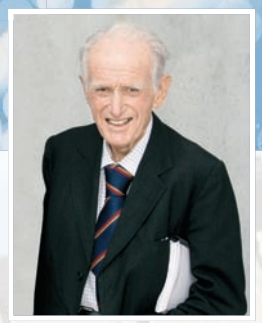
Life on the farm:

Paediatric surgeon Alex Auldist talks about his passion for surgery and farming, page 10

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

Pub: CMC TOTS
Date: 27-JUL-2009
Plate:CMYK
Page: 2

Rowan Nicks Fellowships



AUSTRALIA & NEW ZEALAND/ UNITED KINGDOM & REPUBLIC OF IRELAND

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of the United Kingdom and the Republic of Ireland, and Australia, to apply for the **Rowan Nicks Fellowships**. Rowan Nicks Scholarships and Fellowships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country.

The **Rowan Nicks Australia and New Zealand Fellowship** is offered to a surgeon from Australia to take up the Fellowship in New Zealand. The **Rowan Nicks United Kingdom and the Republic of Ireland Fellowship** is offered to a surgeon from the UK or Republic of Ireland to undertake the Fellowship in Australia or New Zealand. The Fellowships are intended to provide an opportunity for surgeons to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The aim is to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base.

Applications for the 2010 Fellowships close on 31 October 2009.

For further information and application details, please refer to the College website: www.surgeons.org or contact Sunita Varlamos, Secretariat, Rowan Nicks Committee:

Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
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250 - 290 Spring Street
East Melbourne VIC 3002
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Pub: CMC TOTS
Date: 27-JUL-2009
Page: 3
Plate:CMYK

Lies, damned lies, and statistics

'More beds' may be a simplistic slogan but for health in Australia it is an absolute necessity

Ian Gough
President

Australian Hospital Statistics

Both Benjamin Disraeli and Mark Twain would have had cause to re-consider their famous quote if they had read the 2009 version of Hospital Statistics as released by the Australian Institute of Health and Welfare (AIHW). Visit www.aihw.gov.au/

It is an incredible compilation of data and associated analysis reflecting the complexity of the health care sector. It again reflects the inefficiencies of having state based health systems where it proves so difficult to track performance on even the key measures of quality across all the regions of Australia and also over time. Comparison with other countries, even those with substantial similarities like Australia and New Zealand, is very hard indeed.

Having noted some reservations there is an enormous amount of information within this report and there are substantial implications for the College, Specialty Societies and the delivery of surgical care. Importantly, the private hospital sector is progressively the sector where elective surgery is performed. With 62 per cent of elective surgery performed in the private sector and the figure increasing, it could easily be concluded that Government policy is to effectively create a public system that deals with medical issues and emergencies and the private sector that will have a dominant surgical and procedural focus.

With waiting lists increasing in the public sector (now an average of 34 days from 28 days in 2003-2004), with capacity in the emergency departments now regularly being overwhelmed (presentations increasing five per cent per annum) and the inadequacy of government responses to this crisis, the policy direction appears clear: use the private sector for surgical services wherever possible.

All Fellows and Trainees of the College know that our population is growing and it is ageing. Access to beds is always a key measure. It is self-evident that building hospitals and increasing the number of beds has a substantial lead in time. However the AIHW report demonstrates that the bed capacity of public and private acute hospitals stays at about four beds per 1000 population. If anything the numbers of beds are slightly decreasing yet hospital admissions are growing at 3.6 per cent per year. In any one week there would be controversy from almost all regions as hospital planning appears to be badly handled. Given the growing evidence that occupancy of hospitals at greater than 85 per cent produces inefficiencies and increased complications from nosocomial infections, the delays in the planning processes are a substantial concern. 'More beds' is sometimes viewed as a simplistic slogan but for health in Australia it is an absolute necessity.

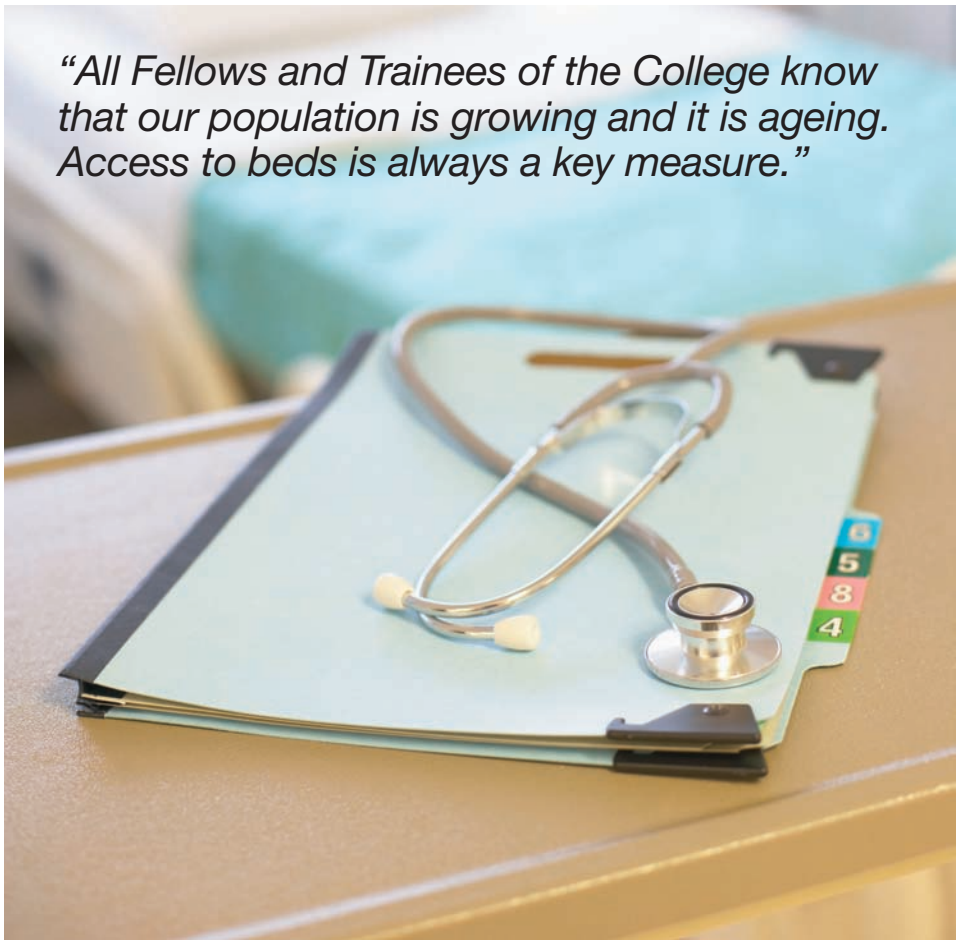
Surgeons are tending to move from the public to the private sector, yet public hospital staff continue to grow. The number of medical officers in hospitals has increased by 5.7 per cent annually since 2003 - 2004 with a total workforce now of 26,996. Increased shift work and the requirement of safe hours is highlighting how issues of continuity and safe hand-over are increasingly critical. Communication and transfer of clinical responsibility from one team to another is an important issue of professional performance and liability.

One of the significant measures within the AIHW report relates to costs. Health care is expensive. Average costs for casemix adjusted admissions have increased by 6.5 per cent annually. The average cost is now $4232. We all have views about whether all of this expenditure is required and how things could be less expensive. However there is no doubt that health related costs are increased substantially more than standard CPI. →

National Health and Hospitals Reform Commission (NHHRC)

Although their final report is yet to be released by the Federal Minister of Health, the commission continues to release position papers that are available on their website (www.nhhrc.org.au/). Their report on efficiency gains is a review of the efficiency on health care systems and health outcomes across the world. Again, there are no simple answers as some analyses demonstrate Australia as being highly efficient while others portray substantial gaps in performance. However, there is no doubt about the commitment to trying to simplify the systems and reduce the confusion between the aged care, community based and acute hospital sectors. The commission will be advocating strongly the introduction of a nationally recognised activity based funding approach. They also want clinical education to be involved with this as well.

Components on this report highlighted the outstanding work of the Australian Orthopaedic Association (AOA) Joint Register in its review of prosthetic revisions followed by either cemented or non-cemented joint prostheses. The other major concern was the inefficiency through lack of the availability of health related records. The NHHRC has separately supported person-controlled electronic health records and are advocating strongly for their introduction by 2012.



Impact on surgeons and surgical training - there is nothing permanent except change

Heraclitus of Ephesus was a Greek philosopher who was known for his doctrine of change being central to the universe. From 500 BC to now is a large span of time but of course change continues and the College will continue to adapt.

The College is committed to training and increased involvement in training in the private sector. Issues of the quality of handover, the best models of care for acute surgery, advocacy for more hospital beds and improved access for patients to clinical records are all issues that are being highly profiled and will be addressed over the next 12 months.

The challenge within reports and reviews is to distil the message and the areas where the College can provide leadership for surgical services. As always, I am interested in your views.

Cover: Photograph courtesy of Andrew Petrie
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Registration and Accreditation

Extensive lobbying by the College has led to changes in the design of the new scheme

Ian Dickinson
Vice President

I hope that Fellows fortunate enough to attend the College's Annual Scientific Congress (ASC) in Brisbane in early May found the experience as professionally interesting and personally enjoyable as I did. I congratulate all those who made presentations and those who delivered keynote addresses.

The College was heartened on the Friday of the ASC to read a communiqué from the Australian Health Workforce Ministerial Council announcing significant changes to the design of the new National Registration and Accreditation Scheme. Many of you will be aware that the College, along with a host of other interested parties, actively advocated against several key features of the original design.

The College has also just received the exposure draft of the bill and will be scrutinising it closely over coming days.

Accreditation – an independent process involving experts

The Ministerial Council has now agreed that "the accreditation function will be independent of governments". This was the most important change we had sought, fearing that any accreditation body that was answerable to politicians or public servants would inevitably come under pressure to increase the number of health professionals by merely lowering educational standards. Accreditation standards will now "be developed by the independent accrediting body or the accreditation committee of the board where an external body has not been assigned the function".

While the final decision on the accreditation of courses will be the responsibility of the national board, the accrediting body will be able to make its recommendations publicly available should it disagree with the national board's decision. The Ministerial Council will have the power to act when it considers changes to an accreditation standard would have "a significantly negative effect", but at least this would be a transparent intervention and health professionals would be a party to a very public debate. Further detail regarding this element of the proposals is contained below in the section in this article titled "The way forward".

Existing external accrediting bodies such as the Australian Medical Council and the Australian Pharmacy Council "are expected to continue". This was another amendment to the proposed scheme for which the College strongly lobbied.

Maintaining specialist registers

Ministers agreed that both general and specialist registers will be established and that practitioners will be on one or both of these registers depending on whether their specialist qualification has been recognised under the national scheme. Ministers agreed specialist registers will not cover practitioners registered to practise in an area of need, although a first reading of the draft bill would appear to indicate that this position has been somewhat compromised. The maintenance of specialist registers was considered by the College to be central to the delivery of world class healthcare, and was something we advocated strongly.

Continuing professional development (CPD)

The Ministerial Council agreed that there will be a requirement that, for annual renewal of registration, a registrant "must demonstrate that they have participated in a continuing professional development program as approved by their national board".

The communiqué goes on to say:

"Each profession's requirements will be set by the relevant board. A board may use its accrediting body to set standards for such programs and approve providers of such programs (including, in the case of medicine, specialist medical colleges) where that is the best arrangement for that profession."

This marks the first time in the 14 month consultation period that specialist medical colleges have even been mentioned by those with responsibility for developing and implementing the new scheme and, as such, this is an important step forward for the institutions which have ensured quality healthcare for generations of Australians.

It also recognises the work of the College in establishing and continuing to advocate participation in, and compliance with, a broad based relevant CPD program.

Complaints handling arrangements

The communiqué states:

"Assistance will be provided to members of the public who need help to make a complaint. Ministers agreed that this new arrangement will not affect the services provided by health complaints commissions across the country. However it will help make the complaints process simpler for members of the public... Given the diversity of arrangements in Australia at this time, Ministers have agreed to a flexible model for the administrative arrangements for handling complaints."

This will enable the various jurisdictions to provide the legislative framework for investigations and prosecutions, or to adopt a national legislative framework, while all outcomes will be recorded as part of the single national process. Where the national legislative framework is adopted, each State and Territory will decide whether the investigation and prosecution functions remain with national boards or are undertaken as part of an existing State or Territory based health complaints arrangement. This recognises the progress and success that has been achieved by some of the state agencies. →

Appointments to national boards

National boards will be appointed by the Ministerial Council with vacancies to be advertised. At least half, but not more than two thirds, of the members must be practitioners and at least two must be persons appointed as community members.

Once again, this represents a change to proposed arrangements for which the College lobbied hard and which will ensure that medical considerations, rather than political expediency, drive the boards' decision making process.

State and Territory boards

State and Territory boards will act as the main committee of the national board in each State and Territory and will oversee registration and complaints processes in that jurisdiction where these functions are delegated to them by the national board. Appointments to State and Territory boards will be made by Ministers "following an open and transparent process".

Area of need arrangements

National boards will be required to consider applications for registration from practitioners seeking to work in a location or position that has been declared by the relevant State or Territory Minister as an area of need. Boards will determine whether the practitioner is eligible for registration and, if registration is granted, what conditions will apply.

The way forward – Bill 'B'

While the communiqué represents a vast improvement on the original proposal, the College is mindful of the fact that it represents a statement of intent rather than legislative reality. The draft of the legislation providing the detail of the new arrangements has just been released. This is being examined with the utmost thoroughness. Some of the details in this draft of Bill 'B' remain of concern.

These issues will need close perusal and advocacy. The Ministerial Council may override the National Boards where there will be "a substantive and negative impact on the recruitment or supply of health practitioners to the workforce." The Ministerial Council may also "appoint an entity, other than a committee established by a National Board, to exercise an accreditation function for a health profession under this law." These issues are of serious concern to the College and have the potential to adversely affect standards.

"The maintenance of specialist registers was considered by the College to be central to the delivery of world class healthcare..."

It also appears that limited registration such as in Areas of Need will be permitted under the act as well as the capacity to take the title of "specialist" without a specialist qualification.

There are a number of other aspects of the draft bill which will need close attention as well.

After the release of the Ministerial communiqué, the Senate Committee on Community Affairs, which had convened hearings into the original proposal for National Registration and Accreditation, suspended its consideration of the scheme until such time as the exposure draft was released. This is a sensible decision, and the College stands ready to make further submissions to the Committee, and if necessary appear before it, if the legislation fails to honour the spirit and detail of the communiqué.

Fellows will be aware that the College made an initial submission to the Senate Committee and a response to several of the consultation papers released by the committee charged with developing the new scheme. All of these submissions can be viewed on the College website.

The communiqué of 8 May marks an important advance for Australian healthcare. I congratulate and thank all who have taken an active interest in this important matter. However, the detail in "Bill B" at its initial appraisal does not resolve some very important issues.

Aftermath of the federal budget

Following on from my comments in last month's issue of *Surgical News*, there has been nothing further to allay our initial concerns over the decision to progressively reduce the 30 per cent private health insurance rebate paid to those singles earning more than $75,000 per annum and those couples earning more than $150,000 per annum.

The College is still to be convinced that the corresponding increase in the Medicare levy surcharge will prevent a flow of people out of private health insurance and into the public health system, placing even greater pressure on bed numbers and elective surgery waiting lists. While Treasury modelling that suggests some 25,000 people will drop their private health insurance is noted, so too is the Australian Health Industry Association's estimate that the figure will be closer to one million. Doubtless the real figure lies somewhere in between, but the fact that a sizeable number of Australians with private health cover will be driven back into the public system is bad news for an already overstretched public health system.

It is also worth noting there is considerable concern regarding the budget proposal to cut the Medicare rebate on some medical items including cataract surgery and cardiac procedures. This will exacerbate congestion in our public hospitals and lead to greater out of pocket expenses for all Australians in need of these procedures. There can be little doubt that other rebates are on the "hit list", with likely similar unintended consequences.

Census update

Congratulations to the following Fellows who were randomly selected from the first 100 Fellows to complete the census in their region and have won a $500 Hyatt Hotels gift voucher:

New Zealand: Mr Ian Civil
New South Wales/Australian Capital Territory: Dr Raymond Ko
Victoria/Tasmania: Mr Gregory Harvey
Queensland: Dr Keith Towsey
South Australia/Northern Territory: Dr Robert Whitfield
Western Australia: Mr John Hodge

Thank you to all who participated in the census and I look forward to sharing the findings with you later in the year.

Same old place, brand new address

She has deserted me, slapped me in the face, moved on to a new lover

I.M.A Newfellow

This month I intend to be boring, really boring. Don't read any further unless you are fascinated by buildings, real estate and investment.

Most of us own a home but you also own a building in the Melbourne central business district, heritage listed houses in inner Sydney and North Adelaide and a building site in inner Brisbane. You also even own a building in New Zealand – no, I am sorry it is not in Queenstown but is in "Windy Wellington".

Your magnificent portfolio of property is courtesy of your Fellowship of the College. Well, you don't own them entirely but you do have a share in them.

Now my old nemesis Mr Pot Stirrer may be a pain but he also knows a lot about events in the College. In fact it is said that there has been a relative of Mr Pot Stirrer on Council since the first meeting of Council which is why he seems to know so much.

Apparently there has been a recurring debate in Council over the property issue. "It is not our core business" says one side – "we should sell it all and invest the proceeds in ethical investments" or Scum Bag Finance Limited, depending on your point of view.

The alternate view is that it provides a focus point for the activities of the Fellows. Now Mrs Newfellow says that if I was as focused about house maintenance and lawn cutting as I was about matters relating to the College we would have the best house in the street – but that is another story.

I readily admit that I have grown quite fond of 240 Spring Street, Melbourne 3000, much as one grows fond of an old jumper that has holes and a wavy hem line, or an old guard dog that can no longer hear the intruders.

"There is a certain sense of history to walk in the building with its many portraits of surgeons long since gone to the great surgeons' tea room in the sky..."

It is a great location on its own parklands close to the CBD and Parliament station. There is a certain charm to the "neo-gothic" architecture and the setting. We can not build a sky scraper on the site as the height limit is defined by the view from the surveying quadrant at the front of the building (I bet that you have not noticed the quadrant). The eye's line of sight must still allow the Royal Exhibition Building which lies behind the College building in the Carlton Gardens to be visible from that spot.

There is a certain sense of history to walk in the building with its many portraits of surgeons long since gone to the great surgeons' tea room in the sky, to see the many "objets d'art" donated by surgeons and families, to feel the presence of our fore-bearers and to experience the hustle and bustle of the business of the College going on around oneself. It makes me feel important. Mrs Newfellow interjected here and said that I was not so important that I would not be able to cut the lawn.

I was however startled to read that the old girl has been unfaithful to me. She has deserted me, slapped me in the face, moved on to a new lover and forgotten her humble and loving origins. Well that is really a bit of hyperbole, but she has changed her address. She is now 250-290 Spring Street, East Melbourne, Victoria 3002.

This desertion has been caused by those rotten sods at Australia Post. It would seem that because the old girl is on the Eastern side of Spring Street it is not in the CBD and is no longer 3000.

They tell us that after July 1, 2009 all mail must be addressed to the new address or else it will be sent back.

Now that may create a bit of a problem if you mail your subscription to the old address (I am assuming here that you are a technological Luddite like me and don't trust your hard earned cash to cyberspace). You may find that you are expelled for non payment of subscription and have to win back your Fellowship by a suitable penance such as mowing the lawn out the front of the College. If Mrs Newfellow has her way you may see me there.

Plate:CMYK
Date: 27-JUL-2009
Pub: CMC TOTS
Page: 8

What do Trainees want?

Poor attendance by Trainees has been the reason well-intended training programs have failed in the past

Steve Leibman
Younger Fellows Committee member

I begin by admitting that I don't know the answer. Why is it so difficult to attract junior doctors, keen on a surgical career, to structured formal teaching?

As director of a Basic Surgical Training (BST) network I put together a thorough, varied basic surgical teaching program for BSTs. After consulting with each of them regarding topics and times, I arranged 'protected time', consultant surgeons to donate their time and teach, and video links to the network's rural hospitals. Fairly early in the program, I was forced to abandon it because of poor attendance by the Trainees. I understand that other network directors experienced almost identical outcomes with their attempts at teaching.

I have since left the position (BST no longer exists - a topic for a different article) but know that there remains a large number of junior doctors, interested in surgical training, who MUST want to be taught! So I thought I'd ask them if they could help me to answer the above question. I decided to interview a cohort of current Surgical Education and Training (SETs) program, BSTs or surgical Resident Medical Officers (RMOs) and ask the following questions:

- What do you want from local surgical teaching?
- What do you expect from local surgical teaching?
- What would attract you to teaching sessions?
- What would detract you from sessions?
- Why do you think attendance has been so poor?
- Would you attend Saturday teaching (without being paid?)

"Gone are the days where young doctors made an appointment with the local supervisor of training to ensure they were on the radar."

The first difficulty I came across was actually identifying who these doctors are. Try asking your Junior Medical Staff Unit for a list of BSTs, or even surgical RMOs and you get a very blank look, eventually followed by a printout of a list of doctors, most no longer even employed in your hospital. Gone are the days where young doctors made an appointment with the local supervisor of training to ensure they were on the radar. Eventually I went through the RMOs on each surgical unit and called them to ask if they were surgically 'bent' or simply 'given a surgical term'.

Once identified, I emailed all SETs, BSTs and all Post Graduate Year 2s and 3s doing surgery. The response was far more enthusiastic from the more junior cohort, and it seemed most thought a new teaching program was about to begin (they appear starved of active education from Fellows).

Without space to detail the answers, these were the general themes: Most want and expect the same things, basic science teaching, case scenario based teaching, more skills training, peri-operative care, and primary exam based teaching. Attracting factors include protected time, varied topics, structured programs, and practical topics. Some feel it should be mandatory and a group representative should keep a register and encourage attendance. Others simply wanted food supplied!

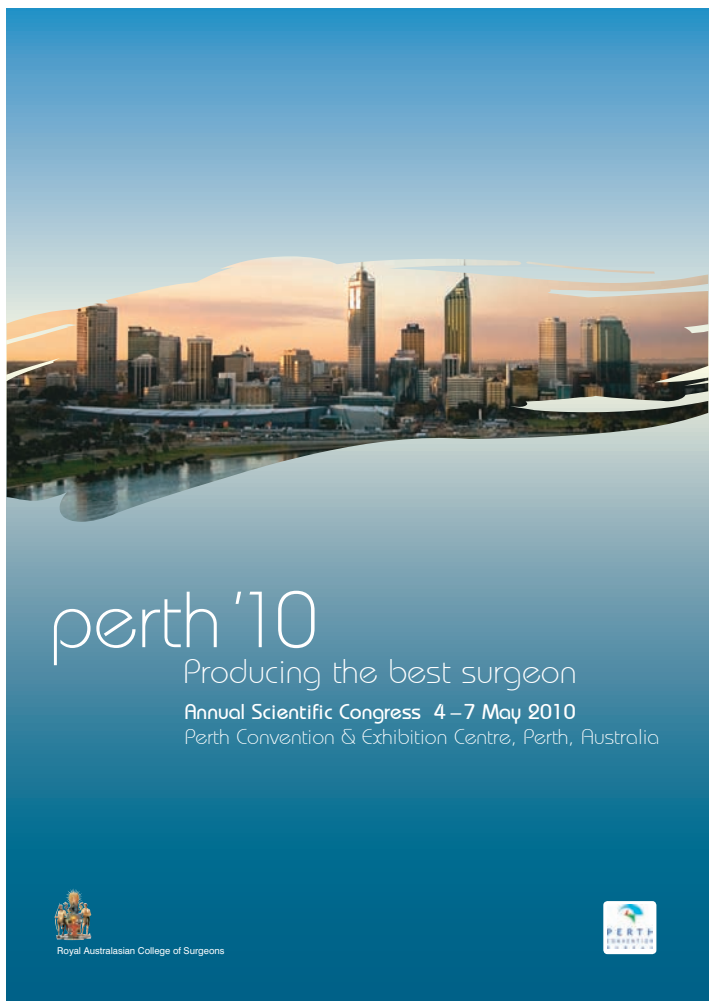
Detracting factors include time commitments, social commitments, junior teachers, trying to cover too many levels of experience in one group, and no longer having to prepare for the primary PRIOR to SET. Unfortunately, none of the respondents could provide real reasons why attendance has been so poor. About 50 per cent were willing to attend on Saturdays.

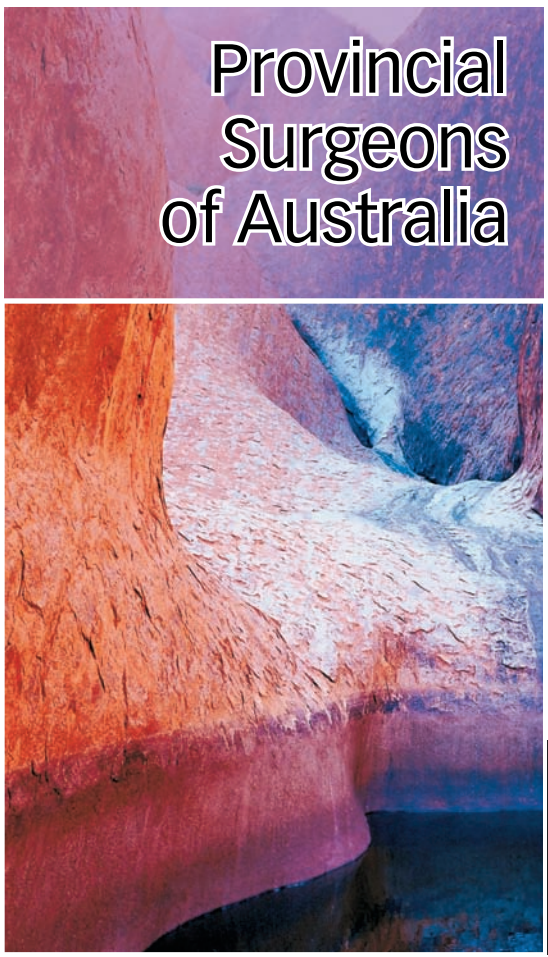
This exercise has left me with more questions than answers. Does the entire philosophy regarding teaching have to change? Do we, the Fellows, need to change with the times and look at new ways of teaching? Is true general basic science teaching no longer relevant? Has selection centralisation eliminated local competitiveness? No local selection means no local pressure to be seen to be enthusiastic and hard working, and makes it impossible to make teaching compulsory! (I'm sure you are all nodding your heads thinking back to those Saturday morning sessions that you attended religiously – even if it was after a 72 hour shift!) What role does the College have in regard to educating future fellows? Where does Insitute of Medical Education and Training fit in?

Teaching junior doctors may be hard work but is a very rewarding task if done successfully. I don't believe structured teaching should be allowed to disappear but the challenge for those enthusiastic is getting it right! I hope to explore this topic further and possibly provide my own potential solutions it future articles. Any help would be most welcome!

College Conferences and Events Management

Contact Lindy Moffat / lindy.moffat@surgeons.org / +61 3 9249 1224





Pub: CMC TOTS Page: 9

Date: 27-JUL-2009 Plate: CMYK

Life on the farm

Farmers and surgeons have to be realistic about life and death and find practical solutions to problems

While paediatric surgeon Mr Alex Auldist has dedicated his professional life to the care of tiny neonates and general paediatric surgery at the Royal Children's Hospital in Melbourne, he has also worked hard to create and enjoy a life outside the hospital.

Despite at times working up to an 80-hour week, Mr Auldist has also found the time over the years to develop his 1400ha farm near Deniliquin, a property which lies on the Edward River about 300km north from Melbourne.

However, unlike some professionals who dabble in hobby farming, Mr Auldist's property is a serious concern producing winter crops and grazing sheep and cattle.

While his son manages the property, Mr Auldist visits most weekends and works on the farm in the days following his consultations and surgical visits to the Victorian regional centres of Shepparton and Echuca.

"Those days consulting in the regional centres are my favourite days of the month. I like working in the country, I like meeting the country folk who I find good to deal with, straight forward and direct, and I like the opportunity to stay on the farm in between," Mr Auldist said.

Yet while he said some people were surprised at his passion for both surgery and farming, he believed the two had more synergy that most people appreciated.

"Both farmers and surgeons have to be realistic about life and death and both are required to constantly find practical solutions to serious problems. I think it also suits the surgical mind because you work with your hands in both professions and you often have to make tough decisions and stick with them," he said.

Mr Auldist said he bought the first parcel of land upon his return from Canada following his training at the Royal Melbourne and Royal Children's Hospitals, having developed a love for the land through his mother's family who own property in the Mallee. His brother, Ian is a farmer at Hay and his son Martin is a dairy research scientist.

Then, it would have been difficult to imagine how difficult farming would become in Australia.

"When I first brought the property, it was an irrigation farm growing rice but in the last three years we have not had enough access to irrigation to produce much rice so we have had to make major adjustments in terms of what we can grow," he said.

"While we have just recently had the first good autumn rains in ten years, the issue of water allocation is a huge one for us and for all the communities in that area. The whole agricultural industry around Deniliquin is struggling with issues surrounding irrigation in particular lack of rain in the catchments and I have no doubt that if plans go ahead to buy back water entitlements, many of those towns and communities will be disadvantaged. The last few years have been very hard and it is stating the obvious to say that it is now a very tough time to be a farmer.

"While the recent autumn rains have put some optimism back into life around there, we need to get follow up rain as well as water to fill the catchments or it won't mean much."

Now approaching his retirement, Mr Auldist has had a distinguished career spanning three decades as a surgeon, research and educator. A general paediatric surgeon, he was Director of Surgery at the Royal Children's Hospital from 1993 to 2005, was awarded Victoria's Senior Australian of the Year and has been a nominee for Senior Australian of the Year.

In 2004 Mr Auldist received the Royal Children's Hospital Chairman's Gold Medal for outstanding service and commitment to the hospital and was honoured by the College in 2005 for his services to paediatric surgery when he was awarded the Peter Jones Medal.

While he admitted that retirement was not an easy transition for him or for many senior surgeons, he said having another life outside the hospital made such a move more palatable.

"I will miss my work as a paediatric surgeon. Dealing with families is a very special experience as is treating new-borns with surgical problems, in my case with oesophageal atresia in particular," Mr Auldist said.

"Some people find the idea of operating on such babies quite daunting but I have never found that. Rather, I think they are very tough little people, remarkably so in fact, which makes working with them such a rewarding experience. The improved results these days are very much due to a team approach. And there will be some families that I will miss, families that I've had a long relationship with and have grown fond of and have become their friend."

Yet it will not be as if he will have time on his hands. Mr Auldist said that since the drought took such a harsh grip on the land in the past three years in particular, he and his son Tom had been forced to lay off farm labour, leaving them all the more to do. Yet despite the difficulties of modern Australian farming, he said he still got great joy from his life on the land.

"My favourite times on the farm would be marking the lambs and bringing in the harvest - when there is one to bring in that is."

RACSTA – a voice for Trainees

RACSTA's support and advocacy portfolio deals directly with Trainees, offering support

Mathew Peters
Chair, RACSTA
Mitchell Nash
Chair, RACSTA Support and Advocacy portfolio

The Royal Australasian College of Surgeons Trainees Association (RACSTA) Board is divided into three distinct portfolios; education, training, and support and advocacy. Although most would expect the education and training portfolios to be of the highest relevance, it is the support and advocacy portfolio that Trainees draw upon the most.

'Support and advocacy' is a broad phrase. It encompasses many of the day-to-day educational, training, and workplace activities which impact on a Trainee's personal and professional life. However, where the education and training portfolios deal with the particulars of educational programmes and curricula, and fatigue management and relocation (for example), the support and advocacy portfolio exists to deal *directly* with the Trainee, providing an anonymous and confidential portal for them to express their concerns.

Examples to date include concerns regarding selection processes, religious practices and their impact on training commitments, underperformance and term failure, and bullying and harassment. Mentor programmes and member benefit initiatives are other support mechanisms that have been addressed. The most recent initiative is the development of a mechanism to link Trainees requiring part-time and job-share arrangements together.

Underlying all of these issues is a concerned Trainee. In some instances this has been a Trainee 'in distress.' The RACSTA Board wants you, the Trainees, to know that RACSTA is YOUR resource should you find yourself in a difficult situation. We can put you in contact with a confidential source of advice and support – a Trainee in your specialty, a fellow who has a special interest in Trainees, or a relevant external representative body. If requested, these advisors may also advocate for you at College meetings if required.

Should you have any concerns please do not hesitate to contact RACSTA. There are many ways to achieve this. You can email racsta@surgeons.org; attend your state RACSTA meeting; or contact any RACSTA representative – their email addresses can be found on the RACSTA website.

Whatever method you use to communicate with RACSTA, the important thing is to make your voice heard. We look forward to hearing from you.

CONGRATULATIONS

June 2009 Queen's Birthday Honours

Australia

Officer (AO) in the General Division
Professor Christopher John O'Brien AO AM

Member (AM) in the General Division
Professor Glyn Garfield Jamieson AM

Medal (OAM) in the General Division
Dr Lawrence Carroll OAM
Dr Ian Caithness Francis OAM
Associate Professor Christopher Francis Perry OAM
Associate Professor Peter Coulthard Reed OAM

Conspicuous Service Cross
Colonel Susan Josephine Neuhaus CSC

New Zealand

Companion of the NZ Order of Merit (CNZM)
Mr John Desmond Todd CNZM

Officer of the NZ Order of Merit (ONZM)
Mr Patrick William Cotter ONZM
Dr Kirsten Annabel Finucane ONZM

The College coat of arms

Craig Subocz
Senior Associate, Russell Kennedy Solicitors

Did you know that the College has registered its coat of arms as a trade mark in Australia? If not, then you'll be interested to know that the registration took effect from 6 July 2005 for goods and services as varied as computer software, jewellery, books, leather and imitation leather goods, umbrellas, glasses, mugs, clothing, education and membership services, and quality standards and assurance services in relation to surgery.

Now that the College has registered its coat of arms as a trade mark, the College has been conferred with the exclusive right to use the coat of arms to promote its goods and services as originating from the College. Therefore, the College's rights in its coat of arms include the right to take action against any person who uses the coat of arms as a trade mark to promote their own goods and/or services without the permission of the College to prevent that person's further use of the coat of arms to promote their goods and/or services and to recover compensation for the unauthorised use of the coat of arms as a trade mark.

Further, the College enjoys exclusive rights in the coat of arms pursuant to the Copyright Act 1968 (Cth) to prevent the unauthorised reproduction of the coat of arms in a material form, the publication and communication of the coat of arms to the public and to recover compensation for the unauthorised exercise of rights conferred on the College by virtue of the Copyright Act 1968 (Cth). Again, like the rights conferred by the Trade Marks Act 1995 (Cth) on the College by virtue of the coat of arms' registration as a trade mark, the rights conferred on the College by the Copyright Act 1968 (Cth) may be licensed by the College to a third party.

The College takes very seriously its intellectual property rights in its coat of arms. The use of the College coat of arms is reserved only for publications and activities where the College has been involved. It is not available for use by individuals.

PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

In 2009 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities will assist you to strengthen your communication, business, leadership and management abilities.

From the Flight Deck

8-9 August – Melbourne
16-17 October – New Zealand

This two-day workshop is facilitated by an experienced doctor and pilot. It examines the lessons learned from the aviation industry and applies them to a medical environment. The program combines rigorous analysis of actual airline accidents and medical incident case studies with group discussions and an opportunity to use a full-motion airline training flight simulator. You will learn more about human error and how to improve individual and team performance.

Proudly supported by an educational grant from Kimberly-Clark Australia

INTEGUSEAL Microbial Sealant Kimberly-Clark

Making Meetings More Effective (New)

21 August – Sydney

Are you tired of spending your valuable time in never ending meetings? Would you like to know how to make meetings more effective? This new whole day workshop, offered to members who sit on a board or a committee, aims to help you understand the characteristics of effective meetings and develop your awareness of the roles and responsibilities of committee chair/members. It will also explore the latest problem solving strategies to make your meetings more productive, letting you spend more time doing what you do best!

Expert Witness

22 August – Melbourne

Don't miss out on this valuable learning experience and an important component of CPD requirements if you are engaging solely in medico legal practice. The full day program brings together legal and surgical experts for a day of practical education to help you prepare for court. Find out how to master examinations in chief, cross and re-examinations in order to become an expert witness.

Practice Made Perfect: Successful Principles for Practice Management

28 August – Brisbane
16 September – Perth

This new 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.

Proudly supported by an educational grant from Health Communication Network

BC BLUE CHIP

Mastering Professional Interactions

31 August – Adelaide
28 October – Brisbane

'Doctor to Doctor' communication is increasingly identified as a significant source of litigation risk. This three-hour workshop focuses on how to deal with the potential areas of conflict which can occur when health professionals communicate with each other in stressful or sensitive situations. You will examine real life examples and generate appropriate responses and actions to reduce exposure in high risk 'Doctor to Doctor' interactions.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: JULY - NOVEMBER 2009

ACT

30 July – 1 August	Surgical Teachers Course, Canberra

NSW

29 July	Mastering Intercultural Interactions, Sydney
15 August	Supervisors and Trainers (SAT SET), Sydney
21 August	Making Meetings More Effective, Sydney
1 September	Beating Burnout, Sydney
17 November	Supervisors and Trainers (SAT SET), Wollongong

NT

29 July	Management of High Risk Diabetic Foot, Alice Springs (PSA)
16 September	Supervisors and Trainers (SAT SET), Alice Springs

QLD

28 August	Practice Made Perfect: Successful Principles for Practice Management, Brisbane
3 October	Supervisors and Trainers (SAT SET), Brisbane
28 October	Mastering Professional Interactions, Brisbane
15 October	Supervisors and Trainers (SAT SET), Cairns
5 November	Supervisors and Trainers (SAT SET), Noosa (ASCTS)

SA

31 August	Mastering Professional Interactions, Adelaide
11 September	Acute Neurotrauma Management (Rural), Adelaide

VIC

8-9 August	From the Flight Deck, Melbourne
14 August	Polishing Presentation Skills, Melbourne
22 August	Expert Witness, Melbourne
24 October	Supervisors and Trainers (SAT SET), Lorne (AGFSM)
10 November	Supervisors and Trainers (SAT SET), Melbourne
13-15 November	Providing Strategic Direction, Melbourne
14 November	Communication Skills for Cancer Clinicians, Melbourne

WA

16 September	Practice Made Perfect: Successful Principles for Practice Management, Perth
25 November	Supervisors and Trainers (SAT SET), Perth

NZ

3 September	Supervisors and Trainers (SAT SET), Napier
17-19 September	Surgical Teachers Course, Auckland
16-17 October	From the Flight Dec, Auckland
20 November	Supervisors and Trainers (SAT SET), Auckland (NZAPS)

Further Information

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.

Plate:CMYK
Date: 27-JUL-2009
Pub: CMC TOTS
Page: 14

Emergency Departments

Providing exposure to Australian emergency department systems and management

While the College has long had a commitment to assist East Timor as it emerges from its troubled past and takes on the long-term task of establishing an independent nation, much of that assistance so far has involved sending Australian surgeons and medical personnel there to operate, to teach and to mentor, as well as working to establish strong links between Australian and East Timorese people.

Recently, however, the College funded a visit to Melbourne by key medical staff from Dili under the Australia Timor Leste Programme of Assistance for Specialist Services (ATLASS) to provide exposure to Australian emergency department systems and management.

The visit, which took place in May, followed an earlier scoping mission to East Timor in January by an emergency department physician and nurse from St Vincent's Hospital, to assess the current functioning of the Emergency Department (ED) at the Dili National Hospital and to assist the ED and hospital administration formulate a strategic plan for the further development of its services.

The initial visit, held in January this year, identified a need for further training and development of key emergency department staff, a need which triggered the invitation for the team to visit Melbourne to gain exposure to Australian systems.

Since then, three staff members were selected to undertake a two-week clinical attachment at St Vincent's Hospital in Melbourne under the supervision of clinical nurse educator Kathryn Bowman and emergency consultants Dr Antony Chenhall and Dr Guy Sansom.

The staff from the Dili National Hospital were Dr Agusto Gusmao, Emergency Department Doctor, Francisco Borges, Nurse Supervisor and Lolita Maria de Araujo, Emergency Department Nurse, all chosen not only because of their key roles in the Emergency Department but their ability to pass on the information to other staff members.

The primary objectives of the visit included providing experience of triage and ideas of how to structure and implement a triage system; demonstrating patient flow management procedures; showing the value of medical and nursing handovers; as well as the importance of shift supervision and the overarching "in-charge" role to enhance patient flow and timely access to medical and nursing care.

While in Melbourne, the Dili team also visited the Royal Melbourne Hospital, the emergency department at Box Hill Hospital and the more varied emergency department at Sunshine Hospital, chosen because Dili hospital sees a similar variety of emergency patients including paediatric presentations, obstetrics and trauma injuries caused by motor vehicle accidents.

"It's an interesting experience to think about what you do and why you do it after so many years."

Ms Kathryn Bowman, the clinical nurse educator from St Vincent's, attended the initial scoping visit in January and worked closely with the team during their visit in May.

"We found on that scoping mission that they had very little control of patient flow in the Dili hospital's emergency department, no formal triage process, significant over-crowding in the main assessment area and no separate area for critically ill patients. There was also no structured system to track patients through the emergency department so as to allow staff to know at any given time who had been discharged, who had been taken to a ward or who was still in an emergency bay and there were significant staffing issues including having only one nurse at times covering the entire night shift," she said.

"Handover procedures and patient assessment also needed improvement and while all these issues had the capacity to compromise patient care, there was great enthusiasm by the local staff to learn what they could to improve their systems."

Ms Bowman said that because of medical and nursing registration requirements the team from East Timor could not work alongside Australian staff but instead were teamed up with their Emergency Department counterparts and included in departmental meetings and education sessions including in-service training, training provided to medical students and registrars and simulation sessions.

She said they found the visit to Sunshine Hospital's emergency department particularly useful given that it so closely resembled the presentations seen in Dili. An emergency department nurse at St Vincent's for 16 years, Ms Bowman said the collaboration had been a rewarding experience for both the Australian medical personnel involved and the team from Dili.

"It's an interesting experience to think about what you do and why you do it after so many years. And they came up with great ideas for how they could adapt our systems to their budget, their equipment, their needs, because it would be impossible for them to go back and mimic directly what we do," she said.

"For example, while our triage systems are now fully computerised some of us can remember using coloured dots on charts and placing them, in order of urgency, in a box and we explained how that once worked and they felt they could easily implement such a system.

"They were greatly interested in this triaging process, in separating patients into various streams of minor injuries and others, of how to track patients through the emergency department, even how to design nursing charts specifically designed for emergency department needs.

Lolita Maria de Araujo, Kathryn Bowman, Anthony Chenhall, Francisco Borges & Agusto Gusmao

"They were also very keen to develop policies and protocols for various presentations and their enthusiasm was such that even during our initial scoping visit they installed a whiteboard to help track patients."

Ms Bowman said that while the recently rebuilt hospital at Dili was clean and modern, basic equipment was still lacking while the management and education of staff had limitations along with those problems experienced in the health systems of most developing countries.

"There are a number of issues that impact on the running of the Dili Hospital's emergency department that are particular to East Timor. They have significant language issues given that while all the nurses are Timorese, the doctors come from Indonesia, China, Cuba and Timor which not only creates difficulty in understanding instructions and written notes but also confusion in that different doctors trained in different countries have different ideas of optimal treatment plans," she said.

"It seemed at times that the doctors found it difficult to agree and that would be very problematic for the nursing staff which is why they felt the design of protocols and procedures to be of such importance. At the same time the nurses felt their career structures were too limited in terms of having only two wage levels which they believed acted as a disincentive to on-going professional development."

The team noted that the visit had given them many ideas that could be revised and adapted for their Emergency department.

"Establishing a triage system is a priority as we will be able to ensure that senior medical staff are dealing with the most urgent patients and that the standard of patient care is improved"

"In addition the implementation of job descriptions for each position within the ED will help people to better understand their position in relation to others and ensure better communication between patients and staff."

One of the recommendations from the January scoping mission was for an organisation to provide long term technical assistance through the placement of an Emergency Department physician and senior ED nurse. The College is now developing a proposal to support an ED physician to work at the Dili hospital with Dr Augusto and the rest of the ED staff for up to two years to provide ongoing support and clinical mentoring to assist with the development of the Dili National Hospital Emergency department.

During their time in Melbourne Dr Augusto, Fransisco and Lolita said they were in favour of long-term support from a doctor and nurse to work in the Dili National Hospital ED.

Following their visit they have developed an action plan to be submitted to their hospital administration and the Timor Leste Ministry of Health requesting technical assistance through the placement of a doctor and nurse as soon as possible to assist them to implement the ideas for change developed during the initial scoping mission and the May visit to Melbourne.

Ms Bowman said that while there was initial concern as to how the scoping mission and external analysis would be seen by local staff, she had been moved by their determination to design systems and implement changes to improve patient care.

"The staff members we worked with at the Dili hospital were so open, so honest and keen they made it much easier for us to work out where problems lay and how they could be addressed even as the new medical director Agusto Gusmao begins to implement his own changes," she said.

"And while we were analysing their practices, it became clear to me that there were things we could learn from them. There, in the Dili hospital, no matter how busy or chaotic the emergency department, every single patient was warmly met.

"None of the medical personnel, no matter how busy, were off-hand or frustrated but made every patient who came in feel welcome."

Student reflections on the ASC

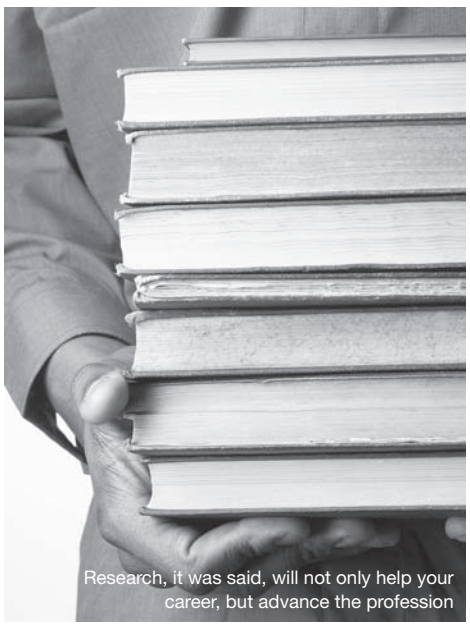
The conference gave me an overall insight into what drives surgeons and the reality of ongoing training and clinical demands

Jimmy Chong
Medical Student

The recent Annual Scientific Congress (ASC) held by the College * challenged traditionally held views regarding the role of the 'surgeon scientist', a phrase coined by Professor Graham Hill as recently as in 2006. The conference discussed the benefits of tending a bedside-bench model, where active research complements and can be used to address dilemmas in clinical practice. Research, it was said, will not only help your career, but advance the profession by shaping the future direction of the field. If clinical practice is the practice of state-of-the-art surgery, then integrating academic research is what defines and expands 'state-of-the-art'. Here I present a number of thoughts raised at the forum:

Academic research increasingly challenges the traditional boundaries of any professional niche. Collaborative work with scientific experts promotes the use of technically intensive and new methods within a broad multidisciplinary approach. A multidisciplinary approach adds depth to answering research questions by bringing scientific discovery into line with changes in daily clinical practice. For the clinician, it provides the opportunity to upskill, direct and stay current with academic interests in the field. For Trainees, taking time to experience research may personally provide time to start a family and support admission into the surgery program through working under the guidance of senior professionals and their teams.

The conference identified a need to address standardisation and quality of literature


Research, it was said, will not only help your career, but advance the profession

produced in general medicine. The bulk of published articles, for example, consist of case reports which outnumber articles available for randomised controlled trials and animal studies. Meanwhile, quality of research depends on a clear and practical framework for mentoring. Good research also demands sustained involvement in the field. In this way, students who show an ambition for research and bring a fresh perspective, often accompanied by an unwavering ethic for hard work, should be nurtured and encouraged. The responsibility of the mentor is then to be open to new concepts, put into practice these ideas and expand the potential of the student and of the profession by providing the means to run effective studies.

Lastly, the conference gave me an overall insight into what drives surgeons and the reality of ongoing training and clinical demands. Surgeons all share a unique personality trait which enables them to biologically and vocationally face stressful situations and often daunting challenges. My personal view is that this profession becomes a lifestyle closely interrelated with a critical balance between personal and private life. Surgical Trainees and consultants touched upon their lifelong commitment. Even when nearing the end of one's operating career, there appears to be a lasting connection with the field, and a desire for pursuing better patient care.

These thought provoking comments in the conference led me to re-evaluate the horizon of options presented to all medical Trainees. Engaging in surgery has its own strengths that drive a passion – ultimately it's more than just cutting, rather it's what drives you and other life priorities. The advice given by the panel was to think about what you want in your future role, as well as where you want it to take you. The next question is to identify a current job that has all these attributes. This could allow Trainees to establish their aims for the future.

My experiences at the conference revealed how the future of academic surgery lies with an institution-wide philosophy to provide continued education and to pass down evidence based advances. Considerable effort is invested in research programs. This suggests that scientific questioning is currently and will continue to be an important cornerstone for progress. Upon reflection, we at Auckland are fortunate to have such leadership that extends all the way down to the passion of medical students, who like myself, now see a growing purpose in research and in particular with academic surgery.

Author's Note: I am sincerely grateful to the Auckland University Medical Students Association for career support and financial aid towards attending the ASC. This was a part of the ASC held in Brisbane, Australia on May 5th, 2009 and brought together Professors, Research Fellows, Surgical Trainees and medical students interested in pursuing research from across Australia, New Zealand and the United States. Thank you to the organising committee for giving me the privilege of attending the inaugural 'Developing a career in academic surgery' workshop run by the College. Congratulations on providing such an excellent forum and I wish for this to be a regular event in meetings to come.

Jimmy Chong is a student, Bachelor of Medicine & Bachelor of Surgery; Bachelor of Human Biology (Honours), University of Auckland, New Zealand.

Invitation to participate in MABEL

Anthony Scott
MABEL Principal Investigator

The Melbourne Institute is pleased to invite Australian doctors to participate in an important nation-wide longitudinal survey — MABEL: *Medicine in Australia: Balancing Employment and Life*. Over 10,500 doctors responded to Wave 1 of the survey in 2008, and Wave 2 of the survey is now 'live'. The latest MABEL newsletter can be viewed at www.mabel.org.au/newsletter/ and it contains a section on frequently asked questions, plus an overview of initial results from Wave 1.

In an era of continuing workforce shortages, MABEL is concerned with obtaining your views and preferences on the key factors influencing your work-life balance. The results will provide valuable information relevant to the development of effective policies to support the medical workforce.

The MABEL survey, funded by the National Health and Medical Research Council, is conducted by researchers from the Melbourne Institute at the University of Melbourne, and Monash University.

If you have received a MABEL survey already, we encourage you to fill it in. If you would like to participate and are a doctor undertaking clinical work, please send an email with your name and medical registration number to enquiries@mabel.org.au, or call +61 3 8344 2600.

Plate:CMYK
Date: 27-JUL-2009
Page: 18
Pub: CMC TOTS

So what is advocacy?

The Queensland Regional Committee has had recent success in changing two Queensland Health policies

Richard Lewandowski
Chair, QLD Regional Committee

One of the most important roles of a College Regional Committee is that of local advocacy. This is especially significant when dealing with jurisdictional health departments given their diverse nature.

So what is advocacy? Wikipedia defines aspects of advocacy as:

- question the way policy is administered
- participate in the agenda setting as they raise significant issues
- target political systems "because those systems are not responding to people's needs"
- are inclusive and engaging
- propose policy solutions
- open up space for public argumentation.

Of the different types of advocacy, it is important that the College adopts:

Bureaucratic advocacy: people considered "experts" have more chance to succeed at presenting their issues to decision-makers. They use bureaucratic advocacy to influence the agenda, however at a slower pace.

NOT

Media advocacy: is "the strategic use of the mass media as a resource to advance a social or public policy initiative" (Jernigan and Wright, 1996.)

Queensland Health has suffered in recent years with government enquiries, daily bad press and an ability to upset its workforce no end with resource issues and planning that at times bemuses the individual.

In the face of this, should the Queensland Regional Committee relinquish its long held view of attempting to work with the power brokers of government through bureaucratic advocacy to join the masses on the sideline screaming at them through the media?

There are substantial reasons for a yes answer but realistically for the betterment of the profession of surgery in Queensland the answer must be no.

So what about Queensland Health, where I believe an honest group of Senior Executives are trying their best to lift this organisation out of the worst five years in its existence? I believe the smart individuals and organisations will use bureaucratic advocacy and attempt to assist Queensland Health with new policy ideas and opportunities for partnerships and profession building projects through being inclusive and engaging.

It is possible to have a long lasting healthy working relationship with the local Health Department without a conflict of interest or looking like you are "in bed" with them. The key to this is always bringing the discussions with Government back to three core points, which are the areas the College is expert in:

1. The College's role in maintaining the professional standing of surgery.
2. The College's commitment to the education and training of registrars.
3. The international recognition of the Fellow of the Royal Australasian College of Surgeons (FRACS) qualification.

Conflicts of interests and accusations of being in bed with Government only occur when a regional committee steps outside these values. By utilising the above, the Queensland Regional Committee with the assistance of the College in Melbourne has had recent success in changing two Queensland Health policies and amendments to the legislation on mandatory reporting. Rather than upsetting the relationship with Queensland Health, the Regional Committee's involvement and liaison with Government has continued to increase. The excellent work being done by the President and others of working within the National Registration and Accreditation debate is another example of where these three core points have served the College well.

The Queensland Regional Committee acknowledges the significant strain on its members created by frequent attendance at Queensland Health meetings; however, without this level of involvement the College's core messages would fail to be included in any surgical strategic planning.

HOMESTAY ACCOMMODATION FOR VISITING SCHOLARS

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

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

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

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

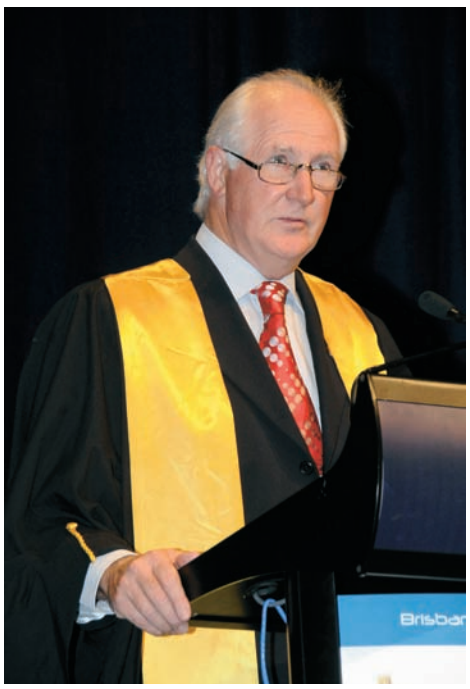
Pub: CMC TOTS Page: 19
Date: 27-JUL-2009 Plate:CMYK

Plate:CMYK
Date: 27-JUL-2009
Pub: CMC TOTS
Page: 20

Hamilton Russell Memorial Lecture

"Tomorrow is another day! But it isn't – tomorrow was created yesterday, you see"

David McNicol
Australian Capital Territory Fellow



I am honored to have been invited by the President to deliver the Hamilton Russell Memorial Lecture, for 2009. The lecturers, who have preceded me over the years since the first lecture in 1935, by E. W. Hey Groves, entitled "The Romance of Surgery", are a diverse and impressive group of surgeons and I am privileged to be considered in their number.

As an orthopaedic surgeon the name of Hamilton Russell has been in my vocabulary since my years as a medical student at the University of Adelaide. I have used his method of balanced traction for the management of femoral fractures and hip problems, in clinical practice for 40 years now.

Robert Hamilton Russell was born in September 1860, at Farningham, Kent, England. He began medical studies in 1878 at King's College Hospital and was a house surgeon to Lord Lister in 1883 &1884. Due to a lung condition he made a very bold decision to move to Melbourne, arriving in 1890.

He was instrumental in founding the Victorian Association of Surgeons, and was one of the three surgeons to whom the College owes its existence urging the formation of the College in the "Foundation Letter" of 19 November, 1925. He was the first Censor-in-Chief, a position he held until his death in 1933.

His paper on the management of femoral fractures was published in the British Journal of Surgery in 1924. He understood the effect that unbalanced muscle pull could have on the broken bone and unless addressed could lead to mal-union, a short leg and altered biomechanics of the limb, so affecting the whole skeleton. His teachings have relevance today and I'm sure around this country and overseas there are patients at this very moment being managed by his traction method. There can be no greater legacy and contribution to Orthopaedics than to reflect on this simple fact!

The privilege of this lecture allows me a freedom I have rarely had in making presentations and that is, to talk freely on matters of interest and concern to me. It is both refreshing and exciting! I would also like to acknowledge the help of Elizabeth Milford, the College Archivist, who completed some research for me.

The title of my lecture comes from John Le Carre's novel, "A most wanted man". The words captured my imagination as I read the novel because they crystallized thoughts I have had with respect to where we are going, with health policy and infrastructure in Australia and internationally. And where we as surgeons and as a community fit into this equation.

Time passes quickly and inevitably tomorrow is shaped by today, and today we create yesterday. This applies particularly to the delivery of surgical services, research and development, manpower and the changes in community needs and aspirations. And orthopedic surgery continues to make massive changes as it adapts to these demands.

In this lecture I will touch, albeit broadly, on my view of surgeons and the community in Australia, now and into the future, and what I think we should be doing today to influence tomorrow.

The "baby boomer bubble" is now beginning to move through the Australian health care system. As I was born in 1945 I'm strictly not a baby boomer but I am close enough to that group to understand their life's aspirations of today. They expect to live longer and be more active, physically and mentally. To achieve this they expect the support of medicine and surgery. This expectation will place ever-increasing demands on our health care system especially musculo-skeletal surgery.

Can our health care system support these demands? My concern is that it will not be able to do so.

For years Governments, politicians and bureaucrats have provided only for the short-term needs of today and not the long-term needs of tomorrow. Tax revenue collected by Federal, State and Territory governments has not usually been put into health infrastructure anticipating community needs, but usually to shore up a deficiency that is creating political heat!

We now have a crisis across the country with respect to hospital bed access, operating theatre time and even drugs and equipment. The fudging of waiting list figures by non-clinical hospital managers to satisfy political bosses is worse than scandalous, it borders on the criminal! Doctors and patients seem powerless to be heard.

Paul Fitzgerald, writing in the "Australian" on March 7, this year talks of "the massive proliferation of managers, few with any clinical background". To quote "most of them are trained to manage money. Hospital budgets are fixed and activity is determined by the budget, not the other way around". "Health enhancements don't translate to votes. On the

other hand, problems in the health system cost votes. Successful politicians give health as little as possible, keeping money for projects that buy votes in marginal electorates, such as roads, schools and public works. This is where the money managers shine. Their allegiance is to their masters, not their workers or customers, and those difficult health professional ethics don't get in the way when making difficult decisions".

"In the public health system generic managers continue to perpetuate their own kind, blind to the fact they are the problem and clinicians could do a better job if given a chance". Fitzgerald concludes by writing "flexible funding structures and a focus on clinical management are the recipe for success in the public hospitals".

Have we not heard that before? The Honorable, Justice Geoffrey Davies, made similar comment in 2005, following his enquiry into disasters in Queensland hospitals. The recent New South Wales Garling report makes the same recommendations, but there are fears that a more direct role for clinicians in hospital management may be watered down by senior health bureaucrats to an impotent "advisory' role.

Australian medical manpower is depleted with a "reverse bubble" of new doctors coming into practice just as our population needs more. Some bureaucrats think that once we weather the "baby boomer bubble" things will settle down. However Australian Bureau of Statistics data shows that our birth rate currently is one of the highest in the world.

Our growth rate is 1.8 per cent, way above the Organisation for Economic Co-operation and Development average. Australia's growth rate not only eclipsed the world average of 1.2 per cent, but also equivalent rates in developing counties such as India [1.6 per cent] and Indonesia [1.2 per cent]. If this rate of growth continues Sustainable Population Australia believes we can expect a doubling of numbers by mid-century. So there will be no abatement of the community's health needs for many decades. Our hospital bed status shows that we do not have enough to meet needs now.

One would think that the Australian Government response to the current world financial crisis, with $42 billion being pumped into the system would have provided an opportunity to address some of health's infrastructure requirements, but this has not been the case. An opportunity missed and it is reflective of the priority the Federal Government places on health needs.

Instead we see the Federal Minister of Health recently more concerned with the issue of midwives taking over the doctor's obstetric role, than dealing with fundamental health issues.

Stephen Robson and co-workers, from the ANU and University of NSW, reported in February 2009, that babies die in public hospitals during labour or shortly after birth at three times the rate compared to private hospitals. This was a study of almost 790,000 births in Australia over the period 2001-2004. There was a high level of medical intervention in the private hospital group -- induced labour, forceps delivery and caesarean sections. However the outcomes favored obstetric care in the private hospital sector. These outcomes could not be explained by socio-economic factors alone. In addition there was twice the incidence of perineal tearing and the need for neonatal resuscitation in the public system compared to the private system.

This data contradicts the vocal view by the midwife lobby that "natural birth" is better for the mother and baby. The better outcomes reported appear to reflect the surgical and knowledge advances in obstetric care. The denial of scientific and surgical advances by the midwife lobby is no more than a return to fundamentalism, and is in my opinion a dangerous and retrograde step.

However, irrespective of my opinion and the scientific data, the fact is that the midwife lobby has engaged with the community more effectively than the medical profession. They are winning the public relations debate and as a result politicians and policy makers are responding to this. There is a lesson in this for us, which I will come back too!

Further, the flow of international medical graduates (IMGs) into Australia, orchestrated by Government, to prop up our manpower needs will have a deleterious effect on those already impoverished countries from which the IMGs migrate. These countries too, have communities that need doctors and surgeons, if they are to survive and prosper in the global village.

In my role as chairman of the Orthopedic Outreach Fund, and project Director for Timor Leste, I see first hand, how essential it is in third world countries to support and grow their community health structures. Good community health, including surgery, is an important arm in eliminating poverty, lifting individual self-worth and growing the country as a whole. We as surgeons can play a decisive role.

"Australian medical manpower is depleted with a "reverse bubble" of new doctors coming into practice just as our population needs more."

The International Committee and External Affairs Department of the College, does a Herculean job in this respect. Education, resourcing and long term support are the ingredients to grow these communities, rather than poaching their people for our own needs.

Subtly I feel that there has been a change in Australia with respect to commitment to the community by the medical profession.

The pledge I took in 1963, as a first-year medical student, reciting the Hippocratic Oath and the Geneva Conventions, was as a new member of a proud and respected profession. I pledged to put my patients' needs ahead of my own material and personal needs.

To me the commercialization of medicine, is a real and worrying shift to materialism ahead of our fiduciary duty to our patients.

The registrars I have worked with over the years, in a teaching hospital environment, have been dedicated and very hard-working to a man and a woman. They remain to be tested however in the outside world of surgery.

Generational change may also have an impact. To generalize about Generation X and Y's commitment to the community would be fallacious other than to say they have grown up in affluent times and the tough and demanding years of tomorrow, working in the health sector, I think will be testing for them, as indeed they would be for my generation. It will be interesting to see how much importance they will put on social responsibility and professional freedom or whether they will see themselves as technicians, for hire, to the highest bidder.

Continued in the next *Surgical News*.

Nationwide research

Practices are to be invited to participate in an Australia-wide study into experiences relating to the Diagnostic Imaging Accreditation Scheme.

Department of Health and Ageing

The Australian Government Department of Health and Ageing has commissioned NWC Opinion Research (NWC) to conduct research into the experiences of practices with Stage one of the Diagnostic Imaging Accreditation Scheme, as well as informing the development of the next phase of the Scheme. The primary aims of this research are to identify:

- the impacts, both positive and negative, of participation in the Diagnostic Imaging Accreditation scheme;
- perceptions of the current operation of the scheme; and
- expectations of the future scope and operation of the scheme.

The research is being undertaken in two phases:

- A qualitative research phase is currently being undertaken and will involve up to 93 in-depth interviews amongst diagnostic imaging practices across Australia to understand the accreditation experience. The sample will include practices from all states and territories, across rural, remote and metropolitan areas, as well as a range of practice types and sizes; and
- A quantitative phase to be conducted during June/July 2009 which will involve a telephone or online survey to quantify impacts and experiences of Stage 1

Accreditation and expectations for the next phase.

NWC will contact practices to invite them to participate in the first phase of the project. Participation will entail an interview with the person mainly responsible for accreditation issues. The interview will be conducted in person and will last approximately 45 minutes. More information about the second phase of the project will be provided in the future.

NWC have a strong track record working with the public sector to independently assess government policies and programs, and extensive experience in health sector research. As members of the Australian Market and Social Research Society, all research activities will comply with the Australian Market and Social Research Code of Professional Behaviour and the Australian Market and Social Research Privacy Principles. The Code requires research be carried out honestly, objectively, without intrusion or disadvantage to participants, and the principles ensure that the Privacy of participants is respected.

If you need any further information about the research, please do not hesitate to contact Nick Connelly or Marita Kenrick at the Department of Health and Ageing on +61 2 9263 3827 or +61 2 9263 3548, or Noel Gibney at NWC on +61 3 9935 5700.

Further information about the research can be found on the Department's website at www.health.gov.au/internet/main/publishing.nsf/Content/diagim-accred4

Pub: CMC TOTS
Page: 23
Date: 27-JUL-2009
Plate:CMYK

Abdominal aortic aneurysm

A new NHMRC funded project will evaluate outcomes after endovascular aneurysm repair (EVAR)

National Health & Medical Research Council

Abdominal aortic aneurysm (AAA) is a common and potentially fatal condition affecting approximately five per cent of men and one per cent of women aged over 60. A treatment known as "endovascular aneurysm repair" (EVAR) has been widely practiced in Australia since the mid 1990s and is now considered the treatment of choice for AAA by many clinicians.

Perioperative mortality (approx two per cent) is lower after EVAR than after open repair in individuals fit for open surgery, however, it is higher (nine per cent) in patients not considered fit for open surgery. In addition, the durability of EVAR is problematic, with a reintervention rate of around 7-11 per 100 patient years required to maintain aneurysm exclusion.

Between 1999 and 2006 the College was responsible for running a government-funded audit to review outcomes following EVAR. The project was run through the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) in Adelaide and helped to provide the Government with the information they required to decide whether or not to fund the procedure through Medicare.

Statistical analysis of the results obtained during the audit showed that a number of pre-operative variables were associated with graft complications and a reduced likelihood of survival. Based on these results an interactive predictive model was developed to provide clinicians with a realistic set of relevant outcome endpoints for individual patients. The interactive model has been made available for download or online use: (www.health.adelaide.edu.au/surgery/evar/predictive.html).

In 2008 Associate Professor Robert Fitridge was awarded $1,036,925 from the National Health and Medical Research Council (NHMRC) to improve and further refine this model. The other chief investigators for the project are Professor Guy Maddern, Professor Jon Golledge, Professor Matthew Thompson (UK), Ms Mary Barnes (CSIRO statistician), and Ms Maggi Boult.

The ultimate aim of the project is to ensure clinicians obtain the best possible outcome predictions for individual patients. As part of this study we also hope to assess whether specific biomarkers collected preoperatively can improve our ability to predict postoperative graft failure. Professor Jon Golledge will oversee this part of the project.

We aim to enrol 1000 patients during the first two years of the project and follow their progress for at least three years. Patients will be recruited by vascular surgeons in Australia and New Zealand and in the United Kingdom by Professor Matthew Thompson.

To assist with the recruitment of surgeons, the following vascular surgeons have agreed to act as state 'leaders': Professor Michael Grigg (VIC), Professor Paul Norman (WA), Professor John Fletcher (NSW), Associate Professor Phil Walker (QLD). Associate Professor Robert Fitridge will assume this role in South Australia. Some of the research funds will be used to employ a part time data assistant in each state to help with the project. However responsibility for the primary collection of data will reside with the operating surgeon.

We are currently in the process of recruiting vascular surgeons to the project and assisting where possible with local requirements for ethics submissions. The process has been made easier for surgeons by the development of generic documents for each site including a national ethics application form (NEAF), a letter to accompany the ethics submission, patient information and consent form, the project protocol and a copy of the acceptance letter received when the ethics application was put through the Central Northern Adelaide Health Service.

Dr Kate Fitzpatrick has been employed as the data manager in Adelaide to co-ordinate the collection of data and assist with establishing the project. Vascular surgeons are encouraged to participate in the study. Those who have not been contacted can contact Kate on +61 8-8133-4015 or email (evar.trial@adelaide.edu.au).

Plate:CMYK
Date: 27-JUL-2009
Page: 24
Pub: CMC TOTS

Primary trauma care in Myanmar

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

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

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

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

Following consultation with the Myanmar Medical Association (MMA), the national organisation which provides continuing medical education, Mr Kong advised the College that the most pressing medical need as listed by the MMA was for help in assisting Myanmar establish a comprehensive trauma system including widespread education for first responders and clinicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

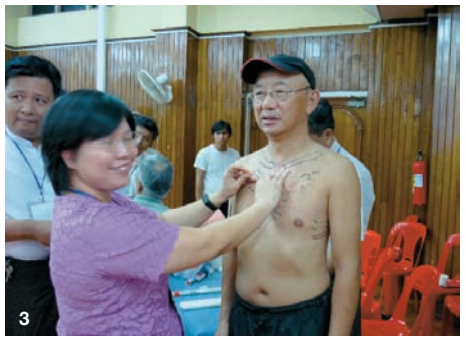
"Given the success of this inaugural course, the College will now approach AusAid and other donors for funding for the on-going training of local Primary Trauma Care instructors. The success of this visit is not only a testament to the team of instructors but to the great enthusiasm of the local doctors. We thought language could be a significant issue given that all the courses were presented in English but we did not need translation," Ms Moss said.

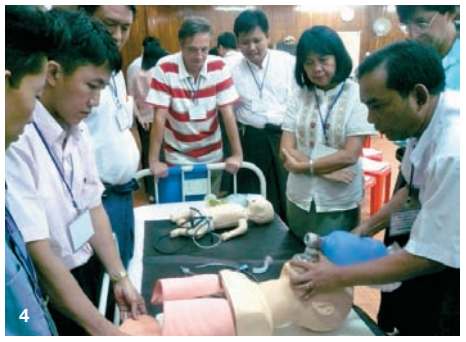
"All the instructors simply made a point of speaking and enunciating clearly and limiting the use of jargon and this, along with the fact that they were presenting to highly skilled doctors, meant that ideas were rapidly absorbed.

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

References

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





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

SADLY
MISSED

‘Jiminy Cricket’ pivotal to safety

Gordon Walgrave Trinca,
AO, OBE, surgeon,
road trauma advocate,
youth leader
7/1/1921 — 19/5/2009

Alan Gregory
Author of *Blood, belts, booze and bikes*

Gordon Trinca, whose visionary road safety crusade led to the introduction of pioneering legislation in Victoria that rippled across Australia and internationally, has died of heart failure at his home in Toorak. He was 88.

Trinca, who was chair of the Royal Australasian College of Surgeons’ influential road trauma committee from 1975 to 1993, played a key role in gaining the support of politicians and decision-makers to implement measures to reduce the road toll.

As a direct result of campaigning by Trinca and a small group of like-minded concerned citizens such as the late police surgeon John Birrell, Victoria led the world with the introduction of random breath testing, 0.5 laws and seatbelt legislation.

A question he posed almost 20 years ago continues to resonate, albeit with slightly different figures: “Can we afford the $6.5 billion, the 2 per cent of GDP and the 10 per cent of total hospital resources that traffic injury consumes each year in Australia?” He had prefaced the question by stating: “Our society can ill afford the loss of human life and productivity and the cost of resources required to repair the damage to body and machine.

Trinca’s deep-rooted concern for humanity was not restricted to road safety. He believed in youth welfare, which underscored his involvement from 1939 with the Lord Somers Camp and Power House organisation. First involved as a youth, he became medical officer, then group leader, deputy camp chief and from 1976 to 1982 headed the organisation as camp chief.

“Our society can ill afford the loss of human life and productivity and the cost of resources required to repair the damage to body and machine.”

Born in Melbourne to Alfred and Adela (nee Collier), he was educated at Melbourne Grammar School, where he was school captain. A medical degree followed at Melbourne University, before he became a general practitioner at Clifton Hill. An interest in surgery led him to qualify as a fellow of the Royal Australasian College of Surgeons (RACS), and he held various posts before he was appointed head of a surgical unit at the Preston and Northcote Community Hospital.

He was aware of the horror of road accidents from the late 1950s, but became more concerned in the 1960s and eventually got “fed up with stitching up” victims while there were no meaningful moves by government to reduce the carnage, so he started collecting statistics. Under his direction, surgeons were no longer “on call” at home, but at the hospital ready to make the all-important first assessment of an accident case. Trinca himself set the example by spending long hours at the hospital at peak crash times. Later research was to show conclusively how important early treatment was for the better recovery of trauma victims.

Notable NSW surgeon Jim McGrath said in a tribute: “Without doubt Gordon Trinca was the dominant force in the college’s road trauma work. His tremendous enthusiasm and drive inspired all of us.”

Another who worked closely with him for more than 30 years, Professor Ian Johnston, former head of Monash University’s Accident Research Centre, said Trinca was “a Jiminy Cricket character who pricked the conscience of politicians and decision-makers ... he was pivotal to the introduction of a raft of road safety measures that led not just Victoria but the world”. Brian Negus, the RACV’s general manager public policy, added: “Gordon will


PHOTOGRAPH BY EAMON GALLAGHER

be remembered as an effective road safety advocate, especially in his role to get compulsory seatbelts in Victorian vehicles".

The latter victory came in December 1970 with Victoria passing the world's first compulsory seatbelt legislation. Much more was to follow, with stricter seatbelt legislation, helmets for cyclists, blood alcohol tests, speed limits, improved vehicle design, safety equipment, road improvement and, vitally, education.

Statistics showed the extent of the achievement. Overall road fatalities for Australia from 1960 to 1994 declined by 49 per cent. Road fatalities per 100,000 people in Australia fell from 30 in 1970 to 10.9 in 1994 (for Victoria it was 8.4 in 1994), and this in a period of increased population and increased numbers of motor vehicles. There was a similar diminution of serious injuries from road crashes.

Trinca became an internationally known figure respected for his work in road trauma. One outcome of this was a group of eight people in the field from different parts of the world who grouped together in 1985 to form the Global Traffic Safety Trust. Informally known as "Trinca's Thinkas", the group developed a project and wrote a book *Reducing Traffic Injury — A Global Challenge*. Their work received the prestigious 1988 international Volvo Traffic Safety Prize, which led to the establishment of a trust.

Trinca received many honours and awards, including being made an Officer of the Order of the British Empire, and Officer in the Order of Australia.

The RACS Gordon Trinca Medal honours him, as does the annual Gordon Trinca lecture of the Australasian Trauma Society.

A keen sportsman and poet, he was happily married for 58 years to Elizabeth (nee Robertson), who died in 2004. He is survived by his sons Simon and Stephen, daughter Angela, three grandchildren, and brothers John and Alan.

Alan Gregory was a friend of Gordon Trinca and author of a book on the road trauma work of the RACS.

Reprinted with kind permission from The Age May 22, 2009.

Over 200 people attended the funeral service of Gordon Trinca on Friday 29 May at St John's Anglican Church, Toorak. Many Fellows were present including past Chairs of the Trauma Committee – Glen Merry and Peter Danne, past and present Trauma Committee members Stephen Deane, Ian Civil, Chris Atkin, Julian Keogh and Frank McDermott. Ken Lay was there to represent Victoria Police, there were members of the Victorian Ambulance and leading trauma professionals from Melbourne hospitals who all came to pay their respects to a man who made such a significant impact on the society in which he lived.

Mr Trinca's eldest son, Simon, spoke of how much the College meant to his father and acknowledged the support and consideration of the College in giving meaning and dignity to Mr Trinca in his final years. The following poem was written by Mr Trinca.


Gordon Trinca in Washington, 1977

Pale sunlight filtering through the trees
Cold puffs of wind disturb the leaves
Which when the day is long o'er
Rest silently on earth's hard floor

Morning mists and dew drenched grass
Follow the lengthening night now past
The sleepy warmth of noonday sun
Beguiles the sense of all's not done

Butterflies flitter through the air
And insects scurry here and there
And busy birds replenish stores
Before winter closes down food doors

Leaves have fallen, red, brown and gold
Short days and long shadows enfold
Increasing cold and wind and rain
Noses tingle and joints complain

As we wait winter's arrival
Contemplate on our survival
Reflect on how life has been spent
And close with spirit of content

Plate:CMYK
Date: 27-JUL-2009
Pub: CMC TOTS
Page: 28

The 2009 Victorian AGSFM

"Training, working, living…. Finding the Balance" is the theme for the meeting at Cumberland Resort Lorne

Andrew Cochrane
Chair, Victorian Regional Committee

Warm greetings from Geelong! This year's Victorian Annual General Scientific and Fellowship Meeting (AGSFM) will take place from 23 to 25 October at Cumberland Resort Lorne, along Victoria's world-renowned and breathtaking surf coast. The organising committee has been meeting regularly and preparations for the upcoming meeting are progressing well.

Besides a strong scientific program, we have planned for plenary sessions around the meeting's theme, "Training, Working, Living…finding the balance". We have secured a number of highly regarded speakers and panel members to discuss, provide and debate their perspectives of our theme this year, including well-respected commentator and clinician Professor Anthony Scott, and Ms Sue Liew, Director of Orthopaedics at the Alfred Hospital.

Furthermore, time has been set aside to socialise and network with fellow surgeons, surgical Trainees, and their families in activities such as an art and sculpture tour, golf, rogaining or simply relaxing on the beach, just to name a few.

This is an interactive event not to be missed and we encourage attendance and participation from all surgical Trainees across the specialties, and their mentors. It is an ideal forum to showcase any research that may be in progress at present but will be ready for October. Remember to get your abstracts in by 24 July 2009. Selection is competitive. Don't miss out!!!

The Victorian Office and meeting conveners would also like to acknowledge the support from their sponsors to enable this program to be presented: Avant, Johnson & Johnson, HCN, Oddessey Finance

Meeting Conveners: Mr Simon Crowley and Mr Glenn Guest
Committee Members: Gleda Ang, Trainee, Mr Sean Mackay, VSC, Mr Paddy Dewan, VSC Hon Treasurer, Mr Michael Dobson, VSC Chair, Denice Spence, AGSFM Coordinator and VRO Manager

Abstract submission and Registration forms available from the College Website
www.surgeons.org/vic

Pub: CMC TOTS Page: 29 Date: 27-JUL-2009 Plate:CMYK

Pub: CMC TOTS Page: 30
Date: 27-JUL-2009 Plate:CMYK

EVs
popping up everywhere

Vehicle companies around the world are switching on to the potential of EVs

With the recent economic downturn, you might have thought car companies would be putting their electric vehicle programs on hold. Not so it seems, with several more companies announcing new EVs for the near future.

Getz an Aussie EV

The only commercially available EV in Australia as yet, the Electron (formerly the Blade Runner), is a Hyundai Getz converted to electric power by Blade Electric Vehicles in Castlemaine, Victoria.

The Electron is available as a complete vehicle for $39,500 (using converted ex-lease vehicles), or you can have your own Getz retrofitted for $29,990.

Blade Electric Vehicles has recently announced that it will be selling the Electron in New Zealand, with a contract to supply 200 of the vehicles. The first vehicle was shipped in November 2008. It's a small start to what could become a booming industry, if all goes well.

The Electron features a 16kWh lithium iron phosphate battery pack with a rated life of around eight years. Range is rated at around 120km.

www.bev.com.au

Will Mitsubishi be the first?

We reported on the i-MiEV previously, and now it seems that Mitsubishi Australia has plans for the little EV. They will be bringing two i-MiEVs into Australia this February—one for display purposes, the other for test drives by potential customers. While this is officially a feasibility study, Mitsubishi's Australian president and CEO, Robert McEniry, states that the chances of the i-MiEV arriving in local dealerships by 2010 are 'very high'.

The i-MiEV has a 47kW motor and a range of up to 160km per charge. Price hasn't been set but it is rumoured to be as low as $30,000.

www.mitsubishi-motors.com/special/ev

Another EV available in Oz—maybe

At the Detroit Motor Show in January, Toyota unveiled a prototype of a small electric vehicle based on their IQ urban commuter vehicle. The FT-EV is still a concept at present, but Toyota has confirmed it plans to produce an urban commuter EV by 2012.

Aimed at the lower cost end of the market, the expected price is in the US$20,000 range.

Whether it makes it to Australia, or how much it will cost, is anyone's guess—that all depends on what happens to the Australian dollar in the interim.

http://pressroom.toyota.com/pr/tms/toyota/maintain-pace-broaden-scope.aspx

Fisker Karma

The Fisker Karma sports car uses Fisker Automotive's plug-in hybrid technology called Q DRIVE.

The vehicle features a 0-100km/h time of 5.8 seconds and a top speed of 200km/h. Of course, it uses AC drive technology and has regenerative braking. Battery-only range is 80km.

The driver can select between two modes of driving. The first mode is 'Stealth Drive', which is the quiet economy mode, and 'Sport Drive', which will access the full power of the vehicle.

Other features include a solar roof to help keep the car interior cool when it is parked in the sun. It also has 22 inch wheels and uses LED taillights. There is even an 'EcoChic' series that is completely animal product free (leather has a very high environmental cost) for the more ethical buyer.

www.fiskerautomotive.com

Is it a bird? Is it a plane?

The Aptera is like no other car available on the market. It was designed to be the most efficient car available, with the most aerodynamic body and lowest energy use per kilometre.

It is made from composite materials and aluminium and weighs around half what a normal car does, while still maintaining high levels of crash protection.

It will initially be available in California, with pricing in the US$30,000 to $40,000 range. Availability in other US states is to follow. Unfortunately, we are unlikely to ever see anything like it here in Australia, at least from any of the major car companies.

www.aptera.com

Extended range EVs

Chrysler recently released details on a trio of potential new electric vehicles. There's a sports car called the Circuit, a minivan (peoplemover) and a Jeep.

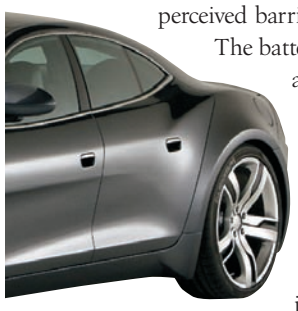
All of these vehicles would use the same drive system, making them what is becoming known as an extended range EV. This is similar to the GM Volt's system, where there is a reasonable sized battery bank that gives 60km range or so and a backup generator if you need to go further.

It seems that Chrysler has not yet decided which of these vehicles it will produce, if any, but it is good to see companies starting to look at cars other than sports cars and mini/micro cars for their electric vehicle programs.

www.chryslerllc.com/en/innovation/envi

Volt is still online

Despite GM being on the verge of bankruptcy in December 2008, it appears the Chevrolet Volt is still on track for a 2010 launch. GM has now decided on a battery system, which was the main perceived barrier to meeting their deadline. The batteries use cells from LG Chem and the packs themselves will be assembled in the US.



GM has released new images of the Volt (see photo), which has changed a bit since its original designs. What's even more interesting though is that there are rumours that GM has plans to take the drive system of the Volt, called the Voltec, to other upcoming vehicles, including a Cadillac.

www.chevrolet.com/electriccar

A serious EV from China

We reported in ReNew 105 that Chinese company BYD was about to release an electric vehicle. Well, things have moved forward, with BYD announcing that the vehicle will be a crossover style vehicle called the e6.

The e6 is a five-seater capable of travelling up to 400km on a single charge. It features dual motors—a 160kW front motor and a 40kW rear motor. Total combined torque is a scary 550Nm, giving this two tonne vehicle a 0-100km/h time of around eight seconds and a top speed of over 160km/h.

The e6 will use BTD's own lithium iron phosphate batteries, which can be quick charged to 50% capacity in 10 minutes, while a full charge from a home power point will take eight hours. These figures seem a little optimistic. An eight hour charge on a 10 amp power point would provide, at most, around 16kWh of charge to the batteries. At a rated energy consumption of 18kWh/100km, there's no way the vehicle could be fully charged overnight unless it was on a 40 amp circuit! Regardless, if this vehicle is even remotely as good as the specifications, it should be a huge hit. The e6 is expected to go into production within two years.

www.byd.com

Still thinking, just!

The Th!nk comes with a choice of two battery pack types – sodium or lithium based. It has a range of up to 180km on the sodium battery and a top speed of 100km/h. Safety features include ABS brakes, airbags and seatbelt pretensioners.

From an eco standpoint, the Th!nk does pretty well. The dashboard can be completely recycled. The fabric, body, supports, air ducts, adhesives and fixings are designed using the same recyclable materials. The plastic body and other plastic panels are unpainted, reducing both energy consumption and toxins, while also making the panels easier to recycle. The batteries are returned to the supplier at the end of their useable life.

The Think Global company has recently hit financial problems, as have many car makers, however, they have recently received financial help from the Norwegian Government to allow them to restructure. Think has been bankrupt twice before and survived. Here's hoping they can finally reorganise themselves into a viable electric car company.

www.think.no

Top: Toyota FT-EV Above middle: Joule EV
Above: Ross blade and getz

A Joule of an EV

Most EVs are being designed by US, European and Japanese companies, so it's good to see one from what many now consider a developing country—South Africa.

The Joule, from Optimal Energy, is a six seat vehicle designed to UN-ECE safety standards and includes all modern safety features such as side impact protection, ABS and airbags. It will use lithium ion batteries and have a range of up to 400km. However, it has been designed to use a range of battery options for flexibility. Interestingly, customers won't buy the car with batteries. Instead, the batteries will be leased to them from Optimal Energy.

Other features of the Joule include regenerative braking, a maximum speed of 135km/h, and a choice of two drive options: an asynchronous permanent magnet motor driving the front wheels through a gearbox, or asynchronous permanent magnet wheel motors.

The Joule is expected to be available in the latter half of 2010. It will initially be available in South Africa, with global export to follow in an unspecified later timeframe. This great little car begs the question; if they can do this in South Africa, why can't we do it here in Australia?

www.optimalenergy.co.za

This article was first published in ReNew magazine issue 107 www.renew.org.au

Expressions of Interest for Foundation for Surgery Board Membership

WE'RE LOOKING FOR SOMEONE TO BUILD ON A STRONG FOUNDATION

The College Foundation for Surgery is an integral part of the College vision, in that it enables the broader community to support projects to promote research that fosters progress in surgery and particularly promotes the health and wellbeing of those in disadvantaged communities in Australia, New Zealand and in the Asia-Pacific region.

Through philanthropy and an extensive volunteer program we are already making a real difference, but there is always more to be done. Publicity through the Foundation for Surgery can increase awareness of our work, leverage the activities of our Fellowship, in supporting the community and encourage corporate support to ensure that excellence in surgery is made available to the greatest number of people.

We would appreciate it if you will canvass your network of Fellows, colleagues and friends, as well as corporate contacts to find suitable candidates who to nominate to serve on the Board of our Foundation.

The Board position being filled is a pro bono activity.

We are seeking someone

- Who understands the need for continued research in a rapidly changing surgical environment
- Who is willing to play a key role in developing innovative fundraising initiatives in a competitive environment, and will work to develop a network of supporters across a range of industry groups
- Who is passionate about providing surgical care to disadvantaged communities
- Who appreciates the educational value of surgical exchange programs
- Who has relevant skills and contacts that that will assist the Foundation in both attracting and providing philanthropy in order to make a real difference

For further information on the Board position please contact the Office of the Foundation for Surgery on (+61 3) 9249 1205 or email foundation@surgeons.org

Fremantle Hospital & Health Service,
Fremantle, Western Australia

SURGICAL FELLOW – (UPPER G I)
Commencing 1st February 2010

Salary: $116,993 to $122,842 p.a. full time 38 hour week or fractional depending on degree of private assisting.

Fremantle Hospital, with 500 beds over 2 campuses, is situated in the historic port city of Fremantle and is the major teaching hospital affiliated with the University of Western Australia, servicing the rapidly expanding South Metropolitan region of Perth, Western Australia, current population 600,000.

General Surgery is practiced as sub-disciplines Colorectal, Endocrine and Upper G.I. Upper GI covers the spectrum of hepato-biliary and pancreatic as well as oesophago-gastric pathology by open surgery, laparoscopic and endoscopic techniques. The latter service, emergency and elective, is jointly managed with the Gastroenterology unit. G.I malignancy is managed by a multidisciplinary team based on protocols with participation in clinical trials. Laparoscopic techniques are extensively used. Training in ERCP is a possibility. Opportunity exists to assist members of the unit who practice Upper GI and bariatric surgery in the private sector.
The successful applicant would be expected to supervise the training of Registrars, Interns and medical students as well as undertake emergency and routine endoscopy.

Qualifications and experience: Appropriate postgraduate qualifications, registrable in Western Australia. (Medical graduates from countries other than the Australia, United Kingdom, New Zealand, United States of America and Canada must have completed the MCQ examination of the Australian Medical Council. Further information available from www.amc.org.) Recognition in gastroscopy by the Conjoint Committee for Recognition of Training in GastroIntestinal Endoscopy or its equivalent is a prerequisite. Preference will be given to post Fellowship applicants intending a career in Upper G.I. surgery.

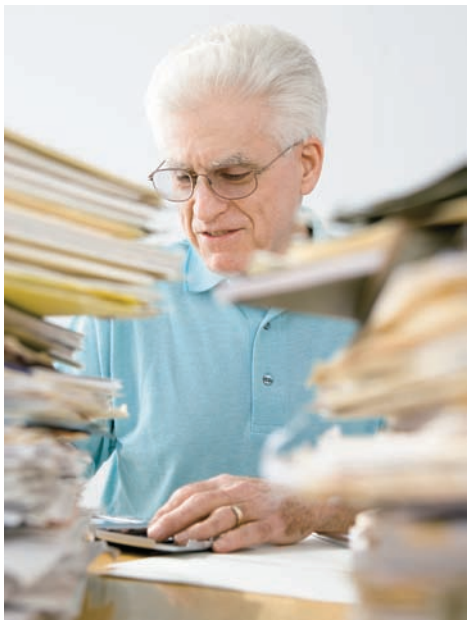
Further details: Further information is available by contacting Prof D. Fletcher, Head of Department, phone +61 8 9431 2500
Hospital website: www.fhhs.health.wa.gov.au
Written Applications: A current CV with the names and address of three referees should be forwarded to Mr Harold Green, Manager, Medical Administration, Fremantle Hospital, PO Box 480, Fremantle 6959, fax (08) 9431 2481.email harold.green@health.wa.gov.au

Pub: CMC TOTS Page: 33 Date: 27-JUL-2009 Plate:CMYK

Life after practice: a surgeon's view

A "good" retirement is usually one that is planned for years, even decades

Pat Alley
New Zealand Fellow



Retirement is an inevitability of any working life, but is a particular challenge to the medical community for several reasons:

- Since the nature of the work is as much vocational as occupational, multiple or even parallel careers that an individual can fall back on are not common.
- The training is long, and getting longer for specialists, and the sense of "owing the community" tends to keep people working, sometimes longer than they should.
- There are increasingly potent fiscal pressures – student debt is but one of many – that keep people in employment for longer.
- Medical practice is by and large fulfilling and interesting work – why would you want to stop doing it?
- There is a widespread fear that if work stops there will not be enough money to live on.

However, none of us can work forever (although there is on record a surgeon in Yugoslavia still operating at the age of 101!). In Australia and New Zealand there is no mandatory age of retirement for anybody. The trick is to get the right answer to the question, "When should I retire?" The simple answer is, "When I am ready, happy to do so and can afford to." Commonly, however, it is not the case that doctors retire willingly and happily, and I now want to explore some of the issues around that.

In surgery it is preferable to have a planned elective operation with all the relevant facts about the patient to hand. Acute unplanned procedures, even if very necessary, are more risky. So it is with retirement. A "good" retirement is usually one that is planned for years, even decades. "Bad" retirements are often acute retirements, which are to be avoided if at all possible. The worst-case scenario for a doctor is being forced to retire because of failing competence or health or both. They have not planned for this eventuality at all. They leave their work unhappily under a cloud of variable darkness. Physical and mental health issues are common consequences of such departures from practice.

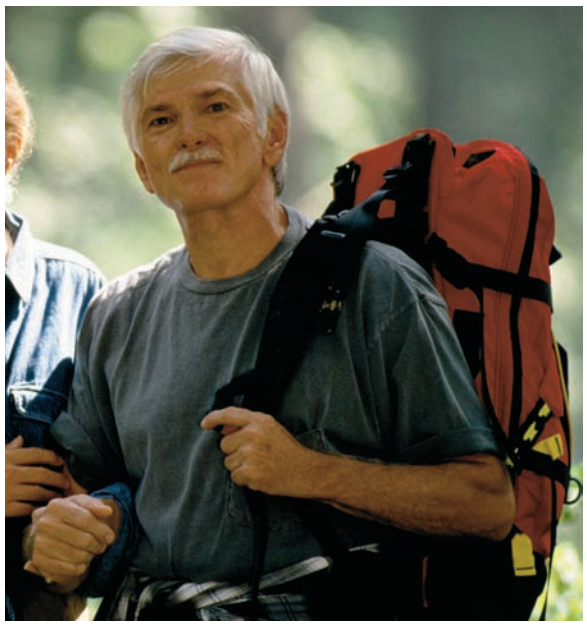
While there is no mandatory age of retirement for any employment group, doctors do represent a special case, simply because their work affects the lives of others in tangible and potent ways. For this reason they should have closer attention paid to them by regulatory authorities. The relationship between competence, health and practice has been exhaustively written about, but all doctors need to be reminded that minor changes in cognitive, clinical and communication ability may well pass unnoticed by the individual. I have heard surgeons say, "I'll retire when I slow up and can't cope with the workload." Sadly, when such an individual makes that judgement, it is usually well past the time they should retire. They should not rely on close third parties, such as a life partner or an anaesthetist (in the case of a surgeon) in making such judgments, because of the reluctance to cause offence by saying, "I'm sorry, you're past doing this job and you should stop now."

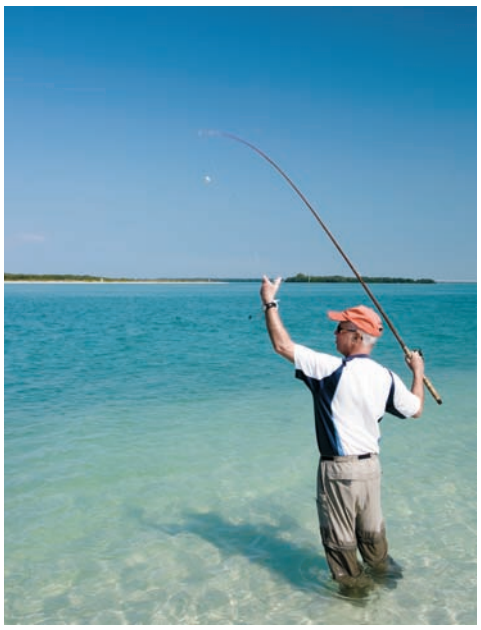
Actuarial data in New Zealand indicate that we can expect to live till our early 80s if we are female and our late 70s if we are male. That means that from a "normal" retirement age there will be up to 15 years, or maybe more, to fill before we shuffle off this mortal coil. Standardised mortality rates for cardiovascular disease in particular are substantially lower for doctors than the general population.

Doctors are well used to planning their employment and education. The undergraduate career is long. The intern and trainee period may be up to eight years or more, and there are more years spent in postgraduate and specialist educational environments preparing for one employment destination. So it is curious to hear a doctor say in November, "Oh – I think I'll retire at the end of this year. Spend a bit more time with the wife and grandchildren and get my golf game sorted out."

Such short–term planning for retirement is bound to fail. And, as an aside, do not even consider using your leisure pursuits as replacement activity for retirement. There is only so much golf you can play in a week and after three months you will begin to hate the game

"You should be developing a range of interests and activities outside your working environment, including your own continuing education."





you once loved. The same goes for occasional recreational pursuits.

So the main message is that retirement has to be planned well in advance.[1]

15–20 years before retirement

Regular health checks with your GP should be well established by now. You should be adhering to a regular (at least three times a week) one hour exercise regime with a view to maintaining cardio–respiratory fitness, reasonable upper and lower body strength, and, importantly, as near to ideal body weight as possible. Have your eyesight checked regularly from now on.

You should be developing a range of interests and activities outside your working environment, including your own continuing education. If you might be considering a parallel career such as counselling or teaching, now is the time to find out what extra qualifications you may need.

In respect of your financial circumstances, now is the time to seek advice on strategies to close the gap between your desired retirement income and your actual likely income. Consider retirement investment options along with superannuation options and tax plans. A financial adviser can also indicate the best time, based on your economic profile, for you to retire.

A related matter is where you intend to live in retirement. If you wish to stay in your locality, is the present house you are living in going to suit a smaller household? Consider the size of your garden – will it be too large for you in retirement?

Five –10 years before retirement

Continue to follow the advice above, with the further consideration of how your current skill set might be adapted for a transitional employment role, if that is what you are considering. The availability of employment parallel to medicine is worth investigating at this time. For example, the clinical departments of medical schools are often seeking good clinical teachers.

This is the time to discuss retirement with your life partner. They very much need to be part of the decision. Medical life by its nature often invades family time and time with one's spouse.

When retirement occurs, adjustments are necessary about such apparently mundane things as whether the recently retired will be in for lunch or not. As the sage wife of a recently retired specialist commented to me, "Retirement is more husband and less money!".

Consultation with your practice partners should occur at this stage as well.

Up to two years before retirement

You should undertake a careful review of your financial plans at this stage. If you are considering ceasing practice totally, take legal advice on the retention or disposal of the medical records of your patients. Your professional indemnity situation should be discussed with the provider who covers you. Review your will.

Travel is often an important theme of retirement – interestingly, most retiring doctors travel extensively, and to unusual places. However, this travel bug seems to depart after about five years, and closer destinations – the east coast of Australia and the Pacific – are favoured by those over 75. So with the expensive travel often done in the early retirement years, some time spent planning travel activity is worthwhile at this stage.

There are several retirement strategies for the general population, which are appropriate for doctors as well. The "crisp method" is a clean break from work with no return to anything remotely related to it. The "blurred method" is a stop–start approach where intermittent return to work occurs; this is not recommended for any employment group, let alone doctors. By far the commonest is the "bridging method" where there is a gradual, staged withdrawal from work.

Whatever method you choose, it is appropriate to recall the "Rs" of retirement:[2]

- Retire the word "retirement"
- Retain the competencies you need
- Restructure your priorities
- Renew your zest for education
- Respond to new opportunities
- Recharge your body by getting and keeping physically fit
- Revisit your childhood dreams
- Remember that your wisdom stays with you.

References

1. Royal Australasian College of Surgeons; Planning Life After Surgery. Discussion document. RACS; 2008 October.
2. Clunie G cited in Waxman B. Winding down from surgical practice. Aust N Z J Surg. 2008

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TRAUMA COMMITTEE REGISTRARS' PAPERS' COMPETITION

9 September 2009

The College Trauma Committee is hosting the third 'Registrars' Paper Competition' in Adelaide on Wednesday 9 September 2009 as part of the Trauma Committee program at the International Surgical Week (ISW) meeting. Trainees/Registrars are invited to submit abstracts of trauma research projects - deadline for abstracts 22 July 2009. A select group, of around 6 registrars, will be asked to present their paper at the ISW meeting on 9 September. Candidates will need to cover their own travel expenses.

Registration for ISW is not necessary if trainees are only attending the ISW for this event. The winner will receive a certificate and may have the opportunity to present their paper at the Annual Meeting of the American College of Surgeons Committee on Trauma – in Las Vegas in March 2010.

Last year's winner, Alexios Adamides, Surgical Trainee – Neurosurgery, presented his paper at the US Residents' Trauma Paper Competition. He won that competition too – well done Alex!

Further information –

www.surgeons.org/trauma - or contact Lyn Journeaux, Executive Officer, Trauma Committee –
Tel: +613 9276 7448;
fax: +613 9276 7432 or
email: lyn.journeaux@surgeons.org

Congratulations on your achievements

Andrew Sutherland - Member, Court of Honour

Andrew Sutherland is unique as both a second generation recipient of the award of membership of the Court of Honour and a second generation President following his late father D'Arcy Sutherland and is the first orthopaedic surgeon to hold the office.

As examiner, senior examiner and then Chair of the Court of Examiners Andrew made significant contributions to the ongoing improvement of the examination processes.

The transition of the College's traditional library to a modern electronic information service was initiated by Andrew as Chair of the Library Committee.

Andrew is an orthopaedic surgeon, openly proud of his specialty's history and achievements. Throughout his 10 years on Council he worked persistently to build a strong mutually beneficial relationship with not only the Australian Orthopaedic Association, but all the Specialist Societies and Associations and the College.

After an intern year at Royal Adelaide Hospital, Andrew went to Canada where he obtained his Canadian Fellowship in Orthopaedic Surgery and later worked in the United Kingdom before returning to Adelaide in the mid seventies and obtaining his Fellowship of this College in 1975.

I have great pleasure in presenting Andrew Sutherland for the award of membership of the Court of Honour. His character and achievements fit him for it well.

Citation kindly provided by Ian Gough

David Ferguson Scott - Member, Court of Honour

David Scott was born in Brisbane, brought up in Nambour, studied medicine at the University of Queensland, completed a Masters of Surgery in 1966 and gained his Fellowship in 1967.

Professor Scott made important contributions as a surgical academic, particularly with lengthening the perfusion time for kidney preservation.

David Scott made significant contributions to the College. His duties included being an examiner (Member of Board 1983-85, Member of Court 1985-95), member and chairman of the Victorian State Committee, and participation in several of its subcommittees.

David was a member of the College Standards Committee (1982-86), Chairman of the Board of General Surgery (1993-1995) and a member of Council (1994-1997). He was appointed Executive Director of Surgical Affairs (Australia) from 1999-2004, including being Acting Chief Executive for much of 2003.

He was Chair of the Scientific Committee for the 1984 and the 1988 Annual Scientific Congresses and Congress Convener for both the 2000 and 2004 ASCs.

David has played an important role in College International Affairs. He has been a member of the International Committee since 1997 and since 2001 he has directed the College program in East Timor. He chaired the International Project Management Committee (2002-7) and in June 2006 convened the first International Medical Aid Symposium held at the College.

The College currently assesses competence and performance in nine domains. When one reviews David's professional achievements it is evident he has excelled in each of these domains. David Scott is a model surgeon, an outstanding individual, and worthy to be a member of the Court of Honour.

Citation kindly provided by David Watters

ANNUAL SCIENTIFIC MEETING COALFACE UPDATES CONTROVERSIES & CURRENT TECHINIQUES

Conference Dinner

Date: Friday 30 October at 7.30pm

Venue: MCG (Harrison Room)

Featuring pianist Alan Kogosowski and violinist Sally Cooper.

Join the master of ceremonies, Tony Charlton as he interviews three great Australians.

Phil Anderson, who rode the torturous 4000km tour de France 13 times and finished five time in the top 10. In 1985 he was ranked number one in the world. Phil was twice a Commonwealth Games gold medallist.

Linley Frame, who is still ranked in the all time top ten fastest Australians in all six breaststroke events, be they over short or long course. Former world champion and record holder.

Mike McKay, the celebrated oarsman, who, in the Olympics won two gold medals, a silver and a bronze and also won three World Championships!

Annual Scientific Meeting

30-31 October 2009 Sebel Hotel, Albert Park

A ½ day meeting for general surgeons presented by the Alfred Hospital, Melbourne.

Sessions on inguinal hernia repair, reflux surgery, right hemicolectomy laparoscopic mesh and incisional hernia repair here

- How I do it sessions on closing the unclosable abdomen; sentinel node biopsy for breast cancer; thyroidectomy; and damage control laparotomy
- Update yourself on botox® injection for anal fissures

The Conference dinner will be held at the MCG with famous Australian sports personalities; Phil Anderson, Mike McKay and Linley Frame and Tony Charlton as the MC. Pianist Alan Kogosowski and violinist Sally Cooper will be performing.

**Book now as it is Melbourne Cup Weekend*

Annual Scientific Meeting

Workshops

Thursday, 29 October, 2009 at the University of Melbourne Veterinary Clinic in Werribee

- Two workshops will be held on Advanced Laparoscopic Skills and Neck Surgery.
- Attendees will rotate through five stations including small bowel, upper GI, hepatobiliary, small bowel, thyroid, colorectal, ventral and incisional hernia.
- The morning and afternoon sessions will be identical and each can accommodate a maximum of 15 attendees.

**Early registration is recommended.*

CME approved by RACS

Further information and if you would like a provisional programme please contact

Lindy Moffat, Conferences & Events at RACS
+ 61 3 9249 1224 or lindy.moffat@surgeons.org

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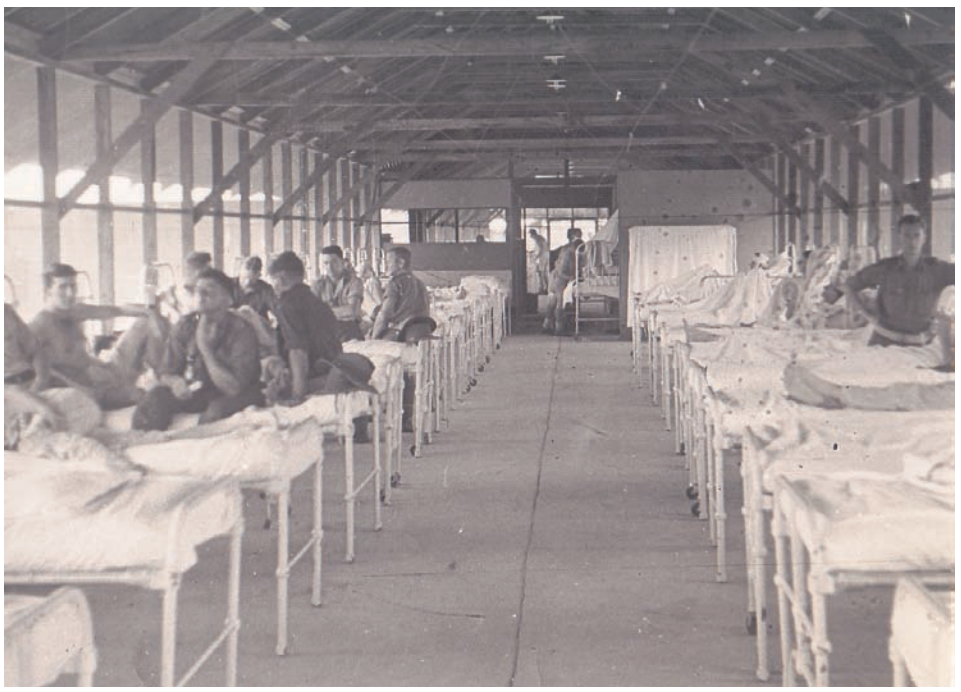
Pub: CMC TOTS Page: 37
Date: 27-JUL-2009 Plate:CMYK

Rank's Royal Show

Benny Rank's career in plastic surgery stretched over many years and locations



Keith Mutimer
Honorary Treasurer

I told him I made it a habit to call every day on the scrounge for whatever might be useful to use in my show. That remark together with the succession of visiting dignitaries was apparently the origin of the plastic surgery unit's unofficial title, 'Rank's Royal Show'.

It is 1941 and Benjamin Rank (Benny to his friends) is in charge of the facio-maxillary and plastic surgery unit at the 2nd AGH at El-Qantara in Egypt. The hospital is located in the desert near the Suez Canal and there are 'no punches pulled' about its location - 'Suez is the depths and El Kantara is 20 miles up it!'

Rank had been in England in the late 1930s 'breaking in' to plastic surgery - a specialty which had rapidly expanded in the United States in the 1930s but, despite the Sidcup experience at Queen Mary's Hospital during World War I, had developed more slowly in Britain. Persistence and a certain amount of luck found Benny Rank working with the doyens of plastic surgery - Sir Harold Gillies, Archibald McIndoe and Rainsford Mowlem – at 'the only centralised plastic surgery unit of any significant size' – St James' Hospital, Balham and at Hill End, the plastic unit attached to St Bartholomew's Hospital.

At the end of 1940 Rank joined the Australian Army from Britain and found himself at El-Qantara. When he arrived, most of the Hospital was still located in tents, facilities were basic and essential equipment inadequate – for Benny Rank, a perfect scenario for innovation and creativity in the treatment of war wounds.

And as Rank says in his book, *–Heads and hands: an era of plastic surgery* – at El-Qantara he 'violated the sacred cows of current surgical war practice' by abrogating the practice of closed treatment of wounds and the use of tannic acid for treating burns. His alternative method, influenced by Archie McIndoe's treatment of injured pilots from the Battle of Britain, consisted of 'hypertonic saline baths and local sulphonamide sprayed on with homemade apparatus, [which] proved effective streptococcal weapons, and the main props of early skin grafting'. And the equipment used – mounted baths for bedside use, tanks constructed from rubbish bins and an improvised filter system – were the result of Benny 'on the scrounge', aided and abetted by the resident engineer.

In 1942, El-Qantara became a British hospital and, with the return to Australia of the medical contingent, Benny Rank's next posting was to the 115th Military Hospital at Heidelberg.

At first the idea of a plastic surgery contingent at the Heidelberg Military Hospital met with some resistance. The role of the specialist surgeon seemed to sit uncomfortably with the Australian practice under which patients were seen first by general surgeons then referred to the specialists.

However, with the war as a catalyst for change, it was unlikely that Rank and his team – with a proven record at El-Qantara and strong supporters such as WA Hailes and Charles Littlejohn, facilitators of Rank's work at El-Qantara and Fay Maclure, a World War I colleague of Sir Harold Gillies at Sidcup – would be ineffective at Heidelberg. The standing of the plastic surgery unit was consolidated further in 1944 when 'Orm' Smith, former commanding officer at El-Qantara, became the OC Surgical at Heidelberg.

Benny Rank was an avid record-keeper, documenting his work to an extent well beyond that required by the military authorities. These records, especially those in visual form– drawings, photographs and a film made at Heidelberg in 1945 –were used as resources for teaching purposes and as a means of validating and promoting the fledgling practice of plastic surgery.

Many of these records have found their way into the College Archive and include eight large photograph albums of patients at Heidelberg Military Hospital. Meticulously

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Pub: CMC TOTS
Page: 43
Date: 27-JUL-2009
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Foundation for Surgery
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Information about deceased Fellows

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

John MacKinnon Grant VIC
Philip Anthony Hefner NSW
Philip Blake Humphris NSW
Christopher John O'Brien NSW
Gordon Key Smith VIC
Graham Douglas Tracy NSW
Gordon Walgrave Trinca VIC
Peter Frederick Williams VIC
William Francis Wilson VIC

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries.

Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website 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
VIC	Denice.spence@surgeons.org
WA	Penny.anderson@surgeons.org
NT	college.nt@surgeons.org

Emil Theodor Kocher

Theodor Kocher was the first surgeon to be awarded the Nobel Prize

Philip Sharp
NSW Fellow

Theodor Kocher was one of a group of extraordinary surgeons who dominated European surgery at the end of the nineteenth century. He rose from relative obscurity in a small university clinic in Bern, Switzerland to prodigious heights as a teacher and innovative surgeon. Cushing, when comparing Kocher and Halsted said *'they represented European and American surgery at its best.'* [2] For a man who earned high praise from his contemporaries, it is surprising how little is known about him today.

He was born on 5 August 1841 in Bern, Switzerland. His teachers advised him to become a philologist. Instead he enrolled in medicine at the University of Bern graduating in 1865 with honours.

Kocher decided to do surgery. He went to Berlin seeking to become Bernhard von Langenbeck's assistant. After his stay in Berlin, Kocher travelled to England and France. He observed Hutchinson, Horsley, Paget, Lister and Wells before going to Paris to attend lectures by Nélaton, Pasteur and Verneuil.

Returning to Bern in 1866, he became assistant in surgery to Professor Albert Lücke. During this time he began developing his meticulous history taking, physical examination, correlation of clinical and laboratory findings and operative techniques that were to become his hallmarks.

In 1872, Kocher applied for the position of Professor of Surgery after Professor Albert Lücke moved to Strasbourg. Franz König of Germany was selected by the faculty. The local physicians and medical students were extremely disappointed. Strong letters from Billroth and Langenbeck and perhaps the Swiss desire for internal selections led to the Board overruling the faculty.

Kocher became Professor of Surgery, a position he held for 45 years. In 1912 he gave $40,000 to the University for medical research. [4] However, he was not above threatening to leave in order to get improvements for his department.

Some of the professional honours he received were: President of the German Surgical Society, President of the Swiss Surgical Society and President of the Congress of the International Surgical Society in Brussels in 1905.

He was of a slight rather cadaverous build with distinctly prominent teeth. He was modest with an old-world courtesy. He spent his holidays visiting other clinics, being a keen traveller and an excellent linguist. Despite his slight build, no-one ever saw him weary.[20]He was difficult to approach with few close friends among whom were Halsted and Cushing.

Kocher's surgical interests were multiple and his accomplishments wide-ranging. In 1870, when he was visiting Billroth's clinic in Vienna, he easily reduced a dislocated shoulder after a number of unsuccessful attempts by other doctors. Kocher never referred to this manoeuvre by his own name; he called it the "rotation-elevation method." His experience with surgery of the extremities was substantial with a fracture of the humerus and incisions of the ankle, knee, hip, wrist, elbow and shoulder named after him.

Kocher was interested in neurosurgery; in particular epilepsy, transsphenoidal surgery for pituitary tumours and raised intracranial pressure. In a grandiose gesture, Kocher had a volcano in Manchuria named after him by a grateful Russian noble following a craniotomy. Not only did the Russian nobility send their sick relatives to Kocher, even Lenin brought his wife to Bern to be operated upon by Kocher.

His experience in abdominal surgery was extensive. He was among the earliest to do cholecystecyomies after Langenbuch in 1882. Mobilisation of the duodenum is referred to as Kocher's manoeuvre. But in 1895, Maurice Joseph had described mobilisation of the first part of the duodenum in cadavers. Vautrin, the following year, presented a review of the problem of common bile duct obstruction by gallstones. He exposed the retroduodenal portion of the common bile duct by mobilising and rotating the duodenum in three patients.[12] It wasn't until 1903 that Kocher recommended mobilising the entire duodenum allowing improved access to the pancreas and common bile duct.[6]

Kocher's research on wound ballistics is virtually unknown. Kocher, a Swiss citizen and a Colonel in the Swiss army, realised that the interaction between penetrating projectiles and body tissues must be understood so wounds could be treated rationally and effectively.

In 1874, Kocher began studying why bullets caused tissue disruption. He shot pig bladders filled with water, leg bones and human cadavers. He recovered the fired bullets from sacks filled with cotton and wool yarn placed behind the targets. He found that fragmentation of the bullet only occurred when it hit bone. He discovered that the increased velocity of modern rifle bullets caused increased hydraulic pressure. This led to disruption of tissues producing temporary cavitation and direct crush of tissue struck by the bullet. Kocher emphasised the more elastic the tissues, the less the disruption.

To understand why bullet wounds became infected he applied various bacteria to pieces of soldier uniforms and shot through the fabric into gelatine cylinders which served as a culture medium. His ideas caused the Swiss Government to develop the full-metal-jacketed bullet in 1880. This became the standard type of military bullet throughout the world.[9]

In 1892, the 1st edition of his textbook of operative surgery appeared. It was a success and was translated into French, Russian, Italian, Japanese and English. It was not a review of other texts. It was much more interesting as iIt was a report of his own experiences and methods. →

He is not remembered for any aphorisms but what he wrote is still pertinent.

The Kocher clamp is a commonly used surgical instrument. He also developed or modified scissors, dissectors, clips, operating tables and an anaesthetic mask for chloroform. His exploits were not limited to surgical patients. Phosphorus necrosis was common among certain Swiss workers. In 1895, Kocher forced the change in the law forbidding the use of phosphorus to make matches.

Kocher's most significant contribution to medicine concerned the thyroid gland. He was the right man in the right place at the right time as goitre was widespread in Switzerland. 80-90 per cent of schoolchildren in Bern had goitres.

I will give you a very brief review of the history of goitres. The Chinese mention goitres as early as 2700BCE. They suggested seaweed and sea sponge, both containing iodine, as remedies. The Arthorva Veda, an ancient Hindu collection of incantations dating from 2000BCE contains extensive forms of exorcisms for goitre.

Galen described operative treatment for an enlarged thyroid on two boys by ignorant physicians who removed "tubercular" nodes with their fingernails causing one boy to become mute by cutting the laryngeal nerve.

Julius Caesar remarked that a big neck was a frequent characteristic of the Gauls. Juvenal, the Roman poet wrote: *'Quis tumidum guttur miratur in Alpibus?' ('Who wonders at goitre in the Alps?')* Goitre is derived from the Latin *'guttur'*, the throat. Fabricius ab Aquapendente of Padua was probably the first to use this term when he described people with goitres as *'gutturosi'*.

Leonardo Da Vinci and Vesalius drew an anatomically accurate healthy thyroid about 1500AD. Bartholomaeus Eustachius noted that it had two lobes connected by an isthmus. In the sixteenth to eighteenth centuries, goitre was also called *'struma'* and often confused with enlarged tuberculous cervical lymph nodes.

In 1656, Thomas Wharton in his book *Adenographia* gave the gland its modern name of thyroid after the Greek word "thureos" a shield.

Thyroid surgery was done well before thyroid gland physiology was understood. Early attempts to treat thyroid enlargement and overactivity were horrifying and associated with very high mortality and morbidity due to asphyxia, infection and air embolism and especially haemorrhage. The first well documented partial thyroidectomy to remove a large adenoma to relieve pressure symptoms was done in 1791 by Pierre Joseph Desault. His patient, a 28 year old woman survived. His second patient died from haemorrhage.

"His experience with surgery of the extremities was substantial with a fracture of the humerus and incisions of the ankle, knee, hip, wrist, elbow and shoulder named after him."

Baron Dupuytren, in 1808 did a total thyroidectomy for a large adenoma. His patient died of respiratory failure 35 hours later.[19] In 1850, the curses of sepsis and haemorrhage forced the French Academy of Medicine to prohibit operations on goitre.

Theodor Billroth had a 40 per cent mortality, almost entirely due to sepsis; 30 per cent recurrent nerve injuries and post-operative tetany occurred frequently following his thyroidectomies.

Four important events provided a tremendous impetus to improving the safety of the operative treatment of goitre. These were:

1 The advent of general anaesthesia in 1846,
2 The introduction of Listerian principles of antisepsis and asepsis in the 1870-1890 period,
3 The development of satisfactory haemostats by Spencer Wells in 1872[7] replaced crude cautery, mass ligatures and the crushing forceps. As a result delicate and deliberate operations became possible…elective surgery was born and
4 Theodor Kocher's succession to the surgical chair at Bern in 1872.

Kocher did his first thyroidectomy in 1872. Two years later he did a total thyroidectomy on 11-year-old Maria Richsel. Follow-up letters from her local doctor indicated a gradual change from a girl who was lively to sullen with a general loss of interest. Further follow-up was lost when her local doctor died.

In 1882, Jacques Louis Reverdin and his cousin Auguste of Geneva reported on ten patients who had symptoms of hypothyroidism following total thyroidectomy. They called this *'myxoed me opératoire'*. Kocher, upon hearing of this paper, reviewed 34 of his patients, 18 who had had a total thyroidectomy. Sixteen of the 18 had varying degrees of hypothyroidism. Kocher called this cretinoid appearance 'cachexia strumipriva'. He concluded that the thyroid gland was an essential organ and that its absence led to a definite clinical picture of cretinism. He vowed "never again to do a total excision for benign disease".

Paracelsus, another Swiss, was the first to suggest a relationship between goitres and cretinism in the 15th century.

There was another involved in this drama - the Austrian psychiatrist Julius Wagner-Jauregg who had discovered that cretinism was caused by malfunction of the thyroid gland but he was not given the credit for this discovery. Was it because Kocher, the man usually cited as the originator of this theory, published his version in a more prestigious journal? Sometime later, on Wagner-Jauregg's advice, the Austrian government started selling salt with added iodine in areas most affected by goitre.

Now I would like you to consider a disease with a high mortality, severe morbidity, unknown pathogenesis, imprecise diagnostic features and no known cure – in short a condition with no hope. Then…there is hope. The disease was neurosyphilis and the magical remedy was "fever therapy". Julius Wagner-Jauregg was awarded the 1927 Nobel Prize in Medicine or Physiology for his treatment of

neurosyphilis by inducing a fever after giving his patients malaria.

He was the first of only two psychiatrists to win this prize.[13,14] (Eric Kandel [the 2000 Nobel prize winner] demonstrated fundamental ways in which nerve cells alter their responsiveness to chemical signals to produce a coordinated change in behaviour. His work has been essential not only for our understanding of the basic processes of learning and memory, but also for highlighting many of the cellular processes that are targets of psychoactive drugs).

Kocher's first series of thyroidectomies (101 patients) had an operative mortality of 12.8 per cent. At the time of his death in 1917 from uraemia, he had done 5314 thyroidectomies[15] with an operative mortality rate of less than 1 per cent.

The keys to his operative success were:

1 To control the blood supply to the gland before any dissection and
2 Meticulous and complete dissection.

He was not fast but safe avoiding infection of haematomas and necrotic tissues. Kocher did a capsular dissection. In his hands, damage to the parathyroid glands and recurrent laryngeal nerve were rare complications.

In 1909, he was awarded the Nobel Prize in Medicine or Physiology *"for his work in physiology, pathology and surgery on the thyroid gland."* Kocher discussed the difficulties of recognizing thyroid disease more subtle than goitre, that is, hyper- and hypothyroidism. He noted that virtually any organ could be affected by alterations in thyroid function, and that the symptoms were often nonspecific. Kocher was the first surgeon to receive this honour and is the only surgeon to get this prize for clinical work.

Kocher's influence on American surgical education was profound. By the end of the 19th century the lack of a scientific basis for the practice of surgery in America was apparent to numerous informed surgeons. Many surgeons would journey to Europe to visit the great clinics and learn from the surgical masters. Kocher, Harvey Cushing and William Halsted enjoyed a lengthy friendship. The relationship between the three demonstrated a deep respect for each others' talents. In addition to their professional admiration, and a strong personal feeling existed between them.

Halsted went to Bern in 1889 to visit Kocher. This is not surprising as Kocher studied surgical problems from an anatomical, pathological and physiological perspective prior to surgery – as did Halsted.

Harvey Cushing spent five months in Bern in 1900 and 1901. Under the guidance of Kocher and the physiologist, Hugo Kronecker, Cushing learned that surgery and research could be combined doing experimental work on raised intracranial pressure.[5,18]

In the United States at the turn of the 20th century substantial deficiencies existed in formal surgical education. Halsted and Cushing brought back Kocher's ideas. As a triumvirate they had a profound influence on American surgery.[11] However, unlike his contemporaries Billroth and Halsted, he never established a school of surgery.[1] The reason for this is not sure.

He was regarded by his patients not only as a wonderful doctor but possessed of "*lucky hands*." His peers regarded him as a virtuoso of surgical thought, technique and innovation. Despite accolades and honours, he remained quiet, courteous, reserved and dedicated to his patients and staff. His modest upbringing and deeply religious beliefs left him free of vanity and conceit. His was a life of dedication, humanity and humility.

The extreme versatility demonstrated by this surgical genius is, in my opinion, unique by present day standards. It bears witness to a single-minded devotion to his love of surgery. In 1909, in his Nobel Lecture, Kocher claimed that physiologists had learned from surgeons how to perform their animal experiments to study the physiological action of organs without distortion.[16] He was a leading figure in the transition of surgery from the mechanical and the physical to the biochemical approach.[10]

I believe it is fitting that we should remember the first surgeon to be awarded the Nobel Prize 100 years ago.

References

1 Moynihan B: Obituary. BMJ 2: 168, 1917
2 Fulton JF: Arnold Krebs and Harvey Cushing at the first International Neurological Congress at Berne in 1931. Bull. Hist. Med. 8: 332 1940
3 Wiese ER and Gilbert JE: Theodor Kocher. Ann. M. Hist. 3: 521 1931
4 Obituary: JAMA 69: 483 1917
5 Fulton JF: Harvey Cushing, a biography. Springfield, 1946, Charles C Thomas
6 Theodor Kocher: Text-Book of Operative Surgery. P549 3rd English Edition, 1911, Adam and Charles Black, London
7 Kirkup J: Spencer Wells' forceps. J Med Biog: 2005 13 (3) 127
8 Obituary: Lancet 2: 167, 1917
9 Fackler ML, Dougherty PJ: Theodor Kocher and the scientific foundation of wound ballistics. Surgery, Gynecology & Obstetrics: 172 1991 153-160
10 Blumgart L: Invited Editorial. Dig Surg 2001; 18: 315-6
11 Modlin IM: Surgical triumvirate of Theodor Kocher, Harvey Cushing and William Halsted. World J Surg: 22, 103-113, 1998
12 Madden JL, Kandalaft S, Eghrari M: Mobilization of the duodenum: A surgical maneuver incorrectly credited to Kocher. Surgery 63 522-6 1968
13 Julius Wagner-Jauregg. The Nobel Prize in Physiology or Medicine 1927. http://nobelprize.org/nobel_prizes/medicine/laureates/1927/wagner-jauregg-bio.html accessed 27/03/2009
14 Raju TNK: Hot Brains: Manipulating body heat to save the brain. Pediatrics 117 2 320-1 2006
15 Gemsenjäger E: Milestones in European Thyroidology. http://www.eurothyroid.com/met/theodor_kocher.html accessed 9/04/2009
16 Emil Theodor Kocher, 'Concerning pathological manifestations in low-grade thyroid diseases', Nobel Lecture, December 11, 1909, in Nobel lectures: Physiology or Medicine, volume 1 1901–1921, published for the Nobel Foundation by Elsevier, Amsterdam, 1964, pp. 330–83, on p. 331.
17 Dietz UA, Kehl F, Hamelmann W, Weißer C: On the 100th Anniversary of Sterile Catgut Kuhn: Franz Kuhn (1866–1929) and the Epistemology of Catgut Sterilization. World J Surg (2007) 31:2275–2283
18 Long, DM: Harvey Cushing at Johns Hopkins. Neurosurgery 45(5), 983-8 1999
19 Hegner, CF: A history of thyroid surgery. Annals Surgery 45(4), 481-492 1932
20 Brett, WR: Some thyroid pioneers. Medical Bookman and Historian 1 (11) 29-31 1947
21 Bonjour, E: Theodor Kocher, Bern 1950 Paul Haupt

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