Surgical news

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THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The Rowan Nicks Legacy

Scholars talk about their prized experiences from receiving Rowan Nicks scholarships

The College of Surgeons of
Australia and New Zealand

ON THE COVER: Mark Ashton (left) and Rowan Nicks scholar Iain Whitaker (right) performing a deep inferior epigastric artery perforator flap in Melbourne.

contents

FRACS

Change is the only constant

We must look at upcoming challenges as an opportunity to adapt and progress

Ian Civil
President

As a membership based organisation, an educational institution of international repute and clinical standards setting body, the College needs to not only understand the demands and requirements of educational bodies and the impact of progressive regulation, but importantly the ambition and talents of our main stakeholders – our own Fellows.

Over the past 10 years we have witnessed substantial changes to the regulation of health and the regulation of education. Workforce crises have produced waves of demands and changes. At the same time the College has become a more substantial organisation with significant capacity. In parallel, the Specialty Societies and Associations have also increased in size, sophistication and focused ambition.

What binds us is the inherent standard and pride of our qualification – the FRACS. Throughout our professional careers it reflects our training, standards achieved and commitment to ongoing surgical excellence. It is respected internationally as the qualification of a world class surgeon.

However, the College must continue to adapt increasingly quickly to changes in the health and educational sectors and the changing nature of and relationship with all our stakeholders.

I have recently written to more than 500 Fellows of the College who are highly involved with College activities to ask them to identify ways in which we can continue to improve. Improve the way in which we can train world class surgeons and support them through their professional careers; improve the way that the College and our stakeholders, but particularly the surgical specialty societies, can interact with and provide direction to the College; improve the cost effectiveness of the way ▶

"What binds us is the inherent standard and pride of our qualification – the FRACS"

we deliver our services and deliver better value for money.

I have been heartened by the positive responses that have been received and the deep thinking that has gone into some of these responses. The College has progressively changed our governance model over the past 15 years. We need to continue to adapt this to ensure the leaders of all the specialty societies can contribute at the College Council level. Equally the senior College Councillors and staff need to be able to attend meetings such as the specialty training board meetings as nothing is so effective as eye to eye contact and direct discussions.

The change from our previous surgical training model of Basic Surgical Training and Specialist Surgical Training to the integrated Surgical Education and Training program has brought many challenges. When trainees are highly committed and able to demonstrate the requirements to enter the training program they can effectively be selected from PGY 2.

However, this advantage also comes with a cost of not always having confidence that the selected trainees will meet all the requirements of being a trainee across all the competencies of being a surgeon. Some specialties need longer to be confident that people being selected have all the skills needed for the training program. By being clearer and more explicit about the required skills that PGY 2 applicants must achieve, this tension can be improved.

Like any organisation that is reflected across nine disciplines and 10 government structures, the impact of how dollars are spent needs to be continually reviewed. How we organise ourselves and how we can be most effective on government structures that must be better informed about surgical issues is something that needs everyone's consideration. Our brand – FRACS – stands for surgical excellence and world class surgeons. It is critical that the value and recognition of this is never lost.

It has often been said that the key to success is the ability to adapt. Adaptation, as we know from our biology lessons requires diversity in make up and the ability to explore different structures. For the College to continue to adapt to the changing environment that surrounds surgery, we need the diversity inherent in our membership and the ability for that diversity to be expressed though a responsive and flexible College. That is our challenge.

Queen's Birthday Honours 2011

AUSTRALIA

Member (AM) in the General Division

A/Professor Barry Hicks AM FRACS

Professor Jeffrey Rosenfeld AM FRACS

Medal (OAM) in the General Division

Mr David Davidson OAM FRACS

Professor John Royle OAM FRACS

A/Professor James Wyllie OAM FRACS

NEW ZEALAND

Officer of the New Zealand Order of Merit (ONZM):

Professor Swee Thong Tan ONZM FRACS

Surgical Workforce Census for 2011 coming your way!

The census is a core activity of the College, assisting with much of our advocacy and programs

Keith Mutimer
Vice President

The College's biannual census serves as a snapshot of surgical activity in Australia and New Zealand and, importantly, helps us identify emerging trends in that activity. With a current and thorough understanding of work volume, workforce intentions and the workplace environment, the College is better able to identify existing and emerging gaps in the provision of surgical care.

This is crucial to meeting future demand for such care and ensuring people, irrespective of where they live, have access to timely surgical care of the highest possible quality.

The census seeks specific information on the scope of work being done by active Fellows of the College, tracks any changes in the mix of public and private working hours, and identifies patterns across the active and retiring membership.

Of particular interest are the changing circumstances of Fellows working in regional, rural and remote locations. This information enables us to gain a more accurate picture of the present and future requirements of surgeons in Australia and New Zealand.

The census also informs our advocacy of governments and bureaucracies across the jurisdictions. As you may be aware, Health Workforce Australia, under the mandate of the Council of Australian Governments, is currently seeking to implement some significant training and workforce reforms. These will directly affect Australian Fellows. Understanding where you perceive yourself to be in your career path will help the College to develop workforce models, and to demonstrate to HWA what surgeons' needs are.

Previous findings with regard to surgeons' working hours and the issue of work-life balance differ with those in much of the current literature. For example, a survey conducted of the Australian Medical Labour Workforce as a whole reported the average number of hours worked per week by surgeons to be 48.4 (AIHW Medical Labour Force Survey, 2006). This is well below the findings of the 2009 College census, which found the average to be 59.5 hours per week.

The issue of support for surgeons has been highlighted in a number of studies across Australia. There is no doubt that dedicated and protected time for supervisors would improve the standard of our training programs, in turn leading to better patient care.

One important question in the 2011 census asks if surgeons have seen improvements, as a result of the numerous reviews into the health care systems, since the 2009 census.

In 2010, the New Zealand government entered a collective agreement with the National District Health Board which provides for 30 per cent non-clinical time for salaried medical officers, including surgeons. Consequently, the 2011 census will ask New Zealand Fellows whether this time is being used by surgeons for the intended purpose of training or is being spent on clinical activities.

Currently there is considerable discussion around task

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delegation and alternative practitioners (i.e. physician assistants and nurse practitioners). A question has been included in this year's census to canvass your thoughts about this.

This year the census will have a core set of questions as well as a separate New Zealand specific component and a smaller Australian specific component.

An invitation to participate will be sent to you shortly. There are two ways to participate in the census.

- Complete the hard copy. A hard copy will be sent automatically to your preferred mailing address. Complete the form and return it in the postage paid envelope.

OR

- Complete the census online. A code* and link to the web address will be emailed to your preferred email account.

***What is the code?**

The code will be unique to each surgeon. This ensures your anonymity, allowing the College's Workforce Department to ascertain that you have completed the census, but not to link you with the detail of your feedback.

But I'm retired

If you have recently retired from surgery and no longer perform any work derived from skills developed as a surgeon, please lodge a signed form to this effect with the College's Fellowship and Standards Department. Fellows still undertaking medico-legal work are considered active.

Participation in the census is voluntary. The census will take approximately 10 to 15 minutes to complete. It is hoped that a response rate of 80 per cent will be achieved as this represents a robust and representative data set of the surgical population.

There will be short window of time from the release date to complete the census. This is so the aggregated results are analysed and back to you by the close of this year.

Prizes?

Participants who respond online will be in the running to win prizes such as Hotel gift vouchers to the value of $500. To be in the running you will need a valid email address to complete the census online. Please notify the College of your changed email address today!

To encourage your participation there will again be prizes on offer – to be in the draw to win you must have completed the census, either in hard copy or electronically.

The findings of the 2011 census will serve as the basis of the College's ongoing efforts to inform and influence decision makers in the 10 governments with which it has dealings, and in health departments across Australia and New Zealand. Only when armed with the most comprehensive and up-to-date information can the College hope to support the development of a properly resourced and sustainable surgical workforce.

Findings will be published in Surgical News, and a full report will be distributed to the Fellowship in a Surgical News mail-out.

If you lose your code or would like more information on how to access the census, contact Kellie Hardy, Workforce Planning & Research Officer, on +61 9249 1108 or at kellie.hardy@surgeons.org

References *AIHW 2008. Medical labour force 2006. Cat. no. HWL 42. Canberra: AIHW. Royal Australasian College of Surgeons. Report - Surgical Workforce Census 2009*

Poison'd chalice

"I am to wait, though waiting so be hell"

(Sonnet 58 – Shakespeare)

Professor U. R. Kidding

You know the old Bard could sum it up pretty well. I was sitting at my desk at work. The world was dark outside. Everyone had departed, fled or had got fed up and left. Mine was the task to try and explain the intricacies of waiting list management to a "Ministerial – please explain".

I remember my younger days when I had spent three years in the UK working with the NHS. Waiting lists had been a matter of pride. How many years could the wait be extended. The amazing thing about the Poms is that they were so thankful when they actually got to the front of the queue and received the care – usually by some Australian expat doing some post-Fellowship years.

Mind you, I hear it has changed. They almost semi-privatised the surgical waiting lists and magically they almost disappeared. Could it be true – even the NHS could be "spurred into action"?

Where was I? Yes locally, waiting was not a game of patience or gratitude. As Shakespeare stated it: "waiting so be hell". And every citizen had at least three if not four politicians they could wind up and demand things on their behalf. Hence the Ministerial – please explain.

I refused to take these home. My better half would shoot me if I was found answering these – surely I could delegate them… Mind you, there seemed to be increasing reasons why I deserved a bullet these days – would one more really matter? However, the CEO had been pretty insistent about getting the answers to this one, like yesterday.

So here I was, tapping away at my keyboard trying to be polite about the realities of lack of funding, excessive demand and clinical priorities. How do you explain to anyone that for every two patients we remove from the waiting list, we add three more, how do you explain that there has been a 9 per cent increase in emergency surgery over the past 12 months in conjunction with a "productivity increase", i.e., you do more for less! Of course I know the Commonwealth is breathing down the Minister's neck – proposing targets for funding! That is to say if you meet the targets you get funded and if you don't meet the targets, you don't get funded! Sounds sensible – not!

Service Delivery

Of course, as a Director of Surgery I could meet the targets required. All it would take is reducing ENT, Plastics and Orthopaedic outpatient clinics to monthly clinics – now there is an idea.

I did decide to point out to the Minister the dramatic and substantial changes that have occurred in the delivery of surgical services in the past 20 years. I remember the furore when we started doing admissions on the day of surgery with progressively compulsory pre-admission clinics.

Then there was the development of 23 hour wards with early discharge or utilisation of "Hospital in the home". Surgeons embraced these as they gave patients greater certainty about access to the care that they needed and over time our confidence grew as the standards of care seemed to improve. The only group that did not seem convinced about them were the physicians who just nodded wisely and then admitted more of their patients to surgical wards.

Now we are into the next wave of changing service delivery. Emergency services are now becoming more "consultant" profiled and led. There is emerging and clear evidence that this provides more effective and safer services for the community.

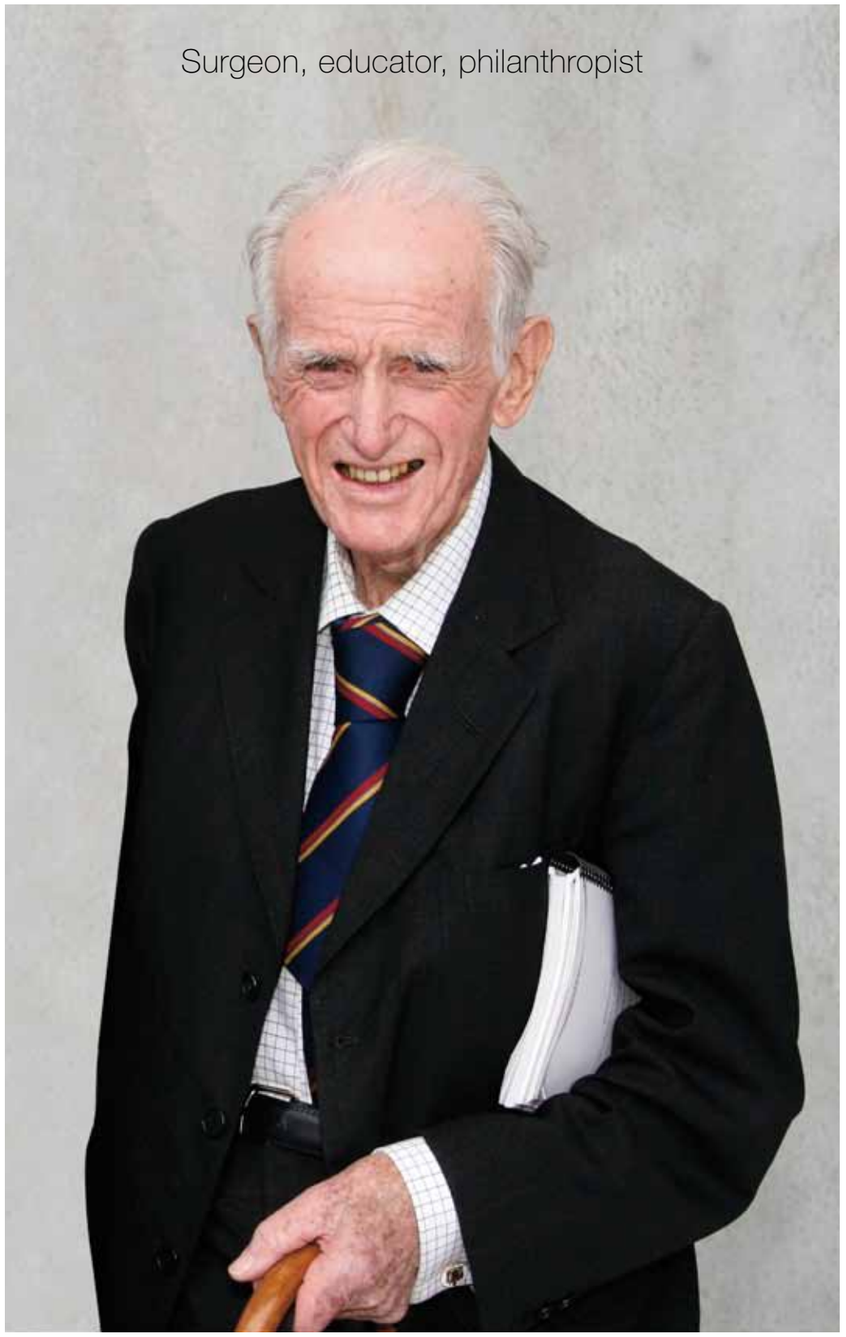
Hopefully there will be more room for the "waiting list" that still grows. And now the Government appears to be accepting that the formal separation of elective surgery from emergency surgery is advantageous to ensure access and improved quality.

Mind you, surgeons have been demonstrating that for years. The Private Sector in Australia and New Zealand is largely elective and with a focus on throughput is both efficient and responsive. Free standing surgical centres may be the way to go in lots of places. And still the physicians just nod their heads and continue to admit more of their patients to surgical wards.

The one thing about waiting lists is it generates lots of interest in prioritisation. As usual, the orthopods are way out in front. Their osteoarthritis assessment questionnaire is held out to be explicit, consistent, clinically defensible and equitable. Quite some accolades for the orthopaedic surgeons – I must mention it in my next Department Heads meeting. I wonder what the physicians would say about that. Probably nothing, just nod wisely.

I was almost finished. Ministerial questions produced more sweat than the long answers for the Fellowship examination. Only one question left – do I recommend that the patient should just use their private insurance and be treated in the private sector. That was the time to leave and head for home…

George Rowan Nicks AO, OBE MD {HON SYD}, FRCS [ENG.], FRACS



**Brian Morgan,
John Masterton
and Marie Bashir AC, CVO**

Rowan Nicks was born in New Zealand on 24 February 1913, the second son of Laura (nee Logan) and George Anthony Nicks. The family was in timber milling, his father a workaholic. His mother was a cultured woman who encouraged him in education, outdoor activities and a career in surgery.

At an early age the family visited his maternal grandfather, William Logan who died soon after their arrival. Laura inherited his property, near Nabiac on the north coast of New South Wales. After deciding to move there, they disliked its remoteness and sold it. They moved back to Auckland where they established a timber mill and prospered.

Rowan developed a great interest in nature and gardening, passions which sustained him all his life. He did well at school and entered the medical school in Dunedin, much to the disappointment of his father, who wanted him to work in the family business.

Rowan was delighted with the course, especially in the latter years. On graduation he returned to Auckland and worked as an intern. The experience was daunting, but stimulating. And he was back with his mother; her influence and that of his future wife Mary led to a lifelong admiration and respect for women.

After his internship he set off by ship for the United Kingdom to further his surgical studies. There he worked as a demonstrator in anatomy at the Middlesex Hospital and passed the first part of the Fellowship of the Royal College of Surgeons of England.

At the outbreak of WWII, Rowan attempted unsuccessfully to join the New Zealand forces. Instead he enlisted as a surgeon lieutenant in the Royal Navy, serving until 1945. He was first posted with the Royal Marines to

Brian Morgan and Rowan at the 2009 Annual Scientific Congress; Russell Stitz awarding Rowan Nicks the College International Medal.

West Africa and later served on the Atlantic convoys. During this time he met Mary Mattenson, a nurse from St. Thomas' Hospital and a sister in the Queen Alexandra's Royal Naval Nursing Service. From North Sea convoy duties he moved to the Mediterranean where he saw action for which he was appointed an Officer of the Order of the British Empire in 1945. This was a seminal year, as he married Mary and also passed the final FRCS examination.

At the end of the war he turned his attention to his future surgical career and was drawn to the specialty which would soon be known as Cardiothoracic Surgery. He gained a 12 month appointment at London's Brompton Hospital, the most highly regarded institution in that field.

At the end of that year Rowan accepted an invitation from Charles Robb of Greenlane Hospital in Auckland to apply for a post there. Green Lane was to become a world-leading centre in the specialty. He was appointed as a surgeon and planned to take up his post in 1947.

Before returning to New Zealand, he undertook a three month educational tour of Scandinavia and the United States, observing leaders in the field. At that time, work at Green Lane mostly involved the treatment of tuberculosis; he now had up-to-date knowledge of the latest procedures. He also established a research laboratory in which to teach himself new procedures.

In 1956 he was offered a position as a Staff Specialist Cardiac Surgeon at the Royal Prince Alfred Hospital in Sydney, a challenge he accepted though the environment was not ideal. With the help of the newly appointed Professor of Surgery, John Loewenthal, Rowan set up a research laboratory on a shoestring budget. He encouraged trainees to participate and devoted much of his time to teaching and research. His major achievement in the latter was the development of cardiac pacemakers. He had two staunch friends at this time: David Cole in Auckland and George Stirling at Melbourne's Alfred Hospital.

In 1969 Rowan's life was shattered by the death of Mary from leukaemia. This was a turning point in his life. As a salve he began to travel widely, visiting hospitals in Africa and India in particular. This was the beginning of his second and most significant career. He became acutely aware of the needs of surgeons and patients in the countries he visited. Young surgeons were desperately in need of exposure to influences and experience unavailable in their local environment. Thus was born the Rowan Nicks mission of helping others by providing scholarship opportunities.

In 1973 Rowan retired from the Royal Prince Alfred Hospital. He was 60 years of age. John Loewenthal praised his outstanding achievements as a teacher, a researcher and particularly his innovative and developmental work in surgery.

Rowan never really retired. He continued to travel and work in hospitals in East Africa, India, Malaysia and also in remote Aboriginal communities in Australia. His great friend Sir Edward (Weary) Dunlop, a man of similar ideals, accompanied him on many of his journeys. Rowan had inherited ample means and he put them to good use by establishing a series of scholarships and fellowships associated with the Royal Australasian College of Surgeons.

He had one central ideal: to teach teachers to teach others. The first of his scholarships is the Rowan Nicks International Scholarship. It has brought young surgeons from Africa, India and Asia to Australia and New Zealand, usually for 12 months.

Since its inception more than 50 surgeons have benefited, and more than $2.5 million has been dispensed. A measure of its effectiveness is the considerable number of scholars who have gone on to become leaders and teachers. Some have been appointed professors in their own countries.

The second series of scholarships are offered to surgeons from the Western Pacific region, notably Papua New Guinea and Fiji.

The third group of scholarships was initiated more recently and is offered to young surgeons from the United Kingdom and the Republic of Ireland and as exchange fellowships between Australia and New Zealand. These fellowships are different from the International and Pacific Islands Scholarships in that they are intended to continue the close relationship that already exists between the surgical communities of these respective countries.

The Rowan Nicks Russell Drysdale Fellowship in Indigenous Health and Welfare commenced in 2006. Rowan was very proud of this scholarship, administered by the University of Sydney. He established this in conjunction with the family of the great Australian artist Russell Drysdale. These scholarships are available to indigenous and non-indigenous health workers and have provided huge benefit to the indigenous community.

In his later years Rowan developed an interest in chamber music, symphony and opera. He attended performances regularly, often accompanied by his great friend Marie Bashir.

His trust and friendship enriched all those who knew him well. He is survived by an extended family in Australia and New Zealand.

The following tribute was delivered at the funeral of Mr Rowan Nicks at St James Church, King Street, Sydney on Tuesday, 7 June, 2011 by the College President, Mr Ian Civil

It is a great honour to be given the opportunity to say a few words about Rowan Nicks. I am the current President of the Royal Australasian College of Surgeons and I have had the privilege of meeting Rowan on a number of occasions. While I did not know him well, the College knew him and he knew the College very well.

But before I begin talking about Rowan and the College I would like to mention my other association with Rowan. Every day I walk past a large photograph of him taken in the early '50s on the wall of my hospital. He features alongside the other pioneers of cardiothoracic surgery at Greenlane Hospital in Auckland, Sir Douglas Robb, Mr David Cole and Sir Brian Barratt-Boyes.

As many of you would know, Rowan was a New Zealander who grew up in Auckland. He was schooled at Takapuna Grammar School on Auckland's North Shore and attended medical school in Dunedin. After graduation in 1937 he did his house surgeon years at Auckland Hospital before working his passage as a ship's surgeon to the United Kingdom.

During the war he joined the Navy and after obtaining the FRCS served as a Surgeon Lieutenant. After the war he was the first cardiothoracic trainee at the Brompton Hospital before becoming full-time surgeon at the Cardiothoracic Unit at Greenlane Hospital in 1947. It must have been an exciting time, with pioneering work in heart lung bypass, correction of congenital cardiac defects, and valve replacements developing from the Unit's work.

In 1956 Rowan came to Sydney and others will speak of his later work, but in New Zealand he established a reputation as a proficient surgeon and a man of the people. Many relationships between himself, his colleagues, and his patients and their families persist to this day.

In the death notices of the New Zealand Herald in this past week there have been a number of testaments from his past patients who to this day remember his personal attention and his professional expertise.

After his retirement Rowan travelled widely and appreciated the unmet needs of surgeons around the world, particularly in less developed countries. Rowan had a great desire to help young surgeons from these emerging counties, and to develop their surgical and leadership skills. Fortunately he had both the vision and the means to do this.

In 1987, Rowan established the first of the various Rowan Nicks Scholarships at the College of Surgeons. This first international scholarship category was for African and Asian countries, with the first scholar being Geoffrey Mugati from Zimbabwe who worked with Miles Little at Westmead.

Between 1991 and 2010, more than 50 scholars from 20 countries were awarded Rowan Nicks scholarships. There are now two additional Rowan Nicks Scholarship categories at the College. The Rowan Nicks Pacific Island Scholarships target surgeons in the Pacific and Micronesia, providing experience that is not available in the Islands.

This is the most numerically active group at present, with many past scholars attending our Annual Scientific Congress on a regular basis. The aim of each of the scholarships is to "teach the teacher to teach others" and all scholars must come with a sense of responsibility for the needs of their home country.

The Rowan Nicks ANZ Exchange Fellowship and the UK and Republic of Ireland Fellowship allow exchanges between the UK and Ireland and Australia, and between Australia and New Zealand. These fellowship programs aim to promote international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand, and increase interaction between the surgical communities of Australia, New Zealand and the United Kingdom.

Rowan won many awards and was recognised a number of times by the College. He was awarded the RACS Medal in 1985, and was made a member of the Court of Honour in the same year. In 2005 he was awarded the RACS International Medal. This medal is awarded to an Australian or New Zealand Fellow who has provided a significant and lasting contribution of an exceptional nature over a long period of time in the delivery or development of surgery for underprivileged communities overseas. There has never been a more qualified recipient than Rowan Nicks.

Rowan's greatest award, however, was the regard that Rowan Nicks scholars, now surgeons from a wide range of Pacific, Asian and African countries, hold him in. He offered them an opportunity through the Rowan Nicks Scholarships to obtain training and experience that would otherwise have been unobtainable. And more than that, he was their friend and there is no greater award than that.

The College of Surgeons has lost a great friend and a great colleague. However, through the Rowan Nicks Scholarship his drive, his determination, and his professional example will live on.

The Rowan Nicks *legacy*

Rowan Nicks scholars throughout Australia have been given great opportunities to gain key skills in their field, here a few reflect on their time. The commitment of Mr Rowan Nicks to expanding medical expertise and services to underdeveloped nations as well as forging links between Australasia, England and Ireland has now seen more than 50 international surgeons visit Australia through funding provided by the scholarships and Fellowships endowed by him following his years teaching and working in Africa, India and South-East Asia. The scholarships, established in 1991, provide opportunities for young surgeons who show surgical ability and leadership qualities to learn skills alongside Australasian surgeons before returning to their communities to develop and promote this knowledge. In honour of his great and lasting contribution to surgery around the globe, *Surgical News* spoke to three current Rowan Nicks Scholars

Dr Ramesh Singh Bhandari: General Surgeon, Nepal.

Rowan Nicks International Scholarship recipient.

Why did you wish to come to Australia to work and study?

As the super-specialty training in the fields of medicine and surgery are very limited and do not reach the standards of the developed world, once we complete our postgraduate training in Nepal, we always wish to pursue our higher training abroad. Because of its highly advanced surgical and medical field, Australia has long been one of the top ranked destinations for us to get higher training.

When did you arrive and where have you been working?

I started my training in October last year at the Alfred Hospital, Melbourne. I am attached to the Hepatobiliary Pancreatic Surgery Unit. From July, I will be working at the Austin Hospital, Department of Hepatobiliary Surgery.

What new skills or knowledge have you gained?

In the months of my training at the Alfred Hospital, I have gained huge experience in the field of hepatobiliary surgery. Gaining skills in pancreatic and liver surgery and their perioperative management have been the most rewarding part of my learning. I have also been able to take part in the departmental academic activities and data-research work.

How will this impact upon your work at home and the care of your patients?

I am very confident that once I go back to my country there will be many things that I can improve, not just limited to hepatobiliary surgery. At the Austin Hospital I am expecting to get some exposure in liver transplantation and will try to work out whether in the long run in my country, it will be feasible or not for us to dedicate ourselves to starting such a liver transplantation program.

Have particular surgeons in Australia acted as mentors?

Association Professor Peter Nottle, head UGIS unit and Mr Peter Evans, Head of Hepatobiliary surgery have been my supervisors at the Alfred Hospital. Professor Chris Christophi will be my supervisor at the Austin Hospital.

What has been the highlight of your stay so far?

To date, my time in Australia has been excellent in all aspects. I feel that I am being prepared to become a surgical leader, both as clinician and teacher who will be able to develop the field of HPB surgery in Nepal.

What do you think of Rowan Nicks' legacy and generosity in endowing such scholarships?

I think of myself as having been extremely lucky to have received this scholarship and I consider Mr Nicks to have been a truly great human being.

Dr Bibhusal Thapa: Thoracic Surgeon, Nepal. Rowan Nicks International Scholarship recipient.

Why did you wish to come to Australia to work and study?

I have always known Australia to be a top notch place for training in advanced surgery. I was convinced I would get the best of training here in my field of interest.

When did you arrive and where have you been working?

I came here in July, 2010, and have been working in the Thoracic Surgical Unit at the Austin Hospital, Melbourne.

What new skills have you gained?

I came here to learn Thoracoscopic surgery and I have managed to achieve most of that goal. In addition I have also been able to familiarise myself with newer techniques of therapeutic bronchoscopy, laser treatment and Endobronchial ultrasound. The most important achievement, however, has been the new and broader vision of my subject that I have acquired here.

How will this impact upon your work at home and the care of your patients?

I am hoping to introduce the field of thoracoscopy at home in Nepal. I shall also be taking with me a very new approach to managing and treating thoracic patients.

Have particular surgeons in Australia acted as mentors?

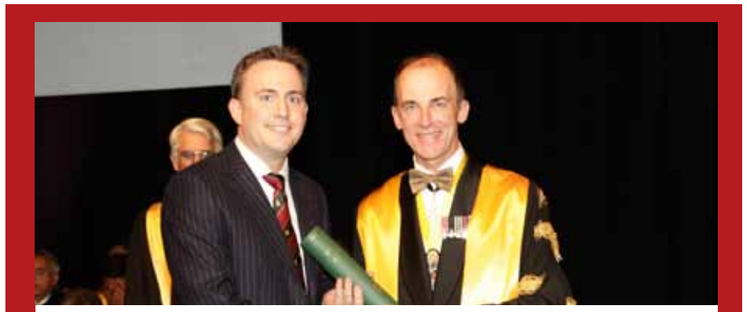
Mr Simon Knight, Director of the Thoracic Surgical Service at the Austin Hospital has been my mentor throughout my training. However, I have also learned a great deal from Mr Siven Seevanayagam, Mr Julian Gooi and Mr Stephen Barnett.

What has been the highlight of your stay so far?

Everything I have experienced while in Australia has been delightful. The warmth and feeling of being welcome and well looked after has been exceptional, however, the highlight surely has to be the brief, but wonderful meeting with Mr Rowan Nicks earlier this year. The personality of the man just stunned me.

What do you think of Rowan Nicks' legacy and generosity in endowing such scholarships?

I was deeply saddened by his passing away. His contribution to training surgeons from all over the world speaks volumes about his great vision. He will be remembered as someone who not only served humanity all his life, but also showed others through his generosity the same path.



Dr Iain Whitaker: Plastic, Reconstructive and Aesthetic Surgeon, England. Rowan Nicks UK and Republic of Ireland Fellowship recipient.

Why did you wish to come to Australia to work and study?

Melbourne has a world class reputation for Plastic and Reconstructive surgery research and clinical practice. The Royal Melbourne Hospital and the Taylor Laboratory are the current home to individuals at the forefront of plastic surgery research.

When did you arrive and where have you been working?

I arrived in January this year and have so far been working in a clinical capacity at the Royal Melbourne Hospital and Francis Perry House, Mercy Private Hospital and St Vincent's and the Western Hospital. My research experience has been at the Taylor Laboratory, Department of Anatomy and Cell Biology, University of Melbourne.

What new skills or knowledge have you gained?

I have gained significant additional clinical experience in microsurgery and new skills in performing cadaveric studies, teaching, supervising research students and laboratory management.

How will this impact upon your work at home and the care of your patients?

The overall experience will have a significant impact on my future practice. On return to the UK, I will be setting up a dedicated plastic surgery research unit and the experience and mentorship by Mark Ashton and Ian Taylor will be crucial in allowing me to do this successfully.

Have particular surgeons in Australia been of assistance?

I must thank Mr John Masterton, Chair of the Rowan Nicks' Scholarship committee for giving me the opportunity to work in Australia. I have rarely met such a humble and kind yet intelligent and decorated individual. As an overall mentor in all aspects of the fellowship, in my opinion Mark Ashton has been a perfect example of the teacher that Rowan Nicks envisaged. I must also thank Professor Ian Taylor and Mr Russell Corlett for embracing me into the Taylor Lab family and being such insightful researchers and individuals. Damien Grinsell has been very supportive and important in expanding my clinical experience in microsurgery and Mr Felix Behan has been a great educator and supporter.

What has been the highlight of your stay so far?

In the clinical arena, the high volume microsurgical experience has been invaluable. The submission of innovative NHMRC grants in collaboration with Mark Ashton in parallel with anatomical studies with Ian Taylor and Mark Ashton have been wonderful opportunities.

What do you think of Rowan Nicks' legacy and generosity in endowing such scholarships?

I am very upset not to have had the chance to meet Mr Nicks. I was planning to visit Sydney on my return from a European Conference as I desperately wanted to shake his hand and thank him for the opportunity he has given to so many surgeons worldwide. It would be difficult to imagine how many lives he has positively affected by his actions and vision, but he must have touched every corner of the globe. In my opinion there is no greater legacy an individual can leave than he has.

Advice on the stress of litigation

Foundation for Surgery Louis Waller Medico-Legal Scholarship has resulted in a key published text that is now in its second run

Australasian surgeons should develop stringent risk management procedures to guide conduct with patients from the minute contact occurs to avoid vexatious or unreasonable litigation, according to medico-legal expert Dr Joseph Smith.

Dr Smith, a recent recipient of the Foundation for Surgery Louis Waller Medico-Legal Scholarship, used the attached funding to write a book in collaboration with South Australia's Professor Guy Maddern entitled: *The Surgical Litigation Crisis: Medical Practice and Legal Reform.*

Published in New York last year, the book is now in its second printing and carries a foreword by Professor Geoffrey Davies AO, a former judge of the Court of Appeal of the Supreme Court of Queensland.

Dr Smith said he decided to investigate the subject following the results of studies undertaken in recent years that suggested that up to 40 per cent of surgeons in the US and Australia were considering early retirement based on the litigation crisis.

He said the most significant finding in his research was that surgeons needed to be litigation aware without letting that became stressful and burdensome to the point of affecting health and well-being.

"Most of the studies undertaken so far on this note the desire felt by a significant proportion of surgeons to retire early from practice, not so much because of litigation as the stress caused by the constant threat of litigation," he said.

"Yet there is no point in hoping for a no-fault compensation scheme to be introduced into Australia so the surgical profession now has to deal with this on a more piecemeal basis.

"The central tips I would give any surgeon would be to develop and impose risk management procedures to guide their contact with patients from the time they first visit the consulting suite to their time in theatre through to post-operative management, all of which should be religiously followed.

"Legally-drafted consent forms should be designed to cover that entire journey specific to each specialty which list every reasonable risk and, while this might take time, it is better than spending time in court.

Dr Joseph Smith collaborated with SA's Professor Guy Maddern on a medico-legal text.

"Also of importance is for surgeons to be open, willing to talk to their patients and to create an atmosphere of good will for it has become very clear that the threat of litigation decreases with greater communication."

Dr Smith wrote the book as part of a PhD after having previously written a book on climate change, health and the law.

"I went from concentrating on global issues and human health to the specifics of health litigation and on the way became a staunch defender of surgeons against the legal fraternity who appear determined to impose strict and silly laws on the surgical profession without a clear understanding of the complex dynamics involved in modern surgery," he said.

"The Louis Waller Medico-Legal Scholarship was a very generous award to receive for which I'm most grateful and I hope my work brings honour to the Fellows of the College."

Dr Smith who received the scholarship funding in 2009 for 2010 is now undertaking initial research into the impact and consequences of the introduction of mandatory reporting by health practitioners introduced last year under the Health Practitioner Regulation National Law Act.

Under the new regulations, 10 health professions have been listed to be required to report other health professionals for "notifiable conduct".

Notifiable conduct

According to Dr Smith, the definition of notifiable conduct is where a registered health practitioner has practiced while intoxicated by alcohol or drugs, engaged in sexual misconduct in connection with the practitioner's profession, placed the public at risk of substantial harm because of impairment or behaviour that has placed the public at risk of harm because the practitioner has practiced the profession in such a way that constitutes a significant departure from accepted professional standards.

Now in the process of seeking research funds to investigate the ramifications of the new laws in detail, Dr Smith said it was already clear that there were potentially serious problems associated with the practical application of the regulations.

"This basically is about how far the law can go to fix a problem without creating new and unnecessary problems," he said.

"Some professional organisations believe that mandatory reporting laws may drive addicted or distressed health professionals underground and discourage them from seeking treatment.

"There is also a danger of unsubstantiated and/or vexatious reporting to medical and other boards and even reporting made in good faith which is subsequently shown to be groundless can have a chilling effect on staff relationships.

"Based on my initial research, it seems there is every indication that these laws have been produced as something of a knee-jerk reaction to public anxiety over various health system failures with politics seeming to have prevailed over protection and evidence-based policy."

With Karen Murphy

The Great rural challenge

Queensland is facing tough challenges in how to provide surgical services for our population

Maurice Stevens,
Queensland Regional Chair

As time passes it becomes more evident to me that the desire of local surgical graduates to practise in rural or remote places is innate rather than learned.

Some of those who practise in those places were born and bred there while some were not, and in recent years some have practised there through necessity, as International Medical Graduates (IMGs) wanting to remain in our country and only being able to do so by accepting positions that others with similar qualifications find undesirable.

Queensland and Western Australia are geographically disadvantaged with respect to the distribution of their medical workforce, and in the case of Queensland we have a population that is increasing at the rate of 1,000 per week. While many of these settle in the south-east corner, not all do. Lifestyle considerations have become more important to recent graduates in surgery and other specialties, including general practise, and rightly so. But we now recognise that rural and remote surgical services in the past have been dependent on a major sacrifice in this respect on the part of the surgeon and his or her family, a commitment that is becoming increasingly difficult to find.

Major efforts have been made by the College and Queensland Health to identify those factors that influence the decision by a surgeon to settle in such places, but we have not made much progress in encouraging a drift to the periphery.

One would think that improvements in communications, in travel and in the educational opportunities for children would assist in this regard, but those advances have not led to a great change in the rural and remote workforce.

I think we know that increased remuneration has little influence over decisions to practise in rural and remote areas. We were hopeful that the establishment of a medical school in Townsville and an increase in the total number of medical graduates in Queensland would address the deficit in the rural and remote workforce, but such results are not yet evident.

Queensland is now dependent upon the efforts of IMGs to maintain surgical services, which requires us to expend considerable time and energy in ensuring that these IMGs have the necessary qualifications, surgical expertise and clinical judgement to provide the standard of surgical service to which Australians have become accustomed and now demand.

The ramifications of failure in this respect were glaringly obvious in Bundaberg, when protocols involving the College's expertise were bypassed by a government looking for a "quick fix".

Regrettably, Queensland Health seems to view the issue purely as one of manpower, and whether the vacancy is in the private or public arena is deemed irrelevant. I find it difficult to come to terms with the concept of Area of Need in metropolitan areas and this will need to be addressed in forthcoming discussions with government.

Toowoomba, which is only 90 minutes' drive west of Brisbane, is now struggling to maintain surgical services in Plastic Surgery and Otolaryngology, but was previously very well serviced. Area of Need in these two surgical specialties is likely to be declared soon, there being no interest at all from local graduates despite succession planning in both specialties.

It should be borne in mind that if Area of Need is declared, and a suitably qualified surgeon from overseas appointed, that person will be in the position for a period of four years, practising potentially in both the private and public sectors. This is a very long time if that person, for whatever reason, is unsuitable.

The College, with funding from Queensland Health, currently has a project underway to investigate the position of IMGs and to make constructive recommendations to government. The project, being very ably run by Dr Peter Woodruff, will hopefully boost confidence in the IMG process and ensure that the community is properly protected.

Private group practises in rural and remote areas are able to access Area of Need for recruitment of overseas surgeons. This creates some problems with respect to conflict of interest.

The first way in which this might happen is when the person making the application has a pecuniary interest in such an appointment.

The second way is when the supervisors of such an appointee are likely to have a vested interest in the satisfactory performance of such a surgeon. I am aware that by the very nature of the manpower problem, appointing impartial supervisors is often difficult for geographical reasons, but I feel that it is sensible that the state committees in the various jurisdictions be consulted not only in the process of declaration of Area of Need, but also with respect to the appointment of assessors.

> *"We now recognise that rural and remote surgical services in the past have been dependent on a major sacrifice… on the part of the surgeon and his or her family"*

The quality of surgical graduates in Australia and New Zealand is something of which we can be justifiably proud, and it is not something many other countries can boast.

We will in the medium term continue to have a problem with the assessment and appointment of overseas graduates, and considerations of patient safety demand there be close scrutiny of these graduates. The increase in the number of local medical graduates may not solve the problem of workforce misdistribution.

It is extremely important that we have a single entity that selects, processes, trains and examines our surgeons so that the product of our efforts remains one of uniform excellence. That entity is the Royal Australasian College of Surgeons.

PICTURE: SERGEANT NEIL RUSKIN

Sergeant Bernadette Rogash and Hospital Medic 1 Barbara Mayer take an Afghan local into the trauma room.

INSERT: Australian Surgical Team, Colonel Susan Neuhaus (left) gives a young Afghan patient a toy to play with during her rounds.

Not only for the soldiers

Battlefield surgery has changed vastly over recent decades to hospitals that look to treat civilians

The complexities of modern warfare now give rise to such difficult ethical issues and real world realities that surgeons must develop personal and professional resilience if they are to survive military service without psychological scarring, according to Associate Professor Susan Neuhaus.

Associate Professor Neuhaus, who has recently retired from a 22-year military career with both the Regular Army and Army Reserve, presented a keynote address at the recent Annual Scientific Congress on the role of the doctor in modern battlefield medicine.

She said that role had changed dramatically in recent decades from the days of two opposing armies facing off in confrontation and that surgeons must be aware of these changes if they were to serve effectively.

She said that although most people saw the role of military surgeons as aiding soldiers injured in battle, up to 90 per cent of those treated in modern warfare by defence personnel were now civilians, which required complex decision-making about resource allocation, quality of life issues, security and safety of staff and impartiality.

Having served in such conflict zones as Cambodia and Bougainville and as Clinical Director at the NATO Hospital in Tarin Kowt, Afghanistan, Associate Professor Neuhaus said surgeons were challenged by the ideals of equality of care between civilians and military personnel and the pragmatics of the conflict environment.

"While International Humanitarian Law covers all participants in conflict, it singles doctors out as a group that has a unique and specific code of conduct applied to them," she said.

"In essence, there are three obligations that make their ethical positions different to that of other serving soldiers. They may not partake in acts of war, they must treat all casualties equally, based on medical need and ignoring nationality, enemy status or religion and they are required by law to speak out against atrocities committed by either side.

"Yet the reality is that while our own wounded military personnel and other designated nationals will be afforded strategic retrieval to a highly sophisticated health facility, locals in war zones have no such option.

"Yet they are often the most seriously wounded given that soldiers wear battle protection and travel in armoured vehicles while civilians can be injured by bombs or gunfire while at the market or walking a goat, yet we don't spend millions on prosthesis and rehabilitation for them because it is simply not a realistic option."

Associate Professor Neuhaus said that while surgeons instinctively wished to fix everything all the time, that was not always possible and that surgeons now serving in modern conflicts must distil treatment decisions down to questions of available resources and what can reasonably be achieved.

She said that while this rarely strayed into such extreme ethical dilemmas such as assisted euthanasia, treatment decisions based on quality of life and follow up care for the severely wounded were common.

"There is the ideal world, which is one in which we do everything we can to save and improve the lives of all the wounded placed in our care and there is the real world which requires extremely difficult decision-making and I think that as a profession we have a responsibility to admit this and work through these issues," she said.

"Up to 90 per cent of those treated in modern warfare by defence personnel were now civilians"

PICTURE: CAPTAIN LACHLAN SIMOND

"For example, if an Australian is injured and left with no arms or eyesight they would receive sophisticated rehabilitation, prosthetics and support services, but for a civilian wounded in a war zone with limited health resources, there may be no quality of life at all with such disabilities."

Associate Professor Neuhaus, a general surgeon from Adelaide with a specialist melanoma and sarcoma practice, began her medical career in the army and was promoted to Colonel in 2008. Her military service was recognised with the Conspicuous Service Cross in the 2009 Queens Birthday Honour's List.

With a particular interest in military medicine and the care of veterans, she has published widely in recent years upon a range of issues such as battlefield euthanasia, terrorism and blast explosion injuries, the use of frozen blood products and a report of a pilot study into simulation training for military surgical and intensive care teams.

She said surgeons wishing to work in conflict zones should undertake training scenarios such as those provided by Defence Mission Rehearsal Exercises and AUSMAT training to both strengthen team-building prior to deployment and to raise awareness of the emotional and professional mine fields soon to be confronted.

She said personal and professional resilience was central to a surgeon's ability to serve effectively in a conflict zone and return home unharmed in mind or spirit and encouraged surgeons wishing to serve in the military to build a strong support network to call on if necessary.

"The issues raised by modern warfare for surgeons and doctors not only relate to medicine, but to issues of security," Associate Professor Neuhaus said.

"Doctors can no longer be placed behind battle lines for the simple reason that in some war zones there are none.

"Now the fighting can take place anywhere at any time in towns and cities or on deserted roads with a much more blurred division in terms of enemies and allies. As we have seen so tragically of late, sometimes the threat comes from the very people you are there to support.

"While dealing with that outside the military hospital, inside surgeons can at times be working with horrific injuries, without the state of the art equipment they are used to, far from home and constantly confronted with man's inhumanity to man."

Despite this, however, Associate Professor Neuhaus said she believed that there was still a pervasive attitude within the surgical profession that such grim realities were part of the job, but that the days of the "hero surgeon" in warfare were gone.

With psychological illness and post traumatic stress disorder now the greatest cause of morbidity confronting modern soldiers upon their return to civilian life, it was dangerous for surgeons to continue to believe themselves immune from such scarring, she said.

"No matter how tough and bold we may think we are, in modern warfare we are now seeing children disastrously injured by a combination of simple curiosity and hidden explosives; we are seeing conditions that are eminently treatable here which cannot be dealt with there, we are asked to work 20-hour days and to bear witness to great tragedy and I think it foolish to say to ourselves that this doesn't affect us.

"As a profession I don't think we are very good at looking after ourselves or even acknowledging that we may need help. In fact, I think we're very bad at that, yet that must change if we are to serve effectively in a military capacity because not all the wounds of war are physical wounds and that must be constantly remembered."

Associate Professor Neuhaus is now conducting and supervising research through the University of Adelaide and Centre for Traumatic Stress Studies.

She said the Centre was now looking into the issues confronting mothers serving in the defence forces.

"This is the first time in history that mothers have served and while we are not placing more or less importance on women or men, we are acknowledging that mothers face different and unique issues," she said.

With Karen Murphy

Whistleblowers Legislation – The State of Play

Whistleblowers and their protection can be important in bringing those not up to standard, into the spotlight

Michael Gorton
College Solicitor

When legislation to protect disclosures – the so called whistleblower legislation – was first mooted in Australia and New Zealand, it was hailed as an effort to promote honesty and efficiency, especially in public administration. Jurisdictions across Australia and New Zealand have now enacted legislation, establishing regimes for the protection of whistleblowers and the investigation of their disclosures.[1]

Recently there have been calls to strengthen the current whistleblower legislation in the health industry.[2] Given these calls, we have reviewed the history and the need for whistleblower legislation, and finish with a brief examination of these new calls.

The need for Whistleblowers

Two high profile cases in particular illustrate the importance and significance of whistleblowing legislation.

Graeme Reeves – "Butcher of Bega"

In 2008 Graeme Reeves, a former obstetrician and gynaecologist, was charged in relation to 800 alleged sexual and indecent assaults and genital mutilation at hospitals in NSW between 2001 and 2003 while employed with Southern Area Health Service.

However, after similar complaints while employed in 1997, he was investigated and banned from working as an obstetrician or gynaecologist by the NSW Medical Board. However, the then legislative framework did not permit the Board to inform other agencies. In particular it could not inform Southern Area Health Service of its ruling when Mr Reeves applied for a position there. The onus to disclose was on Mr Reeves when he applied for the position, which he did not.

Jayant Patel – "Dr Death"

In contrast, internal complaints made against the former director of Bundaberg Base Hospital, US surgeon Jayant Patel, led to his June, 2010, conviction of manslaughter and grievous bodily harm, and sentencing to seven years in jail.

Complaints were first made by one nurse and two administrative staff, who witnessed the mistreatment of an 18-month-old child patient, and the death of a man. The claims were referred to the Queensland Crime and Misconduct Commission, and the three complainants were afforded whistleblower protection.

Mr Patel's former boss, the former Director of Medical Services from Queensland Health, Mr Darren Keating, was also brought before the Queensland Health Practitioners Tribunal, accused of covering up Mr Patel's misconduct, and subsequently banned from ever working as a senior medical administrator in public or private hospitals.

Clearly, had the Southern Area Health Service hospital staff been afforded whistleblower protection, as their Bundaberg counterparts were, the mistreatment of patients by Mr Reeves may have been investigated in 2002, rather than six years after the event. Fortunately, legislative initiatives put in place in 2005 now permit the NSW Medical Board to disclose the status and conditions of a health practitioner's practising licence.

Whistleblower Legislation

Whistleblowing legislation in Australia and New Zealand operates to protect those making disclosures against people or public bodies acting contrary to the public interest. The legislation is designed to promote honesty and efficiency in public administration, impose obligations on those affected and establish penalties for non-compliance.

Using Victoria's law (Whistleblowers Protection Act 2001 (Vic)) as an example, whistleblowing regimes focuses on "protected disclosures": disclosures made by anyone (including the public) relating to "improper conduct" (corruption, substantial mismanagement or substantial risks to public health or safety) by public bodies or officers amounting to criminal behaviour or grounds for dismissal. Disclosures need not be in writing and may include telephone complaints.

A "protected disclosure" may be made to the organisation or to the Ombudsman directly. If made to the organisation, that organisation must determine whether the disclosure is a "public interest disclosure" (engaging in improper conduct in the capacity as a public officer or public body),' in which case it is also referred to the Ombudsman.

Failure to follow up a protected disclosure may leave a public body open to civil or even criminal liability if the complainant pursues the matter. Failure to adequately protect the confidentiality of disclosures and the identity of whistleblowers, or protect the discloser from consequential "detrimental conduct" (violence, threats, discrimination or intimidation) may result in individual criminal liability.

All public bodies are required to have policies for investigating disclosures. The onus is on public bodies to train their staff to recognise a "protected disclosure" and refer it on for further action.

Application to the Health Industry

Whistleblower laws apply to health practitioners who are either an employee of a public body, or an independent contractor, making a health practitioner's employment status at a hospital no bar to lodging a legitimate complaint.

Disclosures relating to health practitioners usually involve medical malpractice (as in the above illustrations). Providing a complaint is made in good faith and on reasonable grounds, health practitioners should feel reassured that disclosures not only protect both the reputation of the profession and the welfare of patients, but that their identity will not be disclosed nor their employment jeopardised.

The recent calls for stronger whistleblower protection in the healthcare industry extend beyond practitioners, and to the companies that supply them; ie to employees and officers of pharmaceutical and medical devices companies. The recent Federal Court ruling against Merck Sharp & Dohme (Australia) Pty Ltd ("MSD") concerning the NSAID Vioxx has been used to argue for extended measures. For example, had there been sufficient whistleblowing protection, MSD employees may have alerted authorities to Vioxx's detrimental effects earlier, potentially preventing many of its health issues.

As a contrast, under anti-fraud laws in the US, whistleblowers may be entitled to between 15 to 30 per cent of proceeds won from the offending company. Similar legislation would ensure that not only are there further incentives for whistleblowers, but a degree of compensation for those disclosing (thus targeting a major source of non-disclosure). It will be interesting to see whether such legislation is introduced to Australia.

If you or somebody you know is concerned about making a disclosure, or as an organisation you are not sure whether your policies are adequate to protect the makers of such disclosures or shield your organisation from possible liability, we recommend getting appropriate legal advice to guide you.

References

1. *Whistleblowers Protection Act 1993* (SA); *Whistleblowers Protection Act 1994* (Qld); *Public Interest Disclosures Act 1994* (NSW); *Protected Disclosures Act 2000* (NZ); *Whistleblowers Protection Act 2001* (Vic); *Public Interest Disclosure Act 2003* (WA).
2. "Call for health whistleblowers to get protection" J Medew, *The Age*, 12 July 2011, sighted 12 July 2011, <http://www.theage.com.au/national/call-for-health-whistleblowers-to-get-protection-20110511-1eizl.html>

Virtual Congress (VC)

All Fellows and Trainees can access the presentations from the recent 2011 Adelaide Annual Scientific Congress on the VC. This extremely valuable educational aid allows surgeons and trainees to review presentations they attended or presentations they missed due to a program clash.

You can access all presentations for which the presenter gave permission for their presentation to be saved.

Access the Virtual Congress on your PC or Mac by entering 'asc.surgeons.org' in your browser and enter your email address in the box on the right of the screen and log on.

There is a new index of presentations to make navigation easier.

All the plenary sessions are available with PowerPoint and video including those from Professor Lord Darzi. The scientific sessions are available with PowerPoint and the audio track. Select a presentation you want to view, click on the 'speaker' icon and the presentation will load. As the presentation proceeds you can click through the slides and move forward and back, independent of the audio track.

At this time it is not possible to access the presentations on an iPad.

Campbell Miles,
ASC Co-ordinator

Younger Fellows

2011 Younger Fellows Forum

The Younger Fellows Forum held this year in the Barossa Valley was another enjoyable success

Christine Lai and Robert Whitfield,
Convenors

After what seemed like endless planning, deliberation, negotiation and co-ordination, the 2011 Younger Fellows Forum (YFF) finally transpired from 29 April to 1 May, just prior to the ASC.

As always, the aim of this year's Forum was to bring together a small group of Younger Fellows, representing as much as possible the diversity of the Younger Fellowship in terms of age, gender, geographic location and sub-specialty interest.

Mix in several College luminaries (the President and two distinguished Councillors), visiting surgeons from Asia and the US, as well as other invited guests, and hopefully the conditions are created to stimulate thoughtful discussion around a number of issues of common interest to the group and the broader Fellowship.

Ultimately the goal is to craft recommendations for action that are then presented to College Council for consideration. In this way, the Younger Fellows have an important and valued voice in the strategic direction of our College.

This year's meeting was held at the Novotel in the picturesque Barossa Valley. We kicked things off with a leadership and mentoring mini-workshop. There were three interesting presentations from speakers representing the corporate world, the legal profession and the military, enlightening us about how these issues are managed in their fields.

We also heard a fascinating talk from a leadership consultant with the Port Adelaide Football Club. Notwithstanding the fact that earlier that week the Power had given the Gold Coast Suns their inaugural AFL victory, a lot of us were surprised by the amount of scientific, evidence-based practice that is involved with inspiring and motivating young footballers to maximise their performance.

The Forum is not all about hard work, though. We also had an enjoyable team-building activity on the first day, involving a "Great Race" around the Barossa Valley. The locals particularly seemed to enjoy watching as the three teams competed to erect a tent next to a main road while blindfolded and barking not necessarily intelligible instructions at each other.

In a memorable photo finish, the winning team managed a come-from-behind, Steven Bradbury inspired win, overtaking their hapless opponents in the final challenge; a victory to savour.

Day two was equally fascinating, as we examined a number of topical issues including the surgical workforce, clinical practice improvement and methods to influence the direction of health policy.

We also spent some time looking at the ways in which social media interacts with our profession. It was interesting that despite the fact that almost all of the people in the room were 'younger' Fellows; most of the group were completely ignorant about anything to do with these burgeoning internet-based communication techniques.

The world is changing and we ignore these developments at our peril!

Day three was the 'work' day, where the group nutted out and finalised the recommendations for Council. Hopefully, the College will find them to be constructive.

Finally we were treated to an excellent presentation from our Association of Academic Surgeons (AAS) visitor, Carmen Solórzano, regarding the challenges of surgical training in the US and had the opportunity to meet with the remainder of the AAS visitors on our return to Adelaide.

We wish to thank all those who were involved in the Forum; thanks for all your hard work! We encourage all Younger Fellows to self-nominate for next year's Forum; we have no doubt that Malaysia will host another fantastic YFF.

For info about next year's Younger Fellows Forum in Kuala Lumpur, email pdactivities@surgeons.org or call +61 3 9276 7441.

Professional Development WORKSHOPS

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

>Keeping Trainees on Track (KToT) *NEW*

18 August, Queenstown

'Keeping Trainees on Track' is a new workshop in the 'Supervisors and Trainers for SET' (SAT SET) series. Over 3 hours it explores how to performance manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. Participants are also given the opportunity to learn methods for encouraging self-directed learning by establishing expectations at the start of term meeting.

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

26 August, Perth

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

>Process Communication Model (PCM) *NEW*

26-28 August, Sydney

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

>Providing Strategic Direction

9-11 September, Sydney

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

>Building Towards Retirement

1 October, Brisbane

Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. The program covers key issues including maintaining health and well being, job opportunities after surgery, superannuation and legal advice, community involvement and building relationships and networks. Learn from surgeons and other experts who can motivate you to start planning and making decisions about the next phase of your life.

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

2011 DATES:
JULY – NOVEMBER

NSW

>8 August, Sydney
Surgeons and Administrators: Working Together to Bridge the Divide

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

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

>20-22 October, Sydney
Surgical Teachers Course

QLD

>6 July, Brisbane
AMA Impairment Guidelines Level 4/5: Difficult Cases

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

>1 October, Brisbane
Building Towards Retirement

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

TAS

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

VIC

>22-24 July, Melbourne *NEW*
Process Communication Model

>29-30 July, Melbourne
From the Flight Deck: Improving Team Performance

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

>12 November, Melbourne
Communication Skills for Cancer Clinicians

WA

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

>21 October, Perth
Polishing Presentation Skills

NZ

>17 August, Auckland
Keeping Trainees on Track (KToT)

>1-3 September, Auckland
Surgical Teachers Course

A SYSTEMATIC REVIEW

Middle ear implant for hearing loss

Reviews of important surgical procedures help us improve our outcomes

Guy Maddern
ASERNIP-S Surgical Director

Hearing loss is very common in Australia – approximately 13 per cent of the population was affected by total or partial hearing loss in 2004/05 (Australian Bureau of Statistics 2007).

Middle ear implants (MEI) are electronic devices that aim to correct hearing loss through stimulation of the ossicular chain or middle ear. MEI are surgically implanted into the middle ear and generally include a microphone, an audio processor, a battery, a receptor and a vibration transducer that attaches to the ossicular chain (Manrique et al 2008).

Currently, MEI are not indicated for use in patients with profound hearing loss. Patients eligible for MEI implantation will have failed all appropriate conservative therapies, including an optimally-fitted external hearing aid.

The objective of our research was to assess the safety and efficacy of the MEI in patients with non-profound hearing loss through a systematic review of the literature. The clinical comparators for the MEI varied according to the type and severity of hearing loss. In patients with mild/moderate sensorineural or mixed hearing loss or mild/moderate/severe conductive hearing loss, the comparator was the bone anchored hearing aid (BAHA). In patients with severe sensorineural or mixed hearing loss, the comparator was the cochlear implant (CI).

Methods

Evidence regarding the safety and efficacy of the MEI was identified through systematic literature searches of various literature databases in August 2009. Pre-determined selection criteria were used to identify eligible studies. The quality of studies was assessed and data were extracted in a standardised manner. A full description of the methodology is presented in the systematic review (Perera et al 2010).

RESULTS:

Safety

No comparative evidence was available to inform on the safety of the MEI compared with either the CI or the BAHA. Safety outcomes for the MEI were drawn from 49 studies reporting on a total of 1,222 patients.

Most adverse events associated with MEI were relatively rare and of low severity and serious adverse events such as facial nerve damage were reported to have occurred rarely. There were no deaths. Damage to the chorda tympani nerve was reported more commonly; however, some instances of resulting taste disturbance were reported to have been transient and resolved over time. Technical complications related to the MEI, such as device malfunction/migration or insufficient gain, were relatively rare.

Thirteen studies reported that patients experienced significant worsening in mean residual hearing loss after MEI implantation. Due to the absence of comparative evidence, it was not possible to compare the rates of adverse events between patients receiving the MEI, CI or BAHA. The limited available evidence indicates that implantation of the MEI is at least as safe as implantation of the CI or the BAHA.

Effectiveness

One comparative study was available to assess the effectiveness of the MEI compared with the CI. No comparative studies were available to assess the effectiveness of the MEI compared with the BAHA. Hence, the evidence for the effectiveness of the MEI was derived from level IV evidence, and may be subject to bias.

Generally, MEI implantation and/or activation led to improvements in patients with mild, moderate and severe sensorineural hearing loss; patients with sensorineural hearing loss of undefined severity; patients with mild, moderate and severe mixed hearing loss; patients with mixed hearing loss of undefined severity; and patients with conductive hearing loss.

The MEI appears to be at least as effective as the external hearing aid. However, these conclusions are limited by the paucity of high-level evidence.

Cost-effectiveness

The incremental cost of using an MEI as opposed to a BAHA is $8,666. The incremental cost saving of using an MEI as opposed to a CI is $10,593. The economic analysis indicates that if the MEI was used in Australian patients as a direct replacement for the BAHA and CI, the cost saving would be over $2.5 million.

Conclusion

There is a paucity of high-level evidence upon which to draw conclusions on the relative safety and effectiveness of MEI, which may be related to the relative youth of the technology and procedure.

The limited available evidence indicates that implantation of the MEI appears to be as safe as implantation of the CI or the BAHA. The MEI appears to be at least as effective as the external hearing aid.

For information, please contact Professor Guy Maddern (asernips@surgeons.org) or Caryn Perera (caryn.perera@surgeons.org) at ASERNIP-S +61 8 8291 0900.

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The Fellowship examiner's training course

The College has recently introduced a course to increase the expertise of examiners

Spencer Beasley
Chair, Court of Examiners

The recently introduced Examiners' Training Course was developed in response to a review of the Fellowship examination, which recognised the increasing expertise required of Fellowship examiners and the need for examiners to be given greater support. In addition, it acknowledged the increased complexity of the role and responsibilities of examiners.

The review also confirmed the need for the Fellowship Examination (FEX) to be integrated into the overall SET assessment processes, and be better aligned to each specialty's curriculum. It reaffirmed the FEX as a true "exit" examination taken near the completion of training, and as such should focus on the higher levels of cognitive performance.

Instead of testing pure knowledge alone (as it used to in anatomy and pathology, both of which are now tested as part of the generic and specialty-specific surgical science examinations) the FEX would be more appropriately focused on the clinical application of that knowledge. It is assumed that candidates have already acquired knowledge in the basic sciences, and at the FEX should explore their ability to apply this knowledge to clinical situations. In short, the review proposed that the examination should concentrate on clinical decision-making and professional judgement.

But to implement these recommendations necessitates that examiners are supported so that they can function at the required high level of expertise – and this is why the Examiners' Training Course was developed. It has been designed to ensure that all examiners are sufficiently equipped to enable them to perform their role to a consistent and high standard. It is expected that this will improve the reliability and validity of the examination.

Table 1:
Topics covered in RACS Examiners' Training Course

1. Purpose of a true "exit" examination
2. How it fits in with other SET assessment processes, and alignment with specialty curricula
3. "Blueprinting" and how it works
4. Assessment of candidates against defined surgical competencies
5. How to set questions at correct cognitive level (high Bloom's taxonomy level)
6. The examiners "toolbox": how to use the assessment tools effectively
7. Setting written questions
8. Preparation for, and conduct of vivas
9. Understanding bias
10. Standard setting, and Angoff method exercises
11. Use of marking descriptors
12. Close marking system
13. Feedback on examiner performance
14. Measurement of reliability and validity
15. Functions of the Court of Examiners

Table 2: Typical preparation for being an examiner.	**Timeline**
1. Nomination submitted by specialty court, and ratified by Council	June
2. Formal pre-examination training & pre-course exercises	June – July
3. Attendance at Examiners' Training Course	July – August
4. Observer at Fellowship examination	September
5. Attendance at Specialty Court Workshop	Feb – March
6. First examination as full examiner	May

At first glance, the scope and content of the one-day course may appear to be ambitious (Table 1). But feedback after the pilot course that was attended by the Senior Examiners and Deputy Senior Examiners from each specialty suggested that it covered the minimum that examiners need to know to perform their task competently at their first examination.

It has now been run twice more, in Sydney and in Melbourne. It is hoped that within a couple of years all current examiners will have attended, and the new timeline for appointments to the Court of Examiners will facilitate all new examiners completing the course prior to their first examination (Table 2).

The course will continue to evolve in the coming years to make sure it remains relevant, and that it achieves its main objective; to support the examiners of the Court.

Congratulations on your achievements

Sir Louis Barnett was responsible for the original proposals in 1920, to create a New Zealand and Australian association of surgeons which would be modelled on the American College of Surgeons and bestow a "hallmark" of surgical excellence. The Sir Louis Barnett Medal is awarded for outstanding contributions to education, training and advancement in Surgery

Professor John Collins MD FRACS

John Collins was born in a farming community in rural Ireland. He left school at 15 to work on the family farm, returning to university three years later to enter medical school. He graduated with honours from the National University of Ireland and went to train in England, initially in Obstetrics and Gynaecology.

Although he completed a Diploma of Obstetrics his experience during this period led him to believe he was less suited to obstetrics and gynaecology than surgery and transferred his efforts.

John undertook surgical training in London and Manchester and obtained fellowships of both the Edinburgh and English surgical colleges. Despite being a great fan of the 'beautiful game', John also had an interest in rugby and at this point he came to New Zealand for one year at Auckland Hospital. During this period the Foundation Professor of Surgery at the University of Auckland, Eric Nanson encouraged him to gain an academic qualification.

Thus began an illustrious academic career which has included many achievements, some of which are recognised by this College in this award of the Sir Louis Barnett medal.

John obtained a Smith and Nephew Commonwealth Foundation Scholarship and returned to the UK to work in Leeds with Professor John Goligher and the then Mr Graham Hill. He completed a Master of Surgery in the field of surgical nutrition and returned to Auckland.

While his original research interests continued this theme and included a paper which won the Moynihan prize in 1978, Professor Collins' attention turned towards medical education.

By this point John was Senior Lecturer in Surgery in the School of Medicine and he became head of the Department of General Surgery at Middlemore Hospital. He developed and implemented the Objective Structured Clinical Examination (OSCE) in surgery for the Auckland School of Medicine and championed this form of examination not only for medical students, but also for surgical trainees.

The current form of the RACS clinical examination owes much to John's work with medical students in the early 1990s. John furthered his educational research with a year as Research Fellow with Professor Ronald Harden and Professor Sir Alfred Cuschieri in Dundee in 1992 and ultimately completed his MD thesis on selection and assessment of Auckland medical students in 1993.

Concurrent with John's academic interest in surgical education has been his clinical interest in breast surgery. In addition to his role within Middlemore Hospital, John had a major role in the initiation of breast screening in NZ, was a member of the NZ Guidelines Group and editor of the New Zealand Guidelines on the management of early breast cancer.

John became actively involved in the College in the mid-90s, first as a member of the Boards of Basic and Advanced Surgical Training and then as an examiner. John went on to become Senior Examiner in General Surgery.

When a serious hand injury curtailed his surgical career, John was appointed the Foundation Dean of Education at the College and to an academic position at the University of Melbourne. He had numerous activities in this role, but perhaps most significant was his input into the development of, and advocacy for, the Surgical Education and Training (SET) program. He was voted Teacher of The Year by Melbourne students in 2006.

After retiring from the College in 2009, John moved to Oxford where he was Visiting Professor in the Nuffield Department of Surgical Sciences and Visiting Research Fellow at Green Templeton College.

Whilst at Oxford, John delivered a Hunterian Lecture and completed a major review of the UK Foundation Program for Medical Education England. John was also honored with an Honorary Fellowship from the Royal College of Surgeons in Ireland and an Honorary Fellowship from the Academy of Medical Education.

Throughout his successful professional career John has been supported by his wife Jenny who hails from Manchester and his son, Andrew, who lives and works in Auckland. Apart from his academic achievements John maintains an active interest in sport and during his time in Auckland, he was Medical Officer at Eden Park, the home of rugby, for nine years.

Professor John Collins has given much to the College – his time and expertise and as a tireless advocate for surgical education. He is a worthy recipient of the Sir Louis Barnett medal

Citation kindly provided by Ian Civil FRACS

Ethical perspectives of surgical training in private hospitals

The following item is an excerpt from a document prepared by the Ethics Committee of the College

John Graham
Chair, Ethics Committee

Surgical training has traditionally been by apprenticeship of Trainees to experienced surgeons. The duty of care exhorts the surgical trainer not to expose the patient to unnecessary risk in the training process (for example, by permitting an inexperienced surgeon to operate with inadequate supervision) and equally to protect the Trainee from unsupported exposure to procedures and situations beyond their capability.

There appears to be a conflict of interest between offering the patient the best possible care and yet providing the Trainee with the best possible training environment. A number of studies have examined this dilemma. Some have found that outcomes are less favourable when less experienced surgeons perform certain complex procedures, but others have equally shown that where surgery has been performed by supervised Trainees, the results have been similar to those of procedures performed by senior staff.

Surgical ethics state that surgeons must treat good patient outcomes as ends in themselves and not as a means to other ends, such as to gain training or experience. In reality, this is not possible as every surgeon, experienced or learning, will gain skill by performance. Hence utilitarian ethical principles are relevant in that there is a need for training to occur and experience to be gained for the furtherance of surgical knowledge and practice for the common good.

Both principles can be balanced by detailed adherence to the consent process, in that the patient is made fully aware that his/her operation will be performed by a Trainee or less-experienced surgeon as equally when an experienced surgeon is undertaking a procedure new to that surgeon. By open disclosure before the procedure, the surgeon is observing the principles of autonomy and justice and permitting the patient the right of choice.

“There appears to be a conflict of interest between offering the patient the best possible care and yet providing the Trainee with the best possible training environment”

Most public hospitals function as teaching hospitals in a system that is built on the principle of a graded training experience for doctors. This principle is enshrined in health service provision. It does not justify the patient being exposed to risk due to inexperience, but should be founded on appropriate supervision and oversight of the training process.

A patient in a private hospital has different expectations from a patient in the public hospital. While physical issues such as a single room may be important to some people, the main perceived value is direct access and contact with the surgeon and anaesthetist of choice and an operation done personally by that chosen surgeon.

This relationship is thus altered by the introduction of a Trainee into the hospital. Most patients will accept the benefit in having a Trainee in a private hospital. They see enhanced service to them in areas such as ward management and that the Trainee may be more rapidly responsive should an unexpected event occur. The concern is that if the Trainee is then to be more closely involved in the surgical procedure to the point of actually being primary operator, will the outcome be the same as if the surgeon alone was the operator?

Involvement of a Trainee in the management / operative process must be associated with the gaining of informed consent for the ‘training’, especially when the Trainee will be primary operator for parts of a case. Certainly, should consent for training be declined, that decision must be respected. In fact, each activity by the Trainee removes closeness of surgeon/patient contact and the degree to which this will occur needs to be clearly identified to the patient, ideally by the hospital as part of its stated values.

SATSET and Keeping Trainees on Track courses provide ideas for training and supervising SET Trainees. See Page 23 for more information.

FRACS

Stationery Pack

Design packages are now on offer for Fellows

Following the recent release of the FRACS logo, the College is pleased to see a number of Fellows are incorporating the logo into their practice stationery. The College has also received a number of calls and has been happy to assist Fellows with design issues relating to the FRACS logo.

To assist further with stationery design, the College is pleased to be able to launch a new service, the FRACS Stationery Pack.

The FRACS Stationery Pack is available for download from our website and includes special discounted design and printing options for Fellows of the College from the designer of the FRACS logo, Big Mouth Marketing Communications.

You can choose to have your designs created and files provided to you to send to your preferred printer. Alternately, you can choose to have your designs created and sent to the Big Mouth printer following your sign off of artwork.

The FRACS Stationery Pack outlines discount ‘design only’ costs and discount ‘design and print’ costs. If you would like Big Mouth to create your artwork with the new FRACS branding, in accordance with the FRACS specifications, then simply fill out the order form available online and send it to Big Mouth via email along with the files required. Printing can also be arranged – please refer to the discount ‘print and design costs’ to access prices.

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More details are available from the College website www.surgeons.org in the Resources for Surgeons section.

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Friday 23 September 12pm

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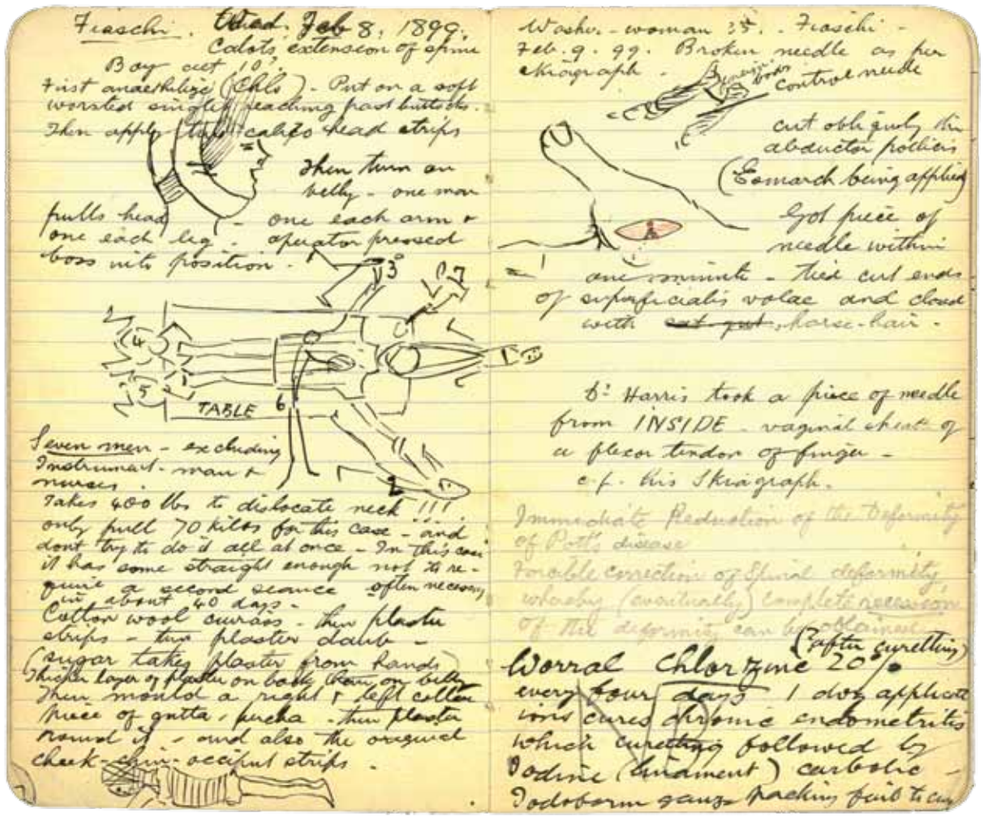

Page from Archibald Watson's Diary Notes on Operations, 1899 describing Fiaschi's procedures for Calot's extension of the spine and an operation for a broken needle in the hand

Stones Ring'

Exploring the Lives of the College's Extraordinary Surgeons – Thomas Henry Fiaschi

College NSW founder Thomas Fiaschi's rich and varied life influenced a number of his colleagues

Mike Hollands
Treasurer

In 1927, two of the College's NSW founders, Thomas Fiaschi and Andrew Brady died. Fiaschi was replaced as a founder by Cyril Corlette, and William Chisholm took Fiaschi's place on the Credentials Committee. Both Corlette and Chisholm had worked with Fiaschi at the Sydney Hospital.

Fiaschi was 73 when he died and had little time to make his mark on the history of the College, but his rich and varied life undoubtedly influenced a number of his colleagues. Born in Florence, Italy, Fiaschi came to Australia when he was 21 and two years later caused a scandal by marrying Sister Mary Regis (Catherine Ann Reynolds) an Irish born nun at St Vincent's Hospital, Sydney. Briefly returning to Italy, Fiaschi graduated with an MD Ch.D from Florence and Pisa Universities in 1877 and then completed further postgraduate study in Europe.

Back in Australia in 1879 he practised in Windsor and was appointed honorary surgeon at the Sydney Hospital in 1894, and by 1909 when a clinical school was established at the hospital, he became the first Chairman of the Medical Board. Ann Mitchell describes Fiaschi's exceptional speech made at the opening of the school as 'an early attempt to place the history of Australian medical practice within the context of the European teaching tradition'.

Fiaschi was no stranger to war – commissioned in the NSW Lancers in 1891, he went with them to Africa and served at the Asmara military hospital during the disastrous first Abyssinian war (1895-6). The war ended when the Italian army was routed at Adowa (Adwa) by the Ethiopians and Fiaschi published a 'Report on the Mutilated and Evirated at the battle of Adowa' in the British Medical Journal (August 1896).

Apart from brief mention of the castration of a small number of Italian soldiers, the report focuses on the mutilation of the Ascari (black soldiers in the Italian service) who when captured, had their right hand and left foot cut off. It also indicates Fiaschi's interest in the different types of war wounds and particularly, asepsis.

…with the exception of carbolic acid lotion for the instruments, no other antiseptic was used but perchloride of mercury lotion of the strength of 1 in 1,000. All instruments were boiled twice a day to make sure. The anaesthetic used was exclusively Merck's Chlorofom…

Decorated by the Italian army for his role in the war, Fiaschi was fêted by his Australian colleagues who organised a banquet at the Australia Hotel in Sydney to welcome him back from Abyssinia. His war service was a catalyst for further study into asepsis and when in America, he also witnessed Charles McBurney's pioneering work in abdominal surgery. By the late1890s he had added hydatids to his list of interests, done some work on exophthalmic goitre, translated Bassini's work on hernia and written a paper about the reintegration of the absent middle third of the tibia.

When the Boer War erupted in 1899, he commanded the New South Wales 1st Field Hospital and was awarded the Distinguished Service Order for conspicuous bravery at Paardeberg. He recorded some of his observations in a letter to the Australian Medical Gazette.

Orange River South Africa 14th January 1900

I saw several cases of Mauser bullet wounds that illustrated to me the fact that a Mauser bullet can go through an elbow or a hip joint without injuring it…Unfortunately, you see also wounds from shells and from Martini-Henry bullets which are of a much more serious character.

Volunteering for service in WWI, he worked at the 3rd Australian General Hospital on Lemnos, then after being invalided to England, continued his service at an Italian military hospital in the Trentino.

Archibald Watson's diary notes on Operations are valuable as a primary source commenting on the operating techniques of many of the College's founders. Watson watched four of Fiaschi's operations and on 1 March 1899, he notes:

> ***Just as I was going – a boy 41/2 who had a halfpenny stuck in his oesophagus for two months came with a radiograph – Fiaschi sent for his coin catcher (price 7/6 with olives for measuring oesophagul [sic]strictures) and pushed it down behind the coin which was extracted at once – there was some cabbage or bean fibre on its edge – Boy had not been able to eat any other solid than bread and had been fed on slops ever since the accident – Fiaschi could feel coin – and he took measurement from boy's teeth before pushing in the instrument – he gave me the coin***

Another of his entries for 1899 mentions the removal of a needle which has been identified by a skiagraph, from a washerwoman's hand. Constantly abreast of new discoveries, this suggests that Fiaschi and his colleagues were using X-Rays just a few years after Roentgen's significant discovery.

Throughout his life, Fiaschi maintained a keen interest in advances in clinical procedures. Just before WWI, he headed a team at Sydney Hospital who following the research of Samuel Meltzer and John Auer at the Rockefeller Institute, pioneered a new technique of anaesthesia. This involved the 'insufflation of anaesthetic gases and oxygen directly into the trachea under positive pressure through a tube.' Fiaschi's team also fostered collaboration between trained anaesthetists and surgeons.

Rigid in his standards and expectations of hospital staff, Fiaschi was a both a respected and colourful character – stories about him include driving in a sulky with two dogs named Cricoid and Thyroid and as Archie

> *"Decorated by the Italian army for his role in the war, Fiaschi was fêted by his Australian colleagues who organised a banquet at the Australia Hotel in Sydney to welcome him back from Abyssinia"*

Thomas Henry Fiaschi, c1920s

Aspinall records in his 1930 paper about Sydney Hospital's early surgeons, his somewhat acidic sense of humour.

One day a nurse told him the wound was 'pussy'. He said 'Who taught you English? There is no such word as 'pussy', it is purulent'. As he left the ward he saw a cat passing and said to his House Surgeon, Dr Arthur Colvin: "there goes purulent, isn't it?"

This brief glimpse of the founder who slipped so quickly into the College's history would not be complete without mentioning his interest in viticulture which began with the Tizzana Winery built on the Hawkesbury in 1887. As President of the Australian Trained Nurses Association, his lecture of 1906 lauded the beneficial properties of wine which he saw as' a valuable support to the healthy man in this thorny path of life'. Paradoxically, wine was Thomas Fiaschi's nemesis – he died after contracting a pulmonary illness accentuated by his habit of sleeping in a tin shack at his vineyard.

With Elizabeth Milford

Surgical skin antisepsis – do we now know which agent is best?

Avoiding infection in the theatre room is an important part

Michael Whitby
Director, Infection Management Services, Metro South, Brisbane

The publication of an article entitled "Chlorhexidine-alcohol versus povidone-iodine for surgical site antisepsis"[1] in the New England Medical Journal recently was designed to clarify this question.

A total of 849 subjects (409 in the Chlorhexidine-alcohol arm and 440 in the Povidone-iodine arm) were randomised to these skin preparations before undergoing operations that would be classified as clean/contaminated surgery in a multi-centre study over six hospitals.

The primary outcome measure was any surgical site infection within 30 days of surgery in both intention to treat populations and per protocol populations. In both groups and in all types of surgery, infection rates were significantly lower in the Chlorhexidine-alcohol arm. In the intention to treat population, an infection rate of 9.5 per cent compared to 16.1 per cent in the Povidone-iodine arm (P=0.004;RR 0.59 (0.41-0.85)) was recorded.

So does this randomised blinded prospective study answer the question as to which agent is the best pre-surgery skin antiseptic? Potential efficacy of skin antiseptic preparations can be assessed indirectly in the absence of clinical data and of SSI rates by proxy information, such as the ability of the antiseptic preparation to decrease skin flora, density, the duration of residual effect, the effect of that agent in the prevention of central catheter infection rates and direct measures of microbiological kill rates when the agent is used for clinical or surgical hand hygiene. Many studies have been performed in these areas, well summarised in references 2 and 3.

On the basis of these indirect measures, some conclusions can be proffered:-

1. Alcohol is the most effective microbiological agent producing the largest and most rapid inactivation of vegetative bacteria, although it is less active against spores.
2. Alcohol has little residual effect.
3. Chlorhexidine has moderate residual effect.
4. Iodophores (eg: Povidone-iodine) have minimal residual effect.
5. Alcohol based hand hygiene products are more efficacious than soaps or antimicrobial agents without alcohol in reducing hand flora.
6. Chlorhexidine at a concentration of 2 per cent is considered superior to povidone-iodine in preventing central line catheter sepsis.

It is therefore intuitive to expect that there may be advantages to an alcohol based preparations in terms of reduction in microbial concentration. Chlorhexidine preparations may be superior to iodophores and this assertion is supported by a meta-analysis published in the *British Journal of Surgery*,[4] in 2010.

However, to truly answer this question, similar products must be considered. The authors of the New England Medical Journal study have compared aqueous povidone-iodine, a very commonly used pre-surgical antiseptic in the US, with alcohol-Chlorhexidine, thus biasing the conclusions very much in favour of the Chlorhexidine arm.

Is this then an argument for optimal effect in both antiseptic agents if mixed with alcohol? This is what theoretical conclusions from indirect data would suggest. It again brings to the fore consideration of flammability and explosion potential. All alcoholic preparations are flammable. Even "Betadine alcoholic antiseptic" which contains 30 per cent alcohol, less than the microbiological ideal of 70 per cent, carries a moderate flammability risk with a documented flash point of 34^{0}C. The lower explosive limit is not recorded on the material safety data sheet.

In summary then, despite the prominence given to the *New England Medical Journal*'s study, I would argue that we are not much further advanced. A study design of a randomised blinded clinical protocol measuring as outcome, surgical site infection rates, taking into consideration the practical problems of allowing time for the antiseptic to dry for maximal activity, the problems that may be encountered with drape adherence should have given us the answer.

However, the comparison of an alcohol based product with an aqueous based product, in my view, biases what was an otherwise good study design and invalidates a conclusion that Chlorhexidine is a more effective agent in surgical skin antisepsis than povidone-iodine, and should not generate a wholesale change in practice.

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Correction

>In the March 2011 issue of *Surgical News* the article "Hot Tubbing with the Best" was incorrectly attributed. The correct author of the article is Professor David Hardman, FRACS.
>In the July 2011 issue of *Surgical News*, some captions for the ASC photos were mis-labelled. On page 13, caption 3 should have read Tim **Keenan** and Leo Pinczewski. On page 14, caption 9 and 10 should be reversed. On page 16, the top left hand photo should read 'Hamilton Russell Memorial Lecture Greg **Bain** and Ian Harris'.
Surgical News apologises for these inaccuracies and is amending processes to ensure that such mistakes are not repeated.


Surgical sketches and sillhouettes
The Carpal Tunnel Syndrome & the Two Fat Ladies
More musings and memories of my surgical mentors
Surgeon Arthur Dickson Wright

Trusting spell-check

In my recent article on the Two Fat Ladies and Dickson Wright (*Surgical News*, Vol 12, No 4), I was disturbed by the apparent spell-check correction of the word "corniche", printed 'cornice', which I had used to describe the Great Ocean Road leading to Lorne and beyond.

The word has always appealed to me, since Rolls Royce brought out their convertible at the London Motor Show, I think in the 1970's.

It is defined as a road along a mountain cliff with a French derivation "route à corniche" or "road on a ledge". Strangely enough, if you pass on to Italy the word becomes cornice, (so that in spite of architectural connotations the spell-check would have been fortuitously correct, depending on which way you were motoring along the French Riviera, as noted by my colleague David Ellis). Around the world there are many such waterfront vistas from Beirut to Cairo, to Luxor on the Nile, even in Cuba, although the Alexandrian Corniche is a notable exception, as it runs along the harbour edge (Trevor, note).

Words are an important factor in our life, as commentators at the recent Sydney Writers Festival expressed. Words will always be present. They make the meaning, convey concepts and help to pass information on to the succeeding generations. Even Samuel Johnson said "words are the means with which we dress our thoughts". One of the commentators there reminded us that there was an outcry at the turn of the century when telegraphic transfer of information became the norm, arguing as we do now with e-communications, that this may suppress the written word. The outcome then – a dozen newspapers over the ensuing years were titled with name 'Telegraph'.

Perhaps I should not have been critical of the computer spell-check for adjusting the spelling, after all, look at the additional information I have gained to share with you.

FELIX C BEHAN
FB:mack

In Memoriam

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

>Rowan Nicks, NSW Cardiothoracic surgeon
>Nicholas Packham, NSW General surgeon
>Leslie Hughes, UK General surgeon
>Peter Cromack, WA Orthopaedic surgeon
>Maurice John Jurkiewicz, US Plastic surgeon – Honorary Fellow

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

Informing the College

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

ACT Eve.edwards@surgeons.org
NSW Beverley.lindley@surgeons.org
NZ Justine.peterson@surgeons.org
QLD David.watson@surgeons.org
SA Daniela.giordano@surgeons.org
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Welcome to the Surgeons' BOOKCLUB

Highlighted in this month's issue are recent and new titles from across the spectrum of books available from John Wiley & Sons.

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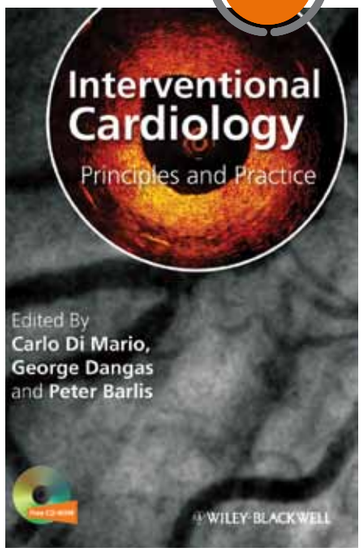

Interventional Cardiology: Principles and Practice

AUST AUTHOR Carlo Di Mario (Editor), George Dangas (Editor), Peter Barlis (Editor)
9781405178877 | Hbk | 592 pages | April 2011

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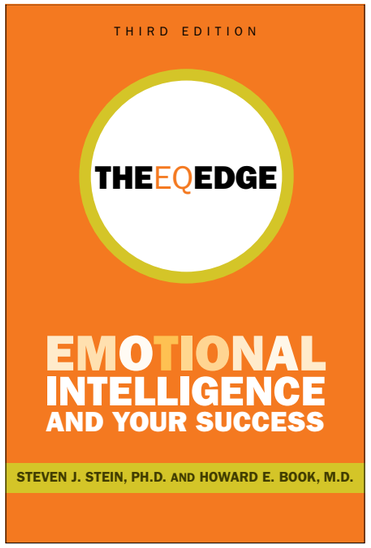

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Steven J. Stein, Howard E. Book
9780470681619 | Pbk | 368 pages | May 2011

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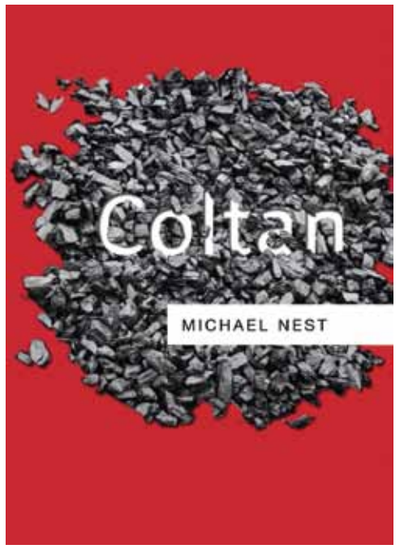

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AUST AUTHOR: Michael Nest
9780745649320 | Pbk | 200 pages | March 2011

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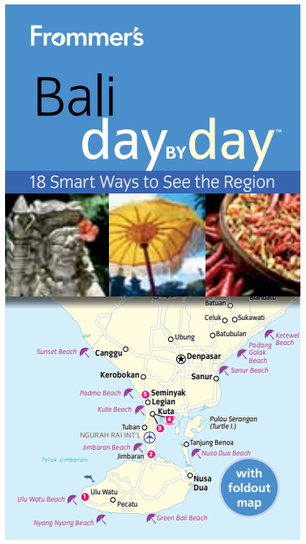

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AUST AUTHOR: Lee Atkinson
9781742468600 | Pbk | 192 pages | March 2011

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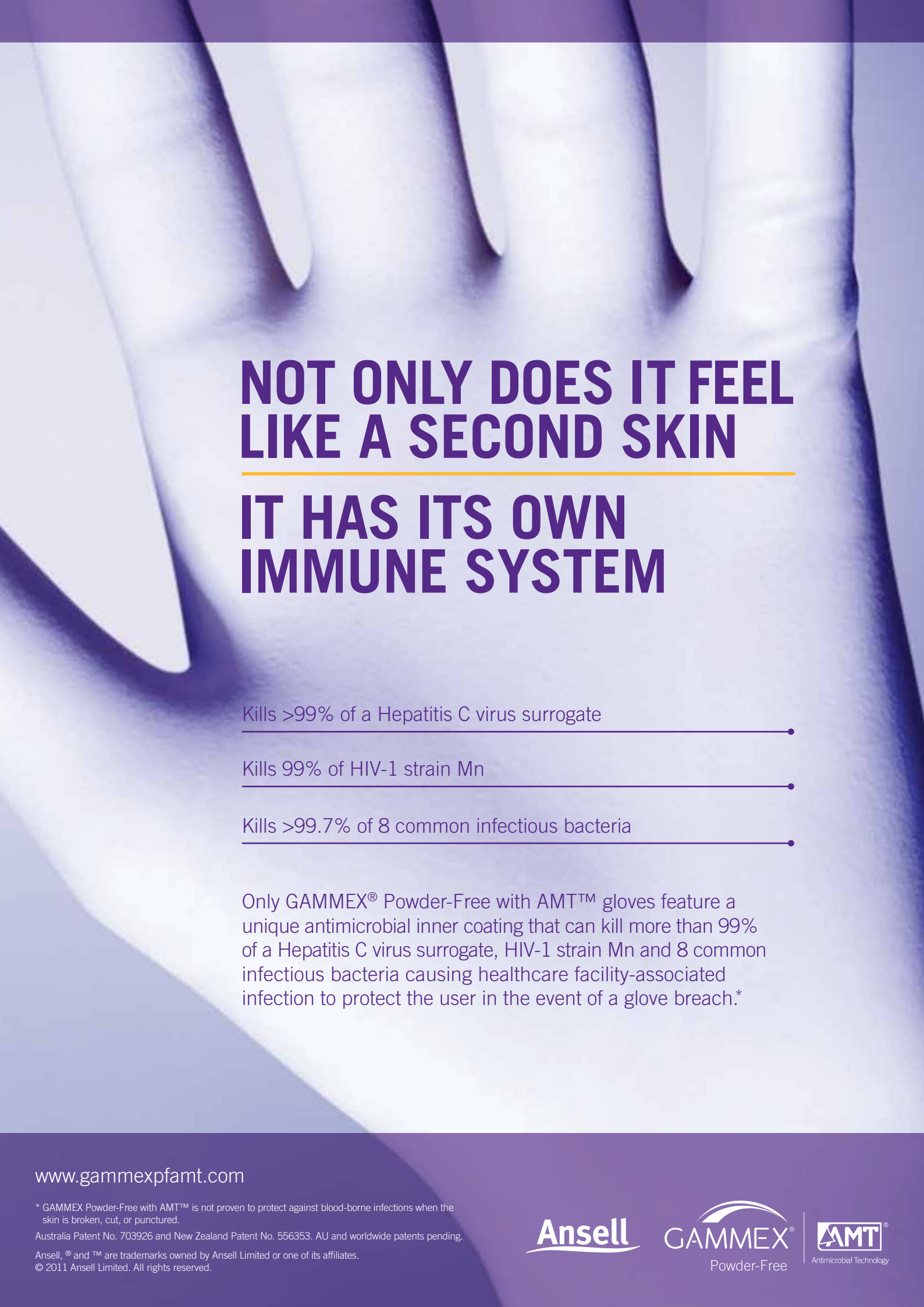

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