

# Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS JULY 2013

*The Winter  
issue of Post Op  
inside!*



The College of  
Surgeons of  
Australia and  
New Zealand

Expanding  
*research*

Another Successful Scholar



# 2013 Workshops & Activities

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

## Keeping Trainees on Track (KTOT)

31 July, Brisbane

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

## Supervisors and Trainers for SET (SAT SET)

2 August, Cairns

13 August, Sydney

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. This workshop is also available as an eLearning activity by logging into the RACS website.

## AOA/RACS/MedLaw Meeting

16-18 August, Gold Coast

All Fellows are cordially invited to the Combined AOA/RACS/MedLaw Meeting on the Gold Coast from 16-18 August 2013 at the Sheraton Mirage Resort. To register please contact Conference Secretariat Kevin Wickham at kevinwickham@iinet.com.au

## Preparation for Practice

24 - 25 August, Melbourne

This two day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice. This activity is proudly supported by The Bongiorno National Network, mlcoa and ROOMS WITH STYLE.



## Non-Technical Skills for Surgeons (NOTSS)

18 October, Hobart;

29 October, Gold Coast

This workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues.

## Management of Acute Neurotrauma

26 September, Sydney

You can gain skills to deal with cases of acute neurotrauma in a rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, you can learn these skills using equipment typically available in smaller hospitals, including the Hudson Brace.

## Surgical Teachers Course

24 - 26 October, Perth

The Surgical Teachers Course builds upon the concepts and skills developed in the SAT SET and KTOT courses. The most substantial of the RACS' suite of faculty education courses, this new course replaces the previous STC course which was developed and delivered over the period 1999-2011. The two-and-a-half day intensive course covers adult learning, teaching skills, feedback and assessment as applicable to the clinical surgical workplace.

## Writing Medicolegal Reports

28 October, Melbourne

This 3 hour evening workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This ability is one of the most important roles of an expert adviser. This activity is proudly supported by Avant and mlcoa.

## NSW

13 August, Sydney  
Supervisors and Trainers for SET (SAT SET)

26 September, Sydney

Acute Neurotrauma

12 November

Keeping Trainees on Track (KTOT),

22-24 November, Sydney

Process Communication Model

## QLD

2 August, Cairns

Supervisors and Trainers for SET (SAT SET)

3 August, Cairns

Keeping Trainees on Track (KTOT)

29 October, Gold Coast

Non-Technical Skills for Surgeons (NOTSS)

## SA

12 September, Adelaide

Polishing Presentation Skills

## TAS

20 September, Hobart

Non-Technical Skills for Surgeons (NOTSS)

18 October, Hobart

Keeping Trainees on Track (KTOT)

## VIC

24 - 25 August, Melbourne

Preparation for Practice

10 September, Melbourne

Keeping Trainees on Track (KTOT)

9 October, Melbourne

Supervisors and Trainers for SET (SAT SET)

11 October, Melbourne

Strategy and Risk for Surgeons

28 October, Melbourne

Writing Medicolegal Reports

16 November, Melbourne

Building Towards Retirement

16 November, Melbourne

Communication Skills for Cancer Clinicians

22 November, Melbourne

Non-Technical Skills for Surgeons (NOTSS)

27 November, Melbourne

AMA Impairment Guidelines

## WA

24 - 26 October, Perth

Surgical Teachers Course

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

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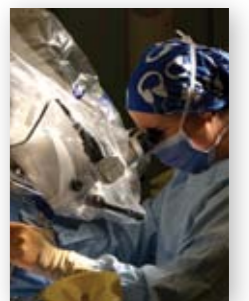
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ON THE COVER:  
This month's Successful Scholar Alice Guidera, featured page 32



President's Perspective

# The Commercialisation of Medicine – but not our DNA

I remember when, in my first intern job, Peter Dwey in Wagga Wagga performed one of Australia's first total hip replacements. I remember the careful preparation, and personal angst for the surgeon, prior to that operation. It was a period of enormous change in medicine with advances in procedures such as open heart surgery, joint prosthetics, total parenteral nutrition and transplants of multiple organs to name just a few.

What is now more amazing is how 'routine' these clinical activities and procedures have become. The entire 'machinery' of surgical care is vastly more comprehensive than was ever considered. Health is no longer a 'cottage' industry – it is a major commercial and industrial enterprise. This challenges us and our patients on a daily basis.

As commercial interests have focused on the increasingly more expensive health sector, costs continue to escalate encouraging governments to intervene and impose controls over the use of new technology and drugs. While our primary responsibility remains to our patients, we also have a range of responsibilities to the community and those who act on behalf of the community such as Departments of Health, and the various regulators.

When funders of health services move from insurance to being providers of comprehensive health packages, the boundaries become even more blurred. Add the complexity of publicly listed companies that must focus on return to shareholders, and the dynamics can be even more intense.

In an increasingly commercial world, it is not just the delivery of health services where health professionals can be under direction of a corporate entity, but also the choice

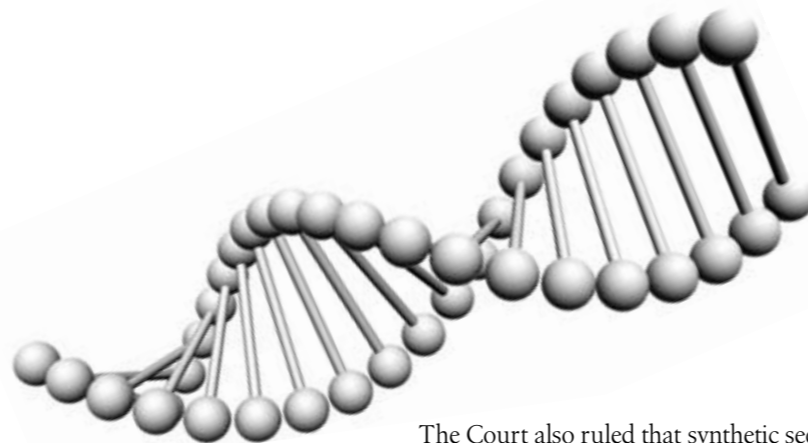
of instruments, drugs and diagnostic tools that we use on a daily basis. The extent to which profit drives the health industry, and the choices we make daily in clinical practice, is a dilemma for us all.

On a different tack, the potential to profit from a scientific discovery which may potentially benefit millions also has significant ethical overtones. I have, for example, substantial concerns about the patents that had been applied to sections of the DNA or genetic code that constitutes the human genome.

A recent example is the discovery of, and testing for, BRCA1 and BRCA2. Identifying the genetic code that predisposes a subgroup of the population to increased risk of breast cancer is an incredible discovery. And that is what it is – an incredible discovery. However, does the description of this genetic sequence represent something that can be protected in an Intellectual Property sense and hence be commercialised?

No doubt there are differing views out there, but I believe that our genetic material should be 'out of bounds'. Intellectual Property and patents can be applied to the machines that make the discovery possible or to the creation of the specific and synthetic proteins that can then be developed, but not to the genetic code itself.

In a landmark decision, the Supreme Court in the US has unanimously ruled that isolating a gene on a chromosome is not able to qualify for patent protection. The case involved a firm called Myriad Genetics that was enforcing a monopoly of testing for BRCA1 and BRCA2. As I understand it, this was an attempt to exclude BRCA1 or BRCA2 from being included in a screen with other genetic sequences.



“

*Health is no longer a 'cottage' industry – it is a major commercial and industrial enterprise* ”

The Court also ruled that synthetic sequences of DNA that were created in the laboratory could be patented.

Hopefully this comprehensive decision will protect our genome while providing ample opportunity for biotech companies to invest in this technology and make a profit where appropriate.

As surgeons we have a responsibility to the community to advocate on health related issues. It is one of our nine College competencies. This is one example where surgeons and their professional body need a clearly considered opinion and be prepared to speak out as appropriate.

*Mike Hollands  
President*

## Queens birthday honours:

### AUSTRALIA

#### Member (AM) in the General Division

Paul Ernest Beaumont  
John Meredith Harrison  
Edgeworth David McIntyre  
Peter Harold Woodruff

#### Medal (OAM) in the General Division

Eric Peter Guazzo  
Ian Edgeworth McInnes

## 2013/2014 Definitive Surgical Trauma Care (DSTC) and Definitive Perioperative Trauma Nursing Care Courses

**DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) brings you courses for 2013/14**

### COURSE DATES 2013

**Sydney (Military Module):** 23 July

**Sydney:** 24 – 25 July

**Auckland:** 29 – 31 July

**Perth:** 7 – 8 November

**Melbourne:** 10 – 12 November

### COURSE DATES 2014

**Adelaide:** 24 & 25 March

**The DSTC course is an exhilarating educational opportunity focusing on**

- surgical decision-making in complex scenarios
- operative technique in critically ill trauma patients
- hands-on practical experience with experienced instructors (national and international)
- insight into difficult trauma situations with learned techniques of haemorrhage control and the ability to handle major thoracic, cardiac and abdominal injuries

**The DSTC course is recommended by the Royal Australasian College of Surgeons for all consultant surgeons and final year Trainees who participate in care of the injured. It is considered essential for surgeons involved in the management of major trauma and those working in remote, regional and rural areas.**

**The Definitive Perioperative Nurses Trauma Care Course (DPNTC) is held in conjunction with many DSTC courses. It is aimed at registered nurses with experience in perioperative nursing and allows them to develop these skills in a similar setting.**

**The Military Module is an optional third day for interested surgeons and Australian Defence Force personnel (this course is only offered in Sydney).**

**DSTC is recommended by The Royal Australasian College of Surgeons for all Consultant Surgeons and final year trainees.**

**Please register early to ensure a place!**

Contact Sonia Gagliardi on 161 2 8738 3928  
or email: [Sonia.Gagliardi@sswahs.nsw.gov.au](mailto:Sonia.Gagliardi@sswahs.nsw.gov.au)

# Raising our voice

The College's work is never done

I want to tell you about three things – the good, the better and the ugly. Firstly the good – an advocacy success.

In 2009, building on the efforts of surgeons, the College launched an advocacy campaign with respect to the development of Acute Surgical Care Units. The College wrote to all health ministers and health network CEOs in Australia and New Zealand, enclosing a comprehensive report that demonstrates beyond any doubt that the emergency workload is predictable as, of course, is the elective workload.

Moreover, by separating the elective and emergency surgical streams and ensuring both have dedicated resources and surgical teams, hospital efficiency improves dramatically, as do patient outcomes. And, importantly, the report pointed out that such separation can be achieved at minimal cost.

This was followed by a sustained advocacy effort involving letters to the editor and, at every opportunity, a reminder to politicians and bureaucrats that real efficiencies can be achieved by using existing resources more wisely.

At the past three Annual Scientific Congresses there have been several presentations reporting the results of trials involving new, dedicated acute care units. These trials have been conducted in hospitals of all sizes, across both our countries.

At this year's Annual Scientific Congress in Auckland, for example, there were reports of Acute Care Unit trials at hospitals as different as Royal Melbourne and Southland in Invercargill. Unsurprisingly, the results are compelling. Patients are much less likely to return to theatre, length of stay declines dramatically and more procedures are performed over a given period.

It is pleasing to note the acute care units are now recognised in health departments' planning and strategic thinking. This is a win for patients, and for the advocacy done on their behalf by surgeons.

The better!

Recently I was called out of 'retirement' to once again be an examiner in the FRACS exams held in Melbourne in May. To run an exam of this size and complexity is a major logistical challenge. It requires the contributions of literally hundreds of surgeons – not only the examiners, but the surgeons who have to find and organise the patients.

To me, it is "core business" for the College and indeed our profession. It is incredibly heartening to see, without exception, everyone working together to achieve a highly professional process and outcome. When one stops to pause and reflect on the entire exercise, it is truly an amazing achievement that it is repeated over and over again.

And now the ugly.

A measure in last May's Australian federal budget will see an annual cap of \$2000 placed on the tax deductibility of self-education costs in Australia from 1 July 2014. Needless to say the College is outraged at this assault on training and self improvement. Perhaps in more than any other field of endeavour, the need to remain 'up to date' is vital for doctors, and for surgeons in particular. As has been pointed out by the College, it is manifestly unreasonable to limit the tax deductibility of activities that the government itself requires us to undertake in order to maintain medical registration.

But even more disturbing is the measure's capacity to act as a disincentive to those of us who easily exceed CPD requirements, but are keen to do further training and attend further conferences *because we know this makes us better surgeons.*

The College has consistently stressed that this is an issue about the quality of surgical care and the safety and wellbeing of our patients.

We have written to the Federal Treasurer and the Health Minister, and their Opposition counterparts, stressing the threat to surgical care posed by the budget measure. We also wrote to the independent members of the House of Representatives urging them to vote against this specific budget measure.

“  
Needless to say the College is outraged at this assault on training and self improvement”

Two paragraphs of the letter are worth repeating here: *Many surgical professional development courses are held outside of Australia. These programs deliver leading edge research and training, and are vital to ensuring Australian surgeons remain at the forefront of surgical techniques and technologies. Again, costs for these essential programs are high. Without surgical staff being able to claim a reasonable level of tax deductibility, fewer will attend such courses and Australia runs the risk of seeing its standards of surgical care diminish commensurately.*

*The proposed cap will predictably limit participation in educational activities for all surgical staff – surgeons, operating room nurses, etc. The College fears that this will translate into relative de-skilling of a workforce that is currently and justifiably a source of national pride, which in turn will compromise patient safety.*

The letters also noted that many surgeons undertaking courses and conferences leave their rooms or hospitals to do so, thereby adding foregone income to the already hefty cost of registration, travel and accommodation. Another point being made by the College is the fact that this measure will fall even more heavily on those surgeons working in regional and rural areas of Australia, for whom travel costs are always higher.

Our advocacy has borne some fruit. The College was pleased to provide some facts and figures about the cost of training and CPD to the office of the Federal Member for Higgins in the House of Representatives, Ms Kelly O'Dwyer. These facts were used by Ms O'Dwyer in a speech she gave during the House's Adjournment Debate on the evening of Tuesday 28 May.

You might be aware that the Australian Government has responded to the concerns of the College and other professional bodies by announcing a consultation process and issuing a discussion paper. You can be assured that the College will be a very active participant in this process.



Michael Grigg  
Vice President

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



Rowan Nicks Russell Drysdale  
Fellowship in  
Australian Indigenous  
Health and Welfare 2014

This Fellowship awards up to \$60,000 (negotiable depending on qualifications &/or experience) for a 12 month period.

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

**Australian Indigenous people are strongly encouraged to apply.**

Fellowships could take the form of

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

The Fellowship is open to Australian citizens or permanent residents who have appropriate prior experience and or education and wish to:

- Undertake approved programs/activities OR
- Undertake further education OR
- Undertake a research project

**Closing date:** Friday 6th September, 2013

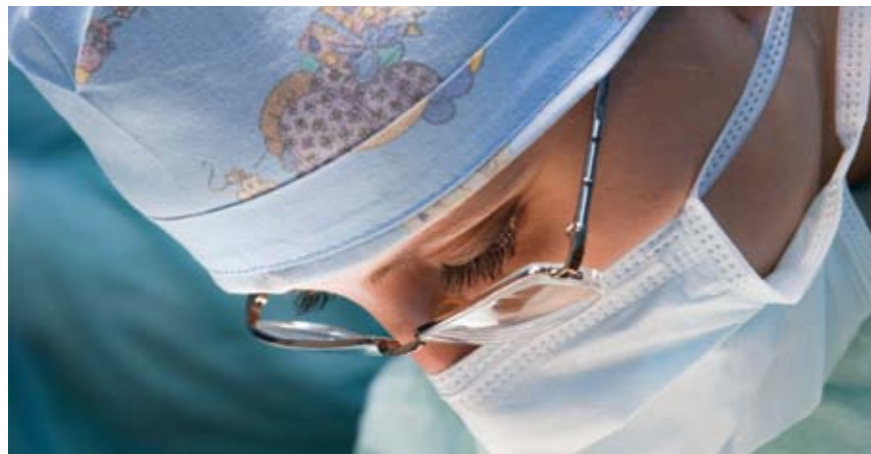
For further information about the Fellowship and for application forms, please visit the website:

[www.medfac.usyd.edu.au/nicksdrysdale/](http://www.medfac.usyd.edu.au/nicksdrysdale/)

Or contact Louise Lawler, Executive Officer, Sydney Medical School, The University of Sydney on 0418 251 864 or at [Louise.Lawler@sydney.edu.au](mailto:Louise.Lawler@sydney.edu.au).

<http://sydney.edu.au/medicine/scholarships/indigenous/index.php#rowan>





**Hear it for the women**

Chair of the College Trainees Association Carolyn Vasey has responded to an earlier article in the Fairfax papers bemoaning the lack of female surgeons, saying the piece by Dr Ranjana Srivastava overlooks important information. The proportion of female surgical Trainees is much greater than the proportion of females who are surgeons," Dr Vasey said. She referenced Workforce data from the College that shows the number of female applicants for surgical training has increased by 64 per cent over the past four years, while 27 per cent of Trainees are female. "Addressing the imbalance between male and female surgeons will obviously take many years, but the process is clearly underway," Dr Vasey said. *TheAge, May 31*

**Open speed limits lead to death**  
The College has partnered with the College of Physicians and the College of Emergency Medicine to warn the Northern Territory Government of the serious consequences of re-introducing open speed limits on NT roads. In a Letter to the Editor, representatives talked of witnessing the tragedy of brain damage and spinal injuries too often. "The evidence linking speed to road crashes is very clear: The higher the speed, the greater the risk of crash, the worse the injuries and the higher chance of death." *NT News, June 25*

**Private insurance for public funding**

The Australian Private Hospitals Association has warned that public hospitals are encouraging patients to use their private health insurance in an effort to top-up their funding. Instances have been reported where patients have been repeatedly asked if they hold insurance so they can receive faster treatment. Chair of the College's Victorian Regional Committee Robert Stunden has said it could lead to inequality among patients. "There could be a risk of them being pushed up the waiting list or getting something that other patients are not being offered." *The Age, June 17*

**Value of continuing education**

Fellow and President of the NSW AMA Mr Brian Owler has warned of the huge disadvantages to up and coming specialists with the Government imposed \$2000 cap on self-education expenses. "When ... young doctors start training to become specialists, they spend up to \$20,000 a year on their education and training - expenses they must fund if they are to become fully trained doctors and serve the community," Mr Owler said. He also highlighted the preference for the public to be treated by someone with the latest knowledge and techniques. "It is a pity our politicians don't value professional training and development equally as highly." *Sydney Morning Herald, June 3*



2013 NSA Annual Scientific Meeting

Register by 5 July 2013 for Early Registration Fee

Thursday 3 - Saturday 5 October 2013  
Palmer Coolum Resort, Coolum Beach, Sunshine Coast, Queensland

Further information:  
T: +61 3 9249 1273 www.nsa.org.au  
E: nsa.asm@surgeons.org

Provincial Surgeons of Australia  
49th Annual Scientific Conference

Register your attendance now!  
Request a registration form by emailing [psa@surgeons.org](mailto:psa@surgeons.org)

25 - 27 July 2013  
Hilton Queenstown  
New Zealand

Australian and New Zealand Head & Neck Cancer Society  
15th Annual Scientific Meeting  
Thursday 29 August to Saturday 31 August 2013  
Pullman Melbourne Albert Park  
(formerly The Sebel Albert Park, Melbourne)

Provisional Program now available. Register online now!

For more information visit [www.anzhncs.org](http://www.anzhncs.org)  
Contact T: +61 3 9249 1273 E: [anzhncs.asm@surgeons.org](mailto:anzhncs.asm@surgeons.org)

Evidence Based Vascular Surgery and Organisation of Vascular Surgery Services

ANZSVS 2013 Conference  
12-15 October 2013  
Hotel Grand Chancellor, Hobart, Tasmania



Patrick Alley and Wil Harrison are welcomed at the west Auckland marae by local elders

# A Maori welcome for Indigenous Health

The inclusion of Indigenous Health in the ASC program marks a promising start

A significant figure in New Zealand and Maori political life died late in April this year. Parekura Horomia was an energetic and capable Minister for Maori Affairs and his passing has been mourned by all New Zealanders. One of the traditional Maori beliefs is that rain is an inevitable accompaniment of such events – it is the tears of Rangi, the sky father, for one of his children. So it proved to be when some 40 College visitors attended the Hoani Waititi marae in West Auckland at the beginning of the recent Annual Scientific Congress. The heavens opened and for much of the day. But this did not deter the warmth or sincerity of the welcome which followed traditional Maori protocol.

Hoani Waititi is unusual in that it is an urban marae and has no dedicated tribal affiliation. It commemorates the work of Hoani Waititi, a visionary Maori academic who did so much for welfare, education and maintenance of Maori values not only in West Auckland, but the whole country. We were privileged to hear the history of the marae and its place in the contemporary management of a range of social and health issues confronting Maori in New Zealand. Our visit concluded with spontaneous speeches and songs from the Pacific representatives of the International Surgeons.

The convocation saw a significant Maori presence with formal speeches and songs in Maori after an impressive

challenge from a Maori warrior. College President Michael Hollands rose perfectly to that and punctuated his response with Maori phrases which impressed all. A major highlight was the convocation of two Maori graduates, Maxine Ronald – our first Maori female surgeon, and Vaughan Poutawera. We congratulate them on this wonderful achievement.

The academic program for our inaugural Indigenous Health Forum comprised retrospective and prospective views from both sides on the Tasman Sea. Two knights of the realm – Dame Anne Salmond and Sir Mason Durie addressed the Maori and New Zealand perspective while A/Prof. Shaun Ewen and Dr Jacob Ollapallil took responsibility for the Australian Indigenous aspect. Pleasingly

this session was to a full house – the majority of whom were Trainees. There was a notable absence of grey hair in the audience.

Dame Anne Salmond is New Zealander of the Year and is highly respected for her collaborative work with elders of the Te Whaanau-a-Apanui and Ngati Porou Maori tribes on issues of Maori life. Sir Mason Durie is a member of the Rangitane and Ngati Kauwhata (Maori) tribes. He has been actively engaged in mental health research and policy for more than two decades, and in 1993 established a Maori Health Research Centre that has provided national leadership in outcomes research and research into mental health service delivery.

Shaun Ewen holds many leadership positions, including being the inaugural Associate Dean (Indigenous Development) Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne. Shaun shared many of his experiences and views gained through working with the medical specialties in Indigenous health syllabus development.

Ollapallil Jacob is well known across the College for his tireless work as a trauma surgeon, particularly with Aboriginal and Torres Strait Islanders who constitute the major proportion of his patients in Central Australia. His continued championing of, and passion for, Indigenous health is to be greatly admired and respected.

The presentations by these distinguished guests reflected on the past, and on aspirations for the future. They put into perspective the reasons why our First Nation peoples have experienced, and continue to endure, such devastating health outcomes when compared with non-Indigenous communities in Australia and Aotearoa New Zealand.

Their perspectives on the future included reflections on interpersonal relations, the current political climate and, more importantly, the amazing work being done across the College and in the wider community in the field of Indigenous health and how this can inspire us to do better.

Many of the conversations had with delegates were thought provoking and reinforced our belief in, and understanding of, the importance of Indigenous human rights in the health

sphere. The College's decision to hold this forum and invite such prominent speakers is not only an acknowledgement of the importance of this issue, but also recognition of our responsibility to act and make a difference.

The solution to the imbalance in Indigenous health care indices is the responsibility of tomorrow's surgeons so to see so many of them at this outstanding session was impressively reassuring. It behoves the College to ensure that its commitment to Indigenous health, particularly through our younger Fellows, remains undiminished.

The Indigenous Health Committee looks forward to working with the College to ensure Indigenous health is a regular feature of the ASC. Parekura Horomia would love that!

**Pat Alley**

ASC 2013 Indigenous Health Convenor and Member Indigenous Health Committee

**Kelvin Kong**

Chair Indigenous Health Committee

“ The convocation saw a significant Maori presence with formal speeches and songs in Maori after an impressive challenge from a Maori warrior ”



Top to Bottom: The Hoani Waititi marae; The Indigenous Health group at the gate ready to be welcomed (led by Patrick Alley); Pacific representatives sing their own traditional songs





## In Memoriam

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

Graeme Lim,  
Queensland Fellow

Edward J  
Beckenham,  
New South Wales 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](http://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:** Allan.Chapman@surgeons.org  
**NZ:** Justine.peterson@surgeons.org  
**QLD:** David.watson@surgeons.org  
**SA:** Daniela.Ciccarello@surgeons.org  
**TAS:** Dianne.cornish@surgeons.org  
**VIC:** Denice.spence@surgeons.org  
**WA:** Angela.D'Castro@surgeons.org  
**NT:** college.nt@surgeons.org

## Curmudgeon's Corner



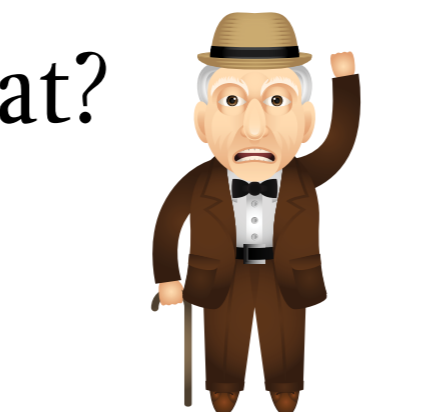
## Late for what?

If it is the first appointment, how can it be late?

There is one thing that really annoys me and that is people who are always late. We curmudgeons tend to be a bit obsessional about time and do not keep people waiting. I was at a professional office the other day and waited 45 minutes for my appointment. Now if he was an obstetrician and had rushed off for a delivery I would understand, but an accountant?

I recall one medical colleague who often ran one to two hours late. The fact that he always arrived at least 45 minutes late for his first appointment did not help matters. By later in the day he was usually two hours late. The office staff had all sorts of ways to keep the waiting patients entertained – a walk in the park, get them a coffee, send them to the local restaurant for a three course lunch and so on. It was rumoured that some staff even mastered a few simple song and dance routines. (It has occurred to me that maybe the word patient is derived from the word patience.)

One day he got his comeuppance. A senior member of the legal fraternity was well into his second hour when he was called to see the great man and he told my colleague that as he had wasted two hours of his time he was leaving so that my medical colleague would waste his



“Now if he was an obstetrician and had rushed off for a delivery I would understand, but an accountant?”

time by having a gap in the appointment day. Needless to say my physician friend was nonplussed, but the next patient was very pleased.

It does seem to me somewhat insulting that any person keeps another waiting for a very long time for a previously made appointment. It basically says “I am so important that my time is much more valuable than your time.” Well, my accountant is about to find out that my time is more valuable than his as I am going to be 45 minutes late for my next appointment with him – that should teach him a lesson!

## Poison'd Chalice

“Let every eye negotiate for itself and trust no agent”

I am sitting in yet another committee meeting. My mind is somewhere else – the mere mention of the phrase “Terms of Reference” has been the stimulus for my mental wandering – a hypnotic signal implanted deep within my brain.

I find myself back in time – as a very junior doctor. Accompanying a very senior surgeon to assist him in private – possibly my first visit to a private hospital. He is carrying a bag – obviously heavy. As we enter the operating suite, he opens his bag and rummages through it producing the instruments and indeed even the suture material that he will require for the operation. This is something of a shock – the surgeon responsible for his own “surgical kit”. Flash sterilisation will have to do. Claudio had it right in ‘Much Ado About Nothing’: “Let every eye negotiate for itself and trust no agent.” You eyeballed the gear and made sure you had what you needed.

It was a purer world back then; now much more convoluted. Now the surgeon has to request the equipment which may or may not be purchased by the hospital. And as for prostheses – it is perhaps indicative of my age that I can remember the partners (wives in those days) of my vascular surgical mentors cutting up silk shirts and fashioning them into aortic grafts! Autoclaving had to be kept to a minimum to prevent disintegration.

The direction of my mental wandering was determined by an incident this morning. I was accosted by a clipboard carrying middle range manager admonishing me about the behaviour of surgeons. Apparently these “wayward surgeons” had the gall to make sure that the equipment they needed would be available in the theatre. They (shock and horror!) had spoken to the Company representative and requested specific equipment was delivered for a case that had been arranged. “Not allowed ... The clip-board carrier glared at me: “Did ‘your surgeons’ understand that they needed to have all equipment reviewed and authorised before it was allowed into the facility. It is critical for standards and of course for cost control. Did they know about the guidelines on introducing new technologies?”

It is marvellous the apparent authority a clipboard conveys – it empowers one with authority. Some years ago I remember attending a meeting that members of the Melbourne Football Club called to discuss a possible merger. The Secretary of the Club asked me to get the members to take their seats. “But I have no authority,” I said. “Here take this,” he said as he thrust a clipboard into my hands. Armed with my clipboard, everyone took notice of me and assumed their seats. Fantastic to behold. At one time I even thought of getting my own clipboard. Fortunately, I never got around to it. Now I know the true meaning of a clipboard – it is a diagnostic symptom of RDS – Relevance Deprivation Syndrome – a condition endemic within hospital bureaucracies. Yet new technologies do present a major challenge for doctors in general and surgeons in



particular. Most, if not all, of the advances in surgery have been developed by surgeons. It is innate that we continue to innovate, to improve. Surgical devices are very different from pharmaceuticals and cannot be subjected to the same rigours before application. No-one would argue that there is a fine line between unethical experimentation and a dramatic advance, but somehow we need to continue to strive for the right balance despite the forces arrayed against us. These forces constantly claim financial responsibility, yet I fear that the real motivation is the attraction of curtailment of clinical autonomy.

So here I am – attending the New Technology Committee meeting. A committee that I created many years ago – its original meaning and focus lost in the mists of time. I am, as is often the case, the only surgeon. I am surrounded by managers (it is not necessarily true that they are nurses who have undertaken further studies with the express aim of making my life more difficult), bureaucrats, or should I say “bean counters” and physicians. There is increasingly little to distinguish them from one another. “We happy few” (Henry V, Act 4).

Yet we continue to innovate, it may have been knitted grafts some 40 years ago, but today it was into electronic gizmos. Everywhere I looked, people were looking to be the software developer of the future, progressing phone apps, patient treatment programs, enormous text books into decipherable and memorable ‘bits’. My registrar had even caught me out the other day. I was struggling to recall a famous quote that was certainly from Shakespeare, but maybe it was from Sallust... ‘The golden age is before us, not behind us.’

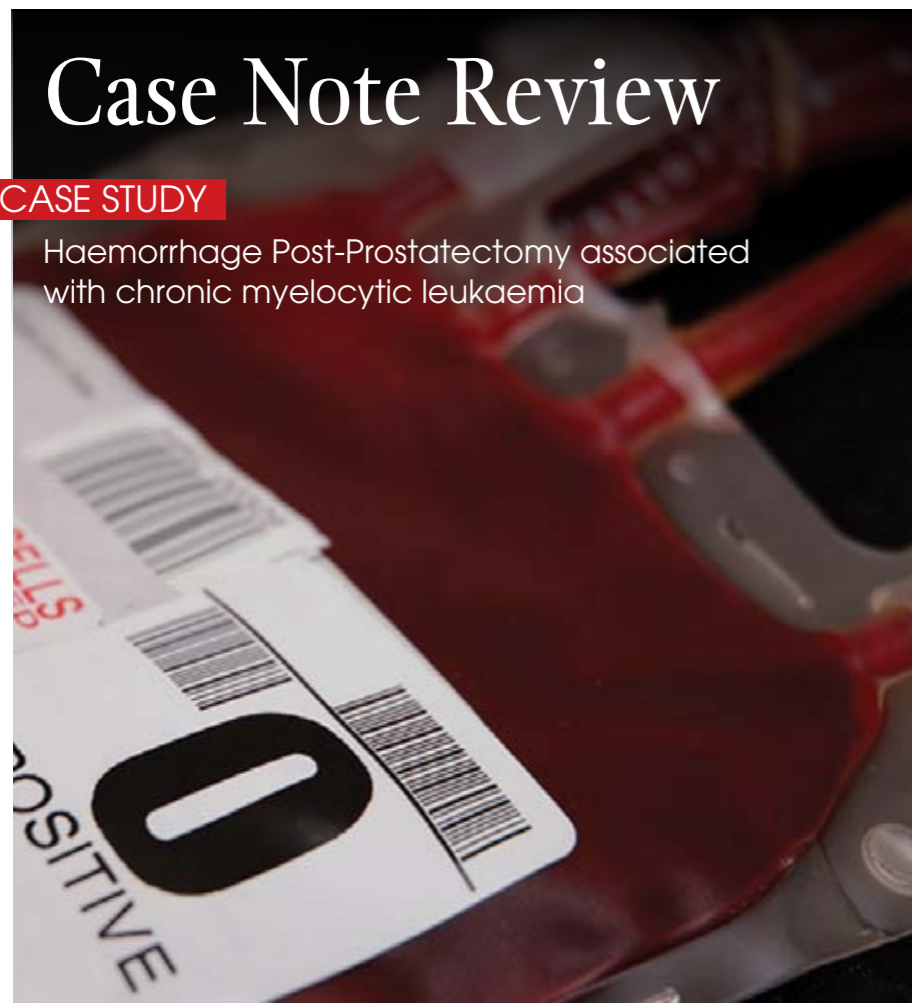
Always on the ready is this registrar ... I have an App for that ... and so she did.

Professor U.R. Kidding

# Case Note Review

**CASE STUDY**

Haemorrhage Post-Prostatectomy associated with chronic myelocytic leukaemia



**Case Summary**

An elderly patient had been catheterised for urinary retention for a month and was admitted electively for a transurethral resection of the prostate (TURP). The patient had known chronic myelocytic leukaemia (CML), but there was no documentation of the date of diagnosis or any known thrombocytopenia.

However, after a cystoscopy, litholapaxy and bladder neck incision several years prior, the patient suffered an unconscious collapse and cardiac arrest secondary to massive haematuria, requiring blood transfusion and fresh frozen plasma (FFP). There was no mention of the CML or thrombocytopenia in the discharge letter at the time.

Thrombocytopenia was noted in the pre-admission clinic and a preoperative platelet transfusion was planned. The patient was admitted to hospital the day before surgery. A duty haematologist was contacted and advice given to transfuse a unit of platelets prior to surgery.

The following day the patient received

the platelet transfusion then underwent a TURP. There was no mention of anything untoward in the operation note. The urine was described as being dark rose on return to the ward and then in the early hours, started bleeding, went into clot retention and became hypotensive. The patient was given Gelofusin, transfused and returned to theatre later in the morning.

At cystoscopy, the clots were evacuated and the only bleeding site was a resected area in the bladder. The patient was taken to ICU while still intubated and ventilated, where they received a large number of units of blood, a couple of units of FFP and a couple of units of platelets.

A few days later the patient was transferred back to the ward with a catheter and irrigation. The catheter was removed several days later, but the patient failed to void adequately and was recatheterised the next day. Irrigation was started again because of dark haematuria and clots. Bleeding continued and that evening

the patient was noted to be anaemic and hypotensive. After further discussion with a haematologist, blood was transfused but platelets were not given.

The patient continued to bleed and required bladder washouts. The patient remained hypotensive and tachycardic until suffering a cardiac arrest. The patient was resuscitated, intubated and ventilated and transferred to ICU, but died soon afterwards.

**“ The patient was resuscitated, intubated and ventilated and transferred to ICU, but died soon afterwards ”**

**Assessor's Comment**

This patient had a very significant complication with the previous urological procedure, namely a cardiac arrest from profound haemorrhage related to chronic myelocytic leukaemia with thrombocytopenia. This led to an extra-careful preparation for this potentially life-threatening surgery. I would have thought that there should have been very active involvement by the haematologists pre- and postoperatively. If this was unavailable at this hospital perhaps the surgery should have been performed at a more central location. It appears likely that there was inadequate platelet function, despite at times a platelet count that was above the usual recommended threshold for platelet transfusion.

The management appears to have been very reactive rather than proactive and the patient probably should have been monitored in the high dependency unit (HDU) or ICU for longer, or returned earlier when the situation deteriorated. It appears that there is virtually no documentation in the notes of any platelet counts or haemoglobin levels.



**Guy Maddern**  
Chair, ANZASM

# Surgeons evaluate surgical mortality audit

A decade on and improvements keep coming

In 2004, three years after the commencement of the Western Australian Audit of Surgical Mortality (WAASM), a survey was sent out to all surgeons in Western Australia seeking their thoughts on audit processes and to determine whether the project, in its formative years, had improved or influenced their practice. There were 190 (73 per cent) respondents who indicated that feedback from WAASM had influenced changes in their practice.

**“ (Of the respondents), 78 per cent indicated that involvement in or feedback from WAASM had changed their practice in at least one way ”**

Following the 10 year anniversary of WAASM in 2012, a second survey modelled on the 2004 evaluation, was sent out to all surgeons in WA to ascertain if a decade of audit activity had influenced their surgical practice. The survey was sent to 396 active consultants on the WAASM database and 303 (77 per cent) completed surveys were returned. Of these, five had missing information and 15 were excluded either on the grounds of non-participation or recent recruitment to the audit. The number of valid surveys analysed is 283 (71 per cent).

Overall, 78 per cent of the 283 respondents indicated that involvement in or feedback from WAASM had changed their practice in at least one way. The main area in which WAASM has influenced practice is attention to prophylaxis for deep vein thrombosis, with 57 per cent of respondents indicating a change in practice in this area. This was closely followed by improvement in the quality of documentation in case notes (51 per

cent), increased constructive discussion amongst surgeon peer groups (49 per cent), management of anti-coagulation (49 per cent) and attention to post-operative care (48 per cent).

When compared to the 2004 survey, responses in 2012 demonstrated that the greatest percentage increase in areas that influenced practice occurred in appropriate referrals of patients (19 per cent increase), attention to DVT prophylaxis (14 per cent increase) and attention to supervision issues

(13 per cent increase). Over the years, WAASM has specifically targeted issues related to Trainee supervision and DVT prophylaxis in symposia, newsletters and case note review booklets.

Case note review booklets appear to be highly regarded by participants with 95 per cent of respondents who read them indicating that they were interesting and 91 per cent stating that they are a valuable educational tool. Case reviews compiled in the booklets are actual cases (de-identified) that have been reviewed through the WAASM process and are indicative of the challenges that are faced before, during and after surgery.

Overall, the preliminary results from the 2012 evaluation demonstrate that WAASM has been involved in increasing the awareness of issues related to surgery by monitoring trends in surgical mortality data and in changing surgical practice to achieve better patient outcomes.

**James Aitken**  
Clinical Director, WAASM



## Fellowship in Rural Surgery

Wagga Wagga, NSW, Australia

**Applications are sought from Fellows who wish to undertake a 12 month Fellowship in Rural Surgery in 2014. Applicants must have passed the Part II Examination and live in Australia.**

**Subspecialty interests are available and include:**

- Breast, Oncoplastic & Endocrine Surgery
- Hepatobiliary, Oesophago-gastric & Bariatric Surgery
- Laparoscopic & Open Colorectal Surgery
- Vascular & Endovascular Surgery
- Paediatric Surgery
- Skin Cancer & Melanoma
- Endoscopy & ERCP
- Academic Surgery

Observerships available. Job description available on request.

Duration of Fellowship = February 2014 to November 2014.

**Forward enquires, applications (with CV) to Dr Michael Payne:**

**Phone:** (02) 6925 1488

**Fax:** (02) 6925 1499

**Email:** drmichaelpayne@bigpond.com

**Post:** Suite 3/325 Edward St, Wagga Wagga, NSW, 2650

**Selection criteria:** CV (40%), Referees (35%), Interview (25%)

**Applications close Friday September 27<sup>th</sup>, 2013.**





# Coming of age

This year marks the 30<sup>th</sup> year of Interplast programs

With its dedicated purpose of repairing bodies and rebuilding lives, the plastic surgical aid organisation Interplast Australia and New Zealand is this year celebrating its 30<sup>th</sup> anniversary.

Now sending surgeons, anaesthetists, nurses and allied health professionals to more than 17 nations, Interplast Australia and New Zealand began after Melbourne plastic surgeon Mr Leo Rozner spoke to a local Rotary club about the aid work being done by Interplast (USA).

Such was the support for a program to provide plastic surgery to the people of developing nations of the Asia Pacific region, Interplast Australia was born in 1983 as a joint project between Rotary

District 980 and the College with the first team, fully funded by Rotarians, sent to Samoa in that same year.

With an initial focus on treating congenital or acquired medical conditions such as cleft lip and palate or burn scar contractures, Interplast Australia and New Zealand now treats a broad number of conditions including tumours, birthmarks and cancers and has developed a strong focus on teaching.

Sydney Plastic and Reconstructive Surgeon Dr Peter Hayward has been involved with Interplast since the early 1990s and has so far undertaken 11 trips to PNG, the Philippines, Pakistan, Nepal, Sri Lanka, Tonga, Solomon Islands and Fiji.

He said he believed there were a number of explanations for the success of the organisation over the past three decades.

“One of the reasons Interplast works so well is that it answers a local need,” Dr Hayward said.

“Someone somewhere asks for an Interplast visit and we work to make that happen. It is not driven by bureaucracy or government, it’s not evangelical, it’s simply about a team arriving and doing the work that has been requested of it.

“We also aim to make ourselves redundant wherever possible by training local medical staff to undertake commonly-needed procedures like Chris Bennet has been doing in Laos through a cleft lip and palate program.



Plastic and Reconstructive Surgeon Dr Peter Hayward at work in the Solomon Islands

“Interplast was one of the first surgical and medical aid organisations to focus on this training and it gave the organisation gravitas and high regard in many of the countries who requested team visits.

“Now the organisation runs a number of programs in countries like Cambodia and Nepal that are solely for the purposes of training where Australian and New Zealand surgeons consult along-side local surgeons, attend theatre and give lectures without operating ourselves.

“I would also say that one of the central drivers of the success of Interplast is that we never take registrars and we never will because we are not there to practice on people.

“People in any country we visit get consultant-quality care and I am very glad we adopted this policy which has common sense and integrity about it.

“That single policy decision has been of immense benefit to our reputation and it sends a very strong message not only to the people we are there to treat, but also to the local medical community who we work with.”

Dr Hayward, who works out of the Children’s Hospital in Westmead in Sydney, treats a range of conditions and diseases on his Interplast trips including head and neck cancers, cleft lip and palate, burn contractures, birthmarks and acquired injuries.

He said that while he loved going on such journeys they could often be challenging, from the logistics of getting the equivalent of a vanload of equipment through chaotic airports, to waiting in the heat and humidity for boats and planes that never arrive, to dealing with advanced pathology rarely seen in first world nations.

“Most of us enjoy doing good things, but that is not to say these trips are always enjoyable,” he said.

“You could say they are enjoyable like running a marathon is enjoyable. You’re glad you did it once it’s over.

“You also see much more extreme pathology than anything you are likely to face at home such as giant tumours and very bad burns, so it is not for the faint of heart.” ▶

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One of the reasons  
Interplast works so  
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a local need”



Above right: Interplast Nepal 2007 - Operating and training local surgical registrars  
Above top: Training local medical staff  
Above bottom: Checking on one of his patients



Operating out of the College building in Melbourne, Interplast Australia and New Zealand now employs a core team of 12 staff members who co-ordinate team visits to a diverse range of countries including Bangladesh, Nepal, Vietnam, Kiribati, Myanmar, Indonesia and Laos.

Now receiving AusAID funding, the organisation is still supported by Rotary and now also receives corporate support and generous private donations to allow the surgical teams to treat the thousands of people in need in developing countries.

Dr Hayward, who is waiting to hear the results of a scoping visit to Bougainville and planning a return trip to the Solomon Islands, said he had many fond memories of the patients he has treated over the years.

“During an early trip to PNG we met a boy in his late teens who had ankylosis of the jaw, which meant that he had never been able to eat solid food,” he said.

“We were out in the middle of nowhere, but we thought we could fix it so we conducted a rib graft and tracheostomy and it went well.

“On a later visit we met him again and he proudly showed us how he could eat a banana and his delight was absolutely contagious.

“I also remember a woman from

Bougainville who had a bilateral cleft.

“She was a mother of four kids who had just missed the last Interplast visit before the island was cut off for years during the civil war.

“When we could finally get back in, she turned up at the clinic – having travelled for more than 200 kilometres by hitching rides and walking – just as we were in the process of packing up, but once we heard her story we had to help her.

“I made it clear that we couldn’t do a general anaesthetic, but she was quite happy with a local and we sorted it out.”

Dr Hayward said it was the standing of Interplast Australia and New Zealand and the skills of the people co-ordinating the visits that meant that most plastic surgeons became involved in its work at some stage during their careers.

“Surgeons can feel pressure and the tedium that comes with the growing demands of paperwork and bureaucracy required in modern medicine, but most of us just like to operate,” he said.

“There is a very pure relationship between surgeon and patient on trips like these where it is only about their need and your skill – and I don’t know any surgeons who don’t enjoy that.”

*With Karen Murphy*

## To PSA or not to PSA – that is the question

What is the evidence?

I always thought surgeons were convinced by the aphorism, “if you don’t put your finger in it you’ll put your foot in it”. The other day DR E-luctant consulted me for a mid-life health check, but when I suggested that as he had reached his early 50s he should have a Digital Rectal Examination (DRE) and a serum PSA, he declined.

He then went quiet on me when I added that it was most reasonable for a man in his 50s ... But he was resolute in wishing to avoid both so I didn’t feel inclined to probe further. As every patient needs to leave a consultation with a good outcome, I was now the one squirming, wondering how to send him away without a metaphorical tail between his legs?

I must acknowledge my College (RACGP) does not in fact recommend PSA screening. The US National Cancer Institute is also ambivalent. The American Urological Society have just (May 2013) published a new position paper, now based on evidence rather than consensus, that retracts their earlier stance of advocating PSA screening for all men from age 40 with a life expectancy of at least 10 years. Now they advise against screening men aged 40-54 who have an average risk of prostate cancer.

I would still defend the need [with regard to PSA screening] for the ‘to have or have not’ to be discussed – it is such an important topic in men’s health. However, PSA is a non-specific (for cancer) serine protease, despite being produced only by the prostate, it is rather imprecise and thus not ideal for screening.

Many patients will have a false positive result that will lead to unnecessary angst and either multiple PSAs or undergo TRUS (Trans-rectal

ultrasound-guided prostatic biopsies). The biopsy process has its own side effects of discomfort, occasional bleeding, urinary tract infection and, very rarely, Gram negative septicaemia. Only about a quarter of people who end up having biopsies for an elevated PSA will have cancer. I would have thought that wasn’t a bad rate, but the problem is exacerbated by what do to do about those who do have cancer? For every 1,000 men screened, there will be 120 or so with raised PSAs who are false positives and 110 or so with prostate cancer. Only 4-5 of the 1,000 screened will die of prostate cancer, but so too will 4-5 of the 1000 people who are not screened. The absolute risk of dying from prostate cancer is a paltry 2.6/1000 for unscreened men as opposed to 1.8/1000. That 32 per cent reduction may be statistically significant, but is nevertheless small.

And the treatment we have isn’t all its urological advocates suggest, regardless as to whether the radical prostatectomy is open, laparoscopic or robotic. For every 100 men who have radical prostatectomies about 50 will suffer some functional impairment to save one life. Most of the

impairment will be erectile, only a handful end up with incontinence, but more end up with incontinence than are saved.

For those who were never going to benefit it’s a high price to pay, particularly for younger sexually active middle-aged men and their partners. You may be as likely to win on the horses as to achieve the so-called urological trifecta (PSA <0.2ng/ml, attainment of erections sufficient for intercourse with or without pharmacological agents – phosphodiesterase-5 inhibitors, wearing zero incontinence pads).

There’s been a trial reported in NEJM suggesting the younger you are the more likely you are to benefit from surgery in terms of survival. Sadly, the other trifecta effects will be all the more devastating to a man in his 50s, but you only (did I hear you say ONLY?) need to do seven prostatectomies to prevent one death – a 14 per cent chance that radical prostatectomy will save your life, but with 30 to 80 per cent risk of impotence/erectile dysfunction, and 1 per cent risk of serious incontinence with a few more suffering minor degrees of incontinence. Interestingly for all males (male surgeons) who are over 65, there was no survival benefit. There’s similarly no good evidence for DRE in asymptomatic, normal risk individuals.

DR E-luctant left happy not to be probed or PSA’d. However, my husband is about the same age and I think I’ll try to persuade him as I want him to stick around, though hopefully with everything in full working order. But until there is a better test, at this age it’s a pretty close call.

PS A conundrum: to have or not to have – think of what you might have not.

*Dr BB G-loved*



“  
As every patient needs to  
leave a consultation with a  
good outcome I was now the  
one squirming.”

# A full year for NSW

New premises have helped to ensure continued success for the NSW Regional Committee

This last year has been a momentous time for the New South Wales Regional Office and Committee.

Significantly, the regional office has moved to Kent Street, within the Sydney central business district, and a new Regional Office Manager, Allan Chapman, has taken over the reins from Bev Lindley. The new premises were officially opened by the Federal Minister for Health and Ageing, the Honourable Tanya Plibersek and College President Michael Hollands on August 1, 2012.

The decision to uproot the office from its previous longstanding location in Surry Hills was not taken lightly and was not without discussion. Many questioned the need to move the office. Ultimately, the decision to renovate an old residential building, at considerable cost, and with ongoing limitations to its functionality, or to relocate, had to be made.

Once the decision to relocate was made, my predecessor, Joe Lizzio and Bev Lindley spent many hours searching for a suitable venue. Suggestions ranging from university campuses, to business parks and locations on the outskirts of Sydney were entertained. It was ultimately decided to remain within central Sydney and the current premises were located and inspected by the Regional Committee prior to the lease being signed.

The move has proven to be highly successful and offers NSW Fellows significant benefits. The office is centrally located in a modern office block with spacious conference facilities, onsite parking and easy access by all means of transport. Already the office facilities

have been used to hold highly successful College functions, examinations, interviews and seminars in a businesslike and professional setting. Surgical Societies, hospital surgical departments and outside bodies have also used the facilities.

The office is available to all Fellows to use. Rural groups in particular would find the regional office a convenient location to hold a Sydney based meeting. One surgical society has enquired about possibly establishing its office within the College space. Anyone wishing to use the office facilities can discuss their requirements with Allan Chapman who would be delighted to discuss the facilities available, and help with the planning of any events.

Bev Lindley, who was the manager of the regional office for more than 20 years and the face of the College in New South Wales, was nominated for Honorary Fellowship by all of the surviving NSW regional chairs who worked with her. This was approved by College Council in October last year and the Fellowship was conferred at the recent Auckland ASC. Bev exemplified all of the competencies required to be a Fellow in the current era. She exhibited these qualities well before they were formally identified as essential criteria for a professional individual.

There is no doubt that the practice of surgery has changed in the recent past, but more so recently with the introduction of activity based funding, national elective surgery targets and the change in NSW to smaller local health districts. Surgeons must be more involved and aware of the changes that are taking place within their hospitals and local health district.

There is little to be gained by disinterest and simply complaining when changes are made and implemented. We must all be engaged in implementing change when necessary. The reality of rising healthcare costs and of the need to use the available resources in the most efficient manner must be acknowledged. Fellows need to attend hospital meetings when these issues are discussed and to voice their opinions and concerns, if necessary, in a logical fashion and, if available, with verifiable data.

Hospitals within local health districts must work in a co-operative rather than antagonistic fashion. The roles of some hospitals may need to change and surgeons may need to accept the requirement to move between hospitals in order to treat their patients.

It would appear that Fellows in rural areas are much more in tune with the situation in their local health districts than metropolitan surgeons. Fully acknowledging and accepting that we all have little time for leisure and family, I urge all Fellows to attend meetings when requested to do so by their heads of departments or division of surgery.

In an attempt to stay abreast of the issues that concern the Ministry of Health in New South Wales, the Regional Chair and Secretary meet on a bimonthly basis in the regional office with representatives from the Ministry and health care agencies to discuss and highlight issues which are of concern. These issues are brought back to the Regional Committee for discussion. The committee has representatives from all the surgical specialty groups



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The move has proven to be highly successful and offers NSW Fellows significant benefits  
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NSW Regional Chair Robert Costa, Federal Minister, Hon Tanya Plibersek and College President Michael Hollands opening the new NSW Regional Office in central Sydney.

and the impact of decisions as they apply to all areas of surgery can be more easily assessed and passed onto health authorities and specialty groups. A consensus view can then be passed onto the Ministry.

The provision of surgical services in non-metropolitan hospitals and some rural area of NSW remains an issue in some towns in NSW and is an area of concern to the Ministry of Health. The issue relates not only to the availability of specialist surgeons, but the availability of general practitioners with the surgical skills required in that particular geographical location. The College has initiated a review of GP Proceduralists. The committee was led by Graeme Campbell and is in the process of reporting its findings to Council. The Regional Committee plans to visit rural centres to hear the concerns of Fellows in those centres.

There are moves in NSW to investigate the merit of managing some surgical conditions in designated centres. Upper gastrointestinal malignancy has been one of the

conditions in question. Some surgeons feel that this review has been instigated by the College. However, the review has been initiated by the Cancer Institute after data suggesting that the caseload influences the results of surgery in some conditions became available. In many cases the issue relates to the availability of ancillary services rather than individual technical competency. In the majority of surgical conditions patient outcomes are equal, regardless of the geographical region of treatment.

It is pleasing to see the increasing involvement by Fellows in NSW public hospitals in the reporting of surgical mortality to CHASM. This voluntary review of surgical mortality helps identify areas of weakness in patient care. Disappointingly, with a few key exceptions, the NSW private hospital sector remains uninvolved in this vital sphere of surgical activity.

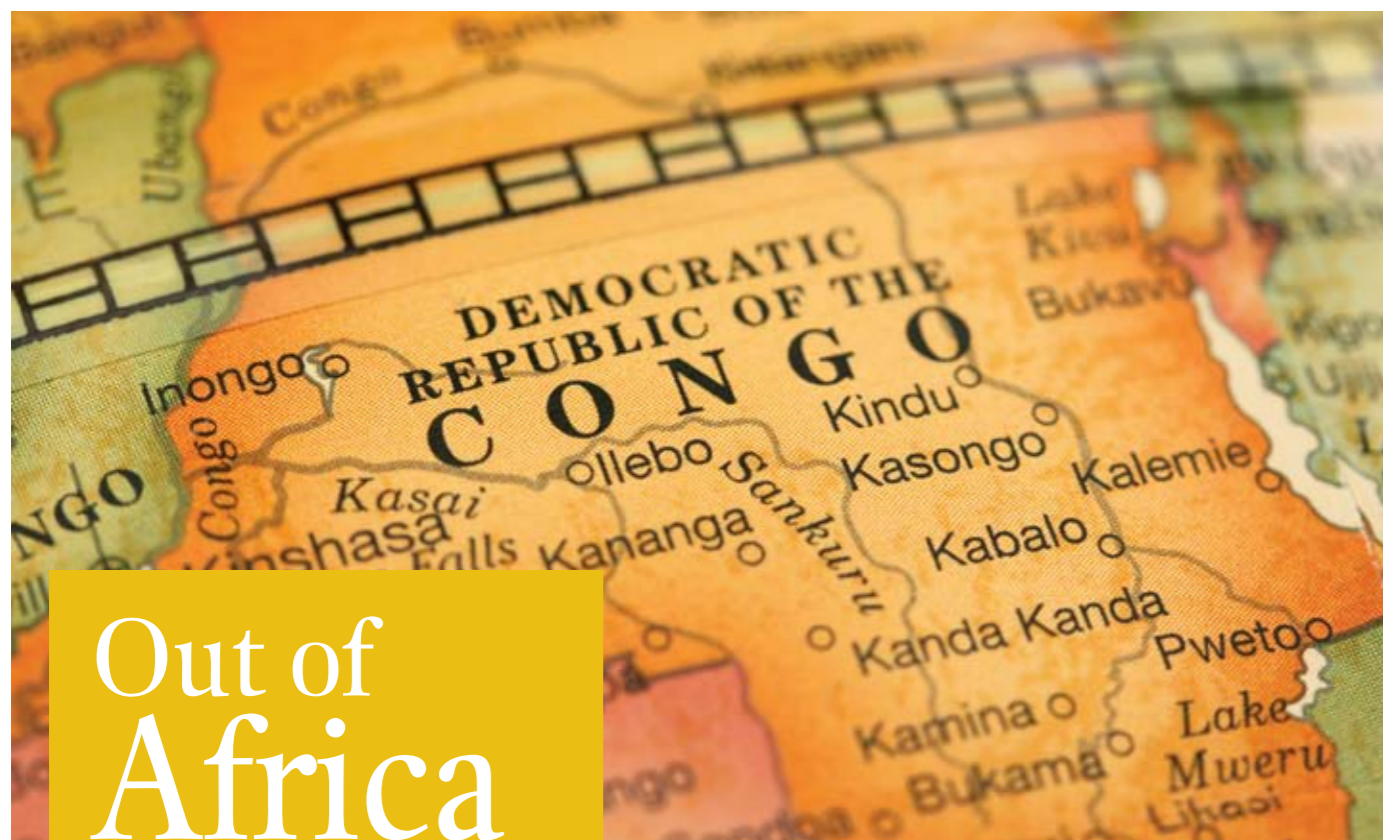
Surgical education remains at the forefront of the College activities and the Regional Committee is no exception. The committee has established dialogue with surgical interest groups at several

universities and now hosts a yearly essay competition. Surgeon's Month will be held in November this year and the aim is to promote involvement and interaction within the various groups and stakeholders in NSW.

A core group of events are being facilitated by the NSW Regional Office, some of which after highlights are two CPD courses, 'Keeping Trainees on Track' and 'Process Communication Model', as well as an opening event, the 'Younger Fellows Preparation for Practice' course, an open debate breakfast and a town hall talk by CHASM and the CEC. In conjunction with these, we are also inviting any stakeholder in NSW to become involved by holding a meeting or event and building awareness during Surgeons' Month.

In NSW, it is our goal to nurture a collegiate attitude where Fellows not only belong, but are proud to belong to our College and where there is increased involvement by Fellows in the life and activities of the College.

**Robert Costa**  
Chair, NSW Regional Committee



# Out of Africa

One of few surgeons in the Eastern Congo, Dr Luc has seen huge benefits in a recent trip to Brisbane and the ASC in Auckland

Dr Malemo 'Luc' Kalisa, one of only six qualified surgeons in Eastern Congo which has a population of approximately 30 million people, recently spent four weeks at the Princess Alexandra Hospital (PAH) in Brisbane and attended the Annual Scientific Congress in Auckland through funding provided by the College.

A recipient of the Surgeons International Award, Dr Luc was nominated by Mr Neil Wetzig, Breast and Endocrine Surgeon and Senior Visiting Surgeon at the PAH, who met Dr Luc during a visit to the strife-torn region in 2003.

Then working at the HEAL Africa hospital in Goma, one of only three tertiary hospitals in the Democratic Republic of Congo (DRC), Dr Luc was so committed to improving the medical care he could offer his patients he gave up his position as Senior Resident and left his family to travel to Kampala, Uganda, to undertake a three year surgical degree.

Throughout years of unrest and violence, Dr Luc focused on his studies to graduate

in 2010 and upon his return to Goma became the Director and the only General Surgeon in the 155-bed hospital which is solely funded through overseas aid sources.

Speaking at the end of his visit to New Zealand and Australia, Dr Luc said the five week trip had been invaluable not only in enhancing his surgical skills and knowledge, but for the opportunity to meet other surgeons and to explain the enormous surgical need in his country which has been largely isolated due to years of violence.

"I am a better surgeon than I was five weeks ago," he said.

"I am the only general surgeon at my hospital for six million people which can be an isolating experience so it was good to have many discussions about surgery at the Auckland meeting.

"I also learned a lot at different sessions particularly about the modern treatment of trauma, gastric surgery and breast and goitre surgery, all of which are major problems in my country.

"I also lecture and teach in Goma and

I learned new ways of teaching which I think will be important."

Dr Luc said that he was hopeful that the new UN-mandated peace-keeping force led by the African Union which has recently entered the region could finally bring some much longed-for stability.

This in turn, he said, could allow for more international surgical assistance to be provided in Goma along with the development of broader professional ties.

"I am hopeful that the African-led peacekeeping mission will stop the fighting in Eastern Congo and allow us to rebuild and when I return I will be going to Kinshasa (capital of DRC) to lobby for official support for trauma training and services," he said.

"Even here, I've found more and more people are aware of the medical needs of my country and two surgeons I think will be arriving to help us at the hospital because we now feel that peace is coming.

"I hope to be a leader of surgery and surgical education when I go home, but I know that we have a very long way to go.

"I was very glad to be able to show pictures of my hospital and patients and present statistics to surgeons and doctors in Auckland and Australia and I believe we will now gain more and more support and that makes me optimistic.

"I would also like to establish formal networks between my hospital and medical school in Goma and Australian surgeons when the security situation is better."

Dr Luc said he especially thanked Dr Wetzig for his mentorship, encouragement and support over the past seven years. He said he was now skilled at treating goitre disease through the training provided by Dr Wetzig. This is a particular problem in that part of Africa because the volcanic soil limits what can be grown, leaving an iodine-deficient diet based around cassava.

He also said he had particularly enjoyed working alongside Australian surgeons and doctors and nurses.

"I have been co-ordinating visits by US teams to the HEAL Africa Hospital for many years, but Australians are different because they ask us what we want, what we need and how they can help us rather than telling us what we should do.

"It is a true collaboration and that makes me very keen to establish strong links with Australia because it has surgeons with the best skills, the best health system and they are the best people to work with.

"I am also grateful to the College and the people in the International Section who helped me with the visa and travel arrangements because it was very stressful for me to get here, but they just kept working to make it possible."

Mr Wetzig not only encouraged Dr Luc to complete his surgical degree, but also helped to establish a charity, AusHEAL, to support Dr Luc's hospital.

Having worked at the Goma hospital and outreach clinics every year since 2006, Mr Wetzig said he knew Dr Luc had the potential to lead surgery in Eastern Congo and was pleased to be able to help.

He said that while Dr Luc could not operate during his time in Australia, surgeons across all specialties at the PAH had actively welcomed him into theatre to watch and learn the procedures of interest to him.

"I asked him at the start what he wanted to learn and he specified Upper GI, some Neurosurgery, abdominal

**"I am a better surgeon than I was five weeks ago"**



Top: 2013 ASC Convocation Luc Malemo with hosts Gwen and Neil Wetzig  
Above: Dr Luc in theatre at Princess Alexandra Hospital

surgery and to see how we teach students and Trainees," Mr Wetzig said.

"I also wanted him to see how we ran our operating theatres, the sterilisation process and access to instruments while also showing him the running of the whole surgical department including morbidity and mortality audit meetings.

"Dr Luc is extraordinary so it is a delight to be of assistance. He is highly intelligent, extremely keen to learn, but perhaps most importantly he is very keen to share his knowledge which is not common in Africa where knowledge is power which equates to status and money.

"He stayed in our home during his time in Brisbane and was a delightful guest and I was thrilled to see how my colleagues embraced him."

Mr Wetzig said he first visited Goma

after Dr Luc's boss and founder of the HEAL Africa hospital in Goma (a Congolese Orthopaedic surgeon) came to Australia asking for specialist visits. He went there in 2003 for an exploratory trip to see if such visits were feasible.

He then led the first team visit in 2006. That team now includes core members: Plastic and Reconstructive Surgeon Paul Millican, Anaesthetists Dr Anthony Fisher and Dr Peter Tralagan, Radiologist Dr Murray Thorn, Radiographer Mrs Sue Reid, Dentist Dr John Yared and retired hospital administrator Mr David Kelly to teach hospital management systems.

Mr Wetzig's wife Gwen co-ordinates the logistics for the team and teaches English during the trips while Robin Yared, an educationalist, helps with teaching and training techniques for the medical teachers. ▶

**Royal Australasian College of Surgeons**  
Nominations invited for the  
**SURGEONS INTERNATIONAL AWARD**

The Surgeons International Award provides for doctors, nurses or other health professionals from developing communities to undertake short term visits to one or more Australian or New Zealand hospitals to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's country.

The Award may cover a return economy class airfare, necessary accommodation costs and living expenses for the recipient. The value of the award varies up to a total amount of AU \$12,000, depending on the requirements of the candidate's program.

Fellows participating in the RACS International Development Program or international outreach work are encouraged to nominate worthy individuals they have identified while undertaking outreach work.

Fellows who nominate worthy individuals with whom they have had contact must be willing to accept the responsibility for arranging a suitable program and acting as a personal host to the award recipient.

**NOMINATIONS MUST INCLUDE**

- > Personal and professional information concerning the nominee;
- > Objectives of the proposed visit;
- > Anticipated benefits to the nominee and their home country;
- > Names of the International Development Program team members responsible for organising the visit (including accommodation, training program and travel within Australia);
- > An outline of the proposed training program and activities; and
- > Letters of recommendation from the nominee's hospital and/or Health Department with an indication of the local importance of any upskilling resulting from the Award.



Dr Malemo Luc Kalisya from the Democratic Republic of Congo was supported to participate at the RACS ASC 2013 in Auckland, and undertook a four week hospital attachment at Princess Alexandra Hospital under the mentorship of Dr Neil Wetzig. Dr Wetzig has been working with Dr Luc and his colleagues during annual visits to the D.R. Congo for over 10 years.

**CONTACT INFORMATION**

*For further information or to submit an application*

International Scholarships Officer  
Royal Australasian College of Surgeons  
College of Surgeons' Gardens  
250 – 290 Spring St, East Melbourne VIC 3002, Australia

*Or by fax or email to:*

Telephone: +61 3 9249 1211 Fax: +61 3 9276 7431  
Email: international.scholarships@surgeons.org



Dr Luc outside the Princess Alexandra Hospital

"I love my trips there and it is hard not to fall in love with Africa and its people over time," Mr Wetzig said.

"But it can be stressful not just because of the unrest, but more because you see medical conditions and advanced pathology that you may never have seen before and you have to work in poor conditions with little backup and no high-tech equipment.

"Sometimes I find that hard, but I just remember that if not for the help I can provide, the patients will continue to suffer and sometimes die and so I just do the best I can.

"The people are also very appreciative and gentle despite what you might expect in such a restive region."

Mr Wetzig said AusHEAL had only been established in recent years and was now receiving some private and corporate donations to support educational and training opportunities for the Congolese hospital staff as well as medical and IT equipment and supplies.

He said that, although the College's main focus was quite rightly the Asia-Pacific region, he hoped the College might continue to offer some support to surgeons working in Africa.

"Dr Luc gave a very compelling talk at the ASC about surgery in isolation even in terms of being unable to consult anyone about difficult cases and if he is saying he would like professional support I would like to think we might be able to provide it," Mr Wetzig said.

"The College has an international profile and we have the potential to improve medical care wherever the need may be, not just within our own geographical region and I think as Australians we have a desire to 'help the underdog'.

"This part of Africa has been largely forgotten because of instability, but if the peace-keeping mission works as planned I think it would be wonderful to help Dr Luc and others to become the best surgeons they can be."

Mr Wetzig is planning another visit to Goma in August.

For further information about AusHEAL and how you may support it please email info@ausheal.org

*With Karen Murphy*

# Training surgeons and informed consent

A balancing act between the need to train and duty to inform a patient



The extensive training programs for medical practitioners provided by teaching hospitals and medical colleges are integral to the growth and success of the medical profession. While, it is important that Trainees are exposed to as broad a range of practical situations involving the treatment and care of patients as is possible, important questions remain when one considers the implications of informed consent and its relationship with the involvement of Trainees in surgery. It

should be the goal of all stakeholders in the medical industry, and for the wider public, that a balance be struck between the need to train doctors and the duty to adequately inform a patient.

The issue is one of disclosure, and the extent to which standard consent forms adequately discharge legal duties to inform patients of material risks in surgeries. This report will examine the current legal position in Australia and New Zealand pertaining to this

issue of adequate disclosure where the involvement of a Trainee could be seen as a material risk.

## Delegation

The first issue that must be examined when looking at whether or not full disclosure of material risks and thus, informed consent, has been achieved is that of delegation. Typically, it is up to the treating doctor to advise a patient of all material risks associated with a surgery and to obtain informed consent.

However, it is also normal in many hospitals for a doctor to delegate this responsibility of obtaining consent to assisting doctors or Trainees. Nevertheless, it must be noted by treating doctors that it is their personal duty to inform a patient of material risks associated with a procedure and in instances of delegation, it is the treating doctor who will be liable for any breach of this duty by those who attempt to inform a patient.

## Informed Consent

The Australian legal position with respect to informed consent comes from the matter of *Rogers v Whitaker*, decided in 1992.<sup>1</sup> In this matter, the High Court of Australia examined the scope of a doctor's duty to inform a patient of all material risks related to their care and treatment. In a joint judgment, the unanimous Court reasoned that:

*"a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."*<sup>2</sup>

In other words, a doctor, in informing their patient of risks associated with a certain treatment, should consider whether or not a patient would be likely to change their mind about undergoing the procedure.

The implications of this are considered by the Court in *Rogers v Whitaker*. For example, the Court noted that even in situations where a reasonable person would not attach significant risk to a course of treatment, if a doctor ought to have realised that a certain patient was

“ It is generally accepted that a patient must be informed if a Trainee or someone of limited experience is to be involved in a procedure ”



likely to consider the risk to be significant they may have breached their duty to obtain informed consent. This could be particularly problematic in the event of a nervous or uncomfortable patient undergoing a routine procedure with a low risk of complication. If that patient were to be informed that their surgeon was relatively inexperienced, they are likely to request a more senior doctor even if it would be perfectly reasonable and normal for a Trainee to perform the procedure. This could prove challenging for hospitals and colleges in two ways, as it will impose added pressure on more experienced doctors while denying Trainees the chance to gain valuable experience.

### Trainees

It is generally accepted that a patient must be informed if a Trainee or someone of limited experience is to be involved in a

procedure. This has been recognised in numerous international cases,<sup>3</sup> as well as in the High Court of Australia decision of *Chappel v Hart*.<sup>4</sup>

In *Chappel v Hart*, the Court noted that the patient-plaintiff would not have undergone the surgery had she been informed of the relative inexperience of the surgeon. While the question of whether or not inexperience amounted to a material risk was not decided by the Court, they indicated a willingness to recognise that it would be reasonable for a patient to attach significant risk to a doctor's level of inexperience.

Academic discussion on this issue, however, holds concerns relating to 'hindsight bias' in finding that a failure to disclose inexperience 'caused' a patient-plaintiff's injury.<sup>5</sup> It is natural that in the instance of surgical complications a plaintiff will argue that had they known that more experienced doctors

were available they never would have agreed to the surgery. Gleeson CJ of the High Court discussed this problem from an evidentiary perspective in the matter of *Rosenberg v Percival* decided in 2001.<sup>6</sup> He reasoned that the Court should have regard to all circumstances of the case in determining whether or not a patient would have or would not have agreed to the surgery. While this may be problematic from an evidentiary perspective it should not affect the proposition that a patient might reasonably attach significant risk to the involvement of a Trainee in surgery.

In fact, a recent study completed by the Archives of Surgery, a journal published by the American Medical Association, indicates that patients do generally attach significant risk to the involvement of Trainees in surgical procedures.<sup>7</sup> This study concluded that while the majority of patients interviewed fully support the

training of surgeons and would be willing for Trainees to participate (94 per cent of those interviewed), their willingness to have a Trainee assist with their surgery declined rapidly as the level of hypothetical Trainee involvement increased. It was concluded that despite the fact that this information could adversely affect Trainee participation and training, providing detail for fully informed consent was preferred.

It was also noted that where more information was given about the particular Trainee, a patient was more likely to be willing to consent to the participation of a senior Trainee as opposed to a junior Trainee. Australian academic discussion exists on this point.<sup>8</sup> It is argued by certain academics that increased disclosure about a Trainee's particular skill level is undesirable as it may lead to confusion between a Trainee's skill level and their experience. Indeed, a Trainee with limited overall experience may be entirely capable of performing certain procedures under the supervision of a more experienced surgeon. Without adequate explanation, this confusion could lead to a misunderstanding as to risk and thus a breach of duty to inform.

Despite all of these examples recognising the importance of disclosure of the involvement of Trainees in surgical procedures from both the patient's perspective and from a liability perspective, there is little legal guidance as to the extent of disclosure required to adequately discharge legal obligations to obtain informed consent.

In New Zealand, a decision of the New Zealand Health & Disability Commissioner also had to consider the consent required where surgery was to be performed by two supervised Registrars, rather than the Consultant Surgeon personally. The Commissioner in that case suggested that it would have been better for the patient to have been advised of "the role of the Trainee neurosurgeons and the extent of (the Consultant's) supervision". The Commissioner was advised by the local Health Board that it was usual that Consultants in Australia

and New Zealand would not specifically advise a patient that the procedure would be carried out by the Consultant, or that some of the procedure may be carried out by Trainees under supervision. In considering the matter, the Commissioner made recommendations that the patient should have been advised of the roles of the Trainees and the Consultant, particularly having regard to New Zealand's Code of Health and Disability Services Consumer Rights, which highlights the need for appropriate informed consent.

It is likely that a Court will require, at the very least, that a patient be informed of the involvement of the Trainee, and, in situations where the doctor ought reasonably to recognise that a patient might attach significant risk to the increasing involvement of a Trainee then for the level of information disclosed to the patient to be adjusted accordingly. This explanation incorporates the test as it stands in *Rogers v Whitaker* while also taking into account the concerns of later Courts.

Put more simply, the disclosure requirement with respect to Trainees is likely to depend on each individual patient, with Courts looking at all relevant evidence to determine whether or not a doctor should have known that the patient would have been concerned about their involvement.

### Public vs. Private Hospitals

One final consideration centres on the practical implications of this understanding of what constitutes adequate disclosure in public and private hospitals. Private hospitals and their clientele obviously have more choice when it comes to the level of use of Trainees in surgery. The hospital, by dint of the fact that they are private, is not forced to act as a 'training hospital' and can therefore exercise greater discretion as to the use of Trainees. Further, given that the patients are private patients, they have greater influence as to who they want operating on them.

This situation in public hospitals is rather different. In those hospitals the

use of Trainees in surgery is required in order to properly train those surgeons. Further, patients have little practical say in who their surgeon is, with many patients sitting on waiting lists for many months. This is due to the fact that while a patient may refuse to give consent to a particular surgeon performing a surgery, they often are not presented with much scope to choose, and may not be in a position to refuse. It is difficult to determine what the eventual consequences of a delineation between public and private might be; however, any further pressure on public hospitals may cause a variance in the quality of services offered.

There continues to be uncertainty at law as to the extent of information required to be provided to a patient where Trainees perform some or all of the work.



Michael Gorton,  
College Solicitor

With Tom Moodie, Law Clerk

### References

1. *Rogers v Whitaker* (1992) 109 ALR 625.
2. *Ibid* at 626.
3. *Considine v Camp Hill Hospital et al* (1982) 133 DLR (3d) 11 (Nova Scotia SC), *Buie v Reynolds* (1977) OK CIV APP 25, *Pugsley v Privette* 263 S.E. 2d 69, 74 (Va. 1980).
4. *Chappel v Hart* (1998) 195 CLR 232.
5. Liability for negligent failure to disclose medical risks, Danuta Mendelson, (2001) 8 JLM 358.
6. *Rosenberg v Percival* (2001) 205 CLR 434.
7. Training surgeons and the informed consent process, Archives of Surgery, September 19, 2011, accessed at [archsurg.ama-assn.org/cgi/content/abstract/archsurg.2011.235v1](http://archsurg.ama-assn.org/cgi/content/abstract/archsurg.2011.235v1)
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# Reflections on the DCAS

Reinvigorating Academic Surgery through grassroots intervention

The recent Developing a Career in Academic Surgery (DCAS) course in Auckland was an event that offered an insight into current issues affecting the field of Academic Surgery and the importance of research, leadership and mentorship in a surgical career. For a group of medical students from Griffith University, the event was inspirational and thought-provoking, and has sparked our motivation to bring the ideas and opportunities provided by DCAS back with us to Griffith University.

The DCAS had a wide range of discussion focused on research for surgeons as a part of clinical practice and as a component of a career in Academic Surgery. The course outlined the benefits for the community, the health care system, patients and clinicians in having a strong research culture in Australasia.

Many centres around the region are pioneering new, innovative and exciting research projects; however, there is room for expansion of this enterprise

in certain sectors to ensure Australasia is a global force in research. The Gold Coast is a good example, where research infrastructure is slowly progressing, but the required funding and support are not in place to produce a vibrant research culture.

In the current climate, there are only a small number of true surgeon-scientists working in Australasia who consider research as a key aspect of their surgical career. It is crucial that the recent increase in surgical research is continued through to the next generation of younger doctors who are progressing through their training. Research has sometimes suffered due to tight budgets and a system with a narrow view of patient care. However, research is a dynamic aspect of serious patient care that directly improves health care provision through innovative new treatments, optimisation of processes and the fine-tuning of continued patient care.

The DCAS course outlined the importance of research in surgical

practice. It was evident from the variety of speakers at the course that gross changes must occur to evolve the science of healthcare and improve innovations in surgical practice and patient care through developments in research.

As members of the next generation of healthcare in the country, we have a responsibility to ensure changes at the grassroots level encourage research in the medical world and enhance the culture and attitude towards research in Australasia. With this belief, along with the healthy dose of inspiration received from the DCAS and its exceptional speakers, the group of Griffith University students who attended the course in Auckland plan to be instrumental in creating a Research Program with our local surgical society, the Surgical Interest Association (Surgia).

Beginning in 2014, the Research Program plans to realise the opportunities discussed and outlined at the DCAS for the hundreds of medical

“

*Research is a dynamic aspect of serious patient care that directly improves health care provision through innovative new treatments, optimisation of processes and fine-tuning continued patient care* ”



At this year's College ASC: Elliot Dolan-Evans, Aditi Rai, Samuel Matthews, Daniel Cattanach

students in South-East Queensland. Operating in a similar way to an honours year, the Program plans to initially link motivated students with researchers for 12 months, matching students and researchers based on interests, goals and personal interactions between the two parties.

Surgia will then provide workshops and seminars throughout the year for students involved in the Program (along with other interested members of the organisation) that aim to increase students' competence in research. These events may target topics such as statistics, presentations and thesis writing, held at times during the Program that is relevant to the current activities of participants. The Research Program will be preceded by a Mixer Evening to link students and researchers, and then be followed by a celebration event,

where students can present the work they produced during the year.

Surgia will provide research opportunities for students who were previously unable to access these and guide them through the potentially difficult research process with supportive guidance from the Program convenors and the range of innovative events.

This Program will be vital in changing the relatively negative attitudes medical students have towards research, and really be an extension of the DCAS Course. Medical research in Australia needs to evolve, and it is the next generation of surgeons at Surgia who will initiate this process.

The future of Academic Surgery will be helped by initiatives such as these, and hopefully the innovative Research Program described here will act as a call

for medical students to take responsibility in addressing current issues where and when change is required.

Students across Australasia see the importance of research and want to partner with more senior surgical mentors in producing research, but often students are unsure of how to access the opportunities available and start their academic journey. The Research Program, along with other Surgia events, demonstrates that medical students can be involved in driving exciting new initiatives alongside a support surgical and medical community – especially when inspirational mentors, such as those at the DCAS, provide the spark to light the fire.

**Elliot Dolan-Evans**  
**John Windsor**  
*Chair, Academic Surgery*

# 2013 Trauma Symposium

Out of the heat and dust ... Sharpening the cutting edge of trauma care – applying lessons learned in war and austere environs

Each year during ‘Trauma Week’, the College Trauma Committee holds a one-day meeting to explore issues surrounding ‘Trauma’ where it is felt that further development or improvements can be made. Past topics have included trauma verification, the cost of trauma, injury in Indigenous populations, road safety, outcome analysis and alcohol related injury.

This year, the Trauma Committee is presenting lessons learned by surgical teams deployed to the Middle East Area of Operations (MEAO) and exploring the application of these lessons to trauma care in Australia and New Zealand.

The stunning survival rate we see in casualties in Afghanistan (98 per cent) has been achieved with improvements in the way we do business rather than in expensive technological developments. The focus has been taking what we already know, and doing it better.

In the MEAO there have been changes in pre-hospital care and retrieval systems. Hospitals have been set up with all systems focused on the trauma patient, and any perceived block to optimal care has been removed. Emergency room (ER) teams are trained and rostered to work as a team with extension of the core ER resuscitation team to include other specialists.

Roles are aligned with individual strengths, territorial boundaries and egos are removed and all trauma care is focused on achieving the best outcome for the patient. Experienced leadership in the care of the trauma patient is critical. This element will be specifically explored from the perspective of various specialties.

The Joint Theater Trauma Registry (JTTR) has continued to develop as a core foundation of the US developed Joint Theater Trauma System (JTTS)

“  
**Roles are aligned with individual strengths, territorial boundaries and egos are removed and all trauma care is focused on achieving the best outcome for the patient**”



Dr Annette Holian

providing data for regular evidence based updating of all clinical practice guidelines. Communication throughout the patient journey from point of injury to rehabilitation centre in continental US is facilitated by weekly teleconferences of all caregivers including the transport

teams involved will individual patients. This gives timely feedback and provides critical information to improve outcomes. Clinical practice guidelines set the benchmark for the standard of care in most clinical scenarios. Deviation from that evidenced based pathway is possible, but must be justified and openly discussed. Medical staff who have deployed and worked within the system will present some of the key features of the relevant clinical pathways.

If a small proportion of these lessons were applied to trauma centres in Australia and New Zealand improved outcomes could result.

We are most fortunate that Dr Annette Holian is convening this symposium. A Group Captain with the Royal Australian Air Force, Annette is an orthopaedic and trauma surgeon, Clinical Director for Surgical and Perioperative Services in RAAF, Deputy Director of Trauma at the National Critical Care and Trauma Response Centre at Royal Darwin Hospital, a member of the College Trauma Committee and Chair of the Disaster Preparedness Sub-Committee. Annette’s experience with the ADF and trauma centres in Australia will bring experts in these fields together hoping to forge new and improved pathways for our trauma patients.

The day long symposium will be held on 21 November in the Hughes Room at the College during Trauma Week. As this is a practical clinical based symposium, registrants will be surgeons, nurses, paramedics, intensivists, emergency physicians and other professional groups with an interest in trauma, the military and remote/ disaster environments.

Speakers include emergency physicians and retrievalists, anaesthetists, general surgeons, orthopaedic surgeons, trauma,

peri-operative and intensive care nurses who bring their experience and expertise to the symposium. Sessions will include:

- Teams and team work
- Pre-hospital care and MERT (Medical Emergency Response Team) training
- ER initial assessment and resuscitation with an ER time limit of 30 minutes
- Damage control surgery with concurrent surgeries and an on-table time limit of 90 minutes
- Clinical guidelines in trauma care developed from trauma registry data
- Leadership in trauma care

If you are interested in participating in this symposium, circle the 21 November date in your diary. Please pass this information on to interested parties.

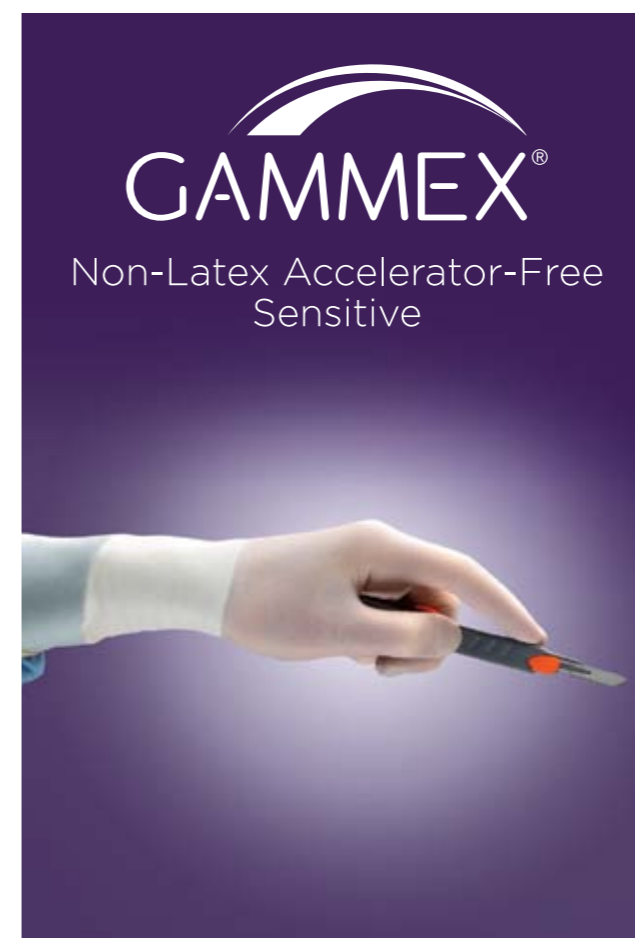
**Daryl Wall**

Chair, Trauma Committee

**Trauma week at the College is a busy time with many trauma professionals in Melbourne to attend meetings, symposiums, courses and conferences. The following activities have been scheduled:**

- 10 – 12 November** DSTC course – (Epworth Hospital)
- 20 November** **AM:** Trauma Sub-Committees face to face meetings: DSTC, Disaster Preparedness, Road Trauma, Trauma Quality Improvement, Trauma Verification  
**PM:** Trauma Committee face-to-face meeting
- 21 November** Trauma Symposium ‘Out of the heat & dust – sharpening the cutting edge of trauma care - Applying lessons learned in war and austere environs’.  
Australian Trauma Society AGM 1pm-2pm

For further information about the Trauma Workshop or any of the trauma activities at the College, go to the Trauma Committee web page on the College website – or contact Lyn Journeaux at the College Trauma office on +61 3 9276 7448 email: [trauma@surgeons.org](mailto:trauma@surgeons.org)



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Cover Story



## A clearer picture

A Foundation for Surgery Scholarship has helped this Trainee update language in her field

ENT Trainee Dr Alice Guidera has used the funds attached to a 2012 Foundation for Surgery Scholarship to develop a detailed understanding of the anatomical arrangement of cervical fascia and clarify the anatomy of the parapharyngeal compartment (PPC).

Dr Guidera said that while an accurate understanding of the PPC and cervical fascia were essential for differential diagnosis, predicting the spread of disease and surgical management, the current terminology was confusing and inconsistent, creating important interdisciplinary differences in understanding.

As part of a Masters of Medical Science Degree through the University of Otago in Dunedin, Dr Guidera first conducted a review of terminology and descriptions in contemporary reference texts recommended by the RACS followed by a detailed review of current scientific and clinical literature.

“The current terminology used to describe the cervical fascia and its compartments is replete with confusing synonyms and inconsistencies and we aimed to revise the nomenclature, underpinned by evidence-based anatomical and radiological findings, in

order to enhance understanding of the region,” she said.

Dr Guidera said that while she had developed new descriptions and a revised nomenclature, she did not expect all medical texts to immediately adopt the study’s conclusions. However, she hopes that her research might stimulate discussion so that antiquated terms were discarded and a more consistent understanding of the cervical fascia would be developed.

“I think the recommendations made by us for the descriptions and nomenclature of the cervical fascia

“

*This approach has limits so we tried to use several different techniques to get a better three-dimensional grasp of the fascial arrangement*”

and its compartments are sound,” she said. “They are based on thorough research of previous descriptions and our own experience, and we have used terminology that we know is useful in clinical practice.”

Also as part of her research, Dr Guidera conducted anatomical investigations of the anatomy of the PPC using dissection, serial histological sections and magnetic resonance imaging of cadaver specimens.

“A lot of previous studies had looked at very specific areas of the PPC in isolation or only employed one investigative technique and then extrapolated their findings to the whole area,” she said.

“This approach has limits so we tried to use several different techniques to get a better three-dimensional grasp of the fascial arrangement.

“My research was informed by newer technologies that are approaching the PPC in a way that has not been extensively described, so the aim of my work was to clearly describe reliable landmarks found in the anatomy of the region so that in complex procedures, surgeons can have secure reference points that will help with reliable and safe surgical approaches.

“The three-dimensional anatomy of the PPC is complex. It is a deep compartment that is difficult to access and one that is not oriented along traditional imaging planes.

“The study has clarified the borders, communications and contents of the PPC which should help to optimise minimally-invasive surgical approaches, particularly transoral approaches,

intraoperative orientation within the compartment, and reduce the risk of inadvertent damage to regional neurovascular structures.”

Working through the Departments of Surgical Sciences and Anatomy, Dr Guidera was supervised by Associate Professor of Otolaryngology Patrick Dawes and Professor of Anatomy Mark Stringer.

Now back as a SET 4 Trainee working at Christchurch Hospital, Dr Guidera said the support of the College had been critical in allowing her to undertake the research. “Having the luxury of having a whole year to really get to the bottom of a problem was invaluable,” she said.

“To read around the issue in depth, have stimulating discussions with my supervisors in a world class anatomy department and be able to dissect and investigate the anatomy for myself was extremely rewarding and I would recommend this type of research to any surgeon.

“Clinical practice requires total concentration and commitment and it would have been very difficult to switch between research and clinical work. Without the support of the RACS I probably wouldn’t have been able to undertake this research.”

The Foundation for Surgery Scholarship provided to Dr Guidera came with a \$55,000 stipend of which 25 per cent was contributed by the Department of Surgical Sciences of the Dunedin School of Medicine.

*With Karen Murphy*

### Publications

**2012** - Guidera A.K., Dawes P.J.D., Stringer M.D. (2012) Cervical fascia: a terminological pain in the neck. ANZ Journal of Surgery 82(11):786-91

**2013** - Guidera A.K., Dawes P.J.D., Fong A., Stinger M.D. (Accepted for publication 2013) Cervical fascia and its compartments: No space for spaces. Head and Neck

### Oral presentations

**2012** - Guidera A.K., Stringer M.D., Fong A., Dawes P.J.D. Surgical Anatomy of the Parapharyngeal Compartment. The 49th Annual Scientific Meeting of the Surgical Research Society, Adelaide, South Australia. November 9 2012

**2013** - Guidera A.K., Stringer M.D., Fong A., Dawes P.J.D. Surgical Anatomy of the Parapharyngeal Compartment. 63rd Annual Scientific Meeting of ASOHNS, Perth, Western Australia. March 16-20 2013

**2013** - Dawes P.J.D. Head and Neck Fascia: No Space for Spaces. 82nd Annual Scientific Congress of the RACS, Auckland, New Zealand. 6-10 May 2013

**2013** - Guidera A.K. Surgical Anatomy of the Parapharyngeal Compartment. Accepted for free paper presentation. 66th Annual General and Scientific Meeting of NZOHNS, Ruapehu, NZ. August 2013

**2013** - Dawes P.J.D., Guidera A.K. Cervical Fascia: A Pain in the Neck. Invited speaker. 66th Annual General and Scientific Meeting of NZOHNS, Ruapehu, NZ. August 2013



76 Squadron at Noemfoor

# Surgeons at war in New Guinea

An insight into another time

It was September 1942 and the war in the Pacific had spread to New Guinea. Captain Alan Watson had been appointed as a Dental Officer to the 2/4<sup>th</sup> Field Ambulance and soon found himself on the Kokoda Trail.

In a world where basic commodities were in short supply and innovation was paramount, it became necessary for Watson to work as an anaesthetist so that he could assist the surgical team. As his war diary records in the last months of 1942, Watson administered more than

90 general anaesthetics. He was also kept busy with his dental work and during his entire period on the Kokoda Trail was not able to acquire any replacement medications or instruments.

An amateur photographer, Alan Watson who owned a Leica camera became unofficial photographer to the 2/4<sup>th</sup> Field Ambulance. His photographs form the basis of a DVD held in the College archive. Although the quality of the migrated photographs is indifferent, the detailed commentary takes the viewer up

the steep and difficult trail to places such as Myola where the Field Ambulance had one of its best camps.

The Field Ambulance was the “first organisation in the field” and capable of “instant movement and change”, it was “spread out along the track in a series of posts”. Watson captures the transitory nature of the unit and its myriad problems like the difficulty of getting supplies and the trials of operating by hurricane lantern. He also praises the role of the indigenous carriers who after carrying heavy loads up the track, returned with the wounded on stretchers. Reference is made to other sources such as the war diary of Lt Colonel Hobson and to Captain Douglas Leslie, a respected colleague and Fellow of the College who was custodian of the 2/4<sup>th</sup> Ambulance’s minute book.

In early 1944 the Admiralty Islands located 320 kilometres North East of mainland New Guinea were taken

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*Our unit had an epidemic of malaria, but some of the cases may have been Dengue fever*”

from the Japanese by allied forces. Soon after the Momote airfield became an allied base and Flight Lieutenant Charles Roe was appointed as 76 Squadron’s medical officer. After the war, Roe had a distinguished career as a Urologist and was active in the AMA. He also wrote an account of his experiences with 76 Squadron and this can be found in the College archive.

When the allies invaded, there were approximately 3,000 Japanese soldiers in the Admiralties but of these, 12 were taken prisoner and the rest were killed. Roe describes the scene after the battle:

*“Disease was rife on the battlefields for a couple of weeks with craters half full of stinking water breeding mosquitoes in the millions, Japanese corpses and rubbish lying everywhere ... our unit had an epidemic of malaria, but some of the cases may have been Dengue fever.”*

Roe’s reminiscences often had to do with food which was scarce when he first arrived in Momote. On one occasion the squadron went fishing, but as Roe says, “this was no ordinary fishing – it was fishing using one of the Squadron’s expendable resources – a 350lb bomb!” Other anecdotes tell of the exploits of the Squadron, the role of American Liberator bombers who used Momote as a base for bombing the Japanese in the Truk Islands and his later experiences with the squadron on the island of Noemfoor.

The sources in the archive relating to the war in New Guinea tell stories that have an immediacy so often found in primary sources – an interesting and at times, unconventional resource, but one that has enduring value for researchers.

*Elizabeth Milford*

Charles Roe, second from right



## DECLARE YOUR LOVE FOR THE CITY

Melbourne Open House  
Saturday 27 and  
Sunday 28 July 2013



**A major public event in the calendar of Melbourne.**

Last year the College opened its doors to the general public as part of the Melbourne Open House weekend.

Some 75 buildings not normally open to the public participated. Over 106,000 people from Melbourne, regional Victoria, interstate and overseas attended. The College received about 750 visitors over the weekend.

**This year we plan to do it again.**

The areas of the College which will be open to the public are: Council Room, Hailes Room, Hughes Room and the Skills Lab.

For more information please contact Geoff Down at the College.  
+61 3 9249 1200

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**HUGH JOHNSTON ANZ CHAPTER  
AMERICAN COLLEGE OF SURGEONS  
TRAVELLING FELLOWSHIP**



The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship has been established to support an Australian or New Zealand Fellow of the College to attend the annual American College of Surgeons (ACS) Congress in October 2014. The Fellowship forms part of a bi-lateral exchange with the ACS. Due to available funding, applications have been extended. This Fellowship is open to Fellows who have gained their FRACS in the past 10 years. Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America.

**While there, they must:**

- Attend and participate in the American College of Surgeons Annual Clinical Congress 2014, being held in San Francisco, CA, USA, **26-30 October 2014**
- Participate in the formal convocation ceremony of that congress
- Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications.

The Scholarship is valued at AU\$8,000

**Applications close Monday 5 August 2013.**



**JOHN BUCKINGHAM TRAVELLING SCHOLARSHIP  
of the ANZ Chapter of the  
American College of Surgeons (ACS)**



**Background**

The late John Buckingham was a well-loved specialist breast cancer surgeon who pioneered the sentinel node mapping technique. He contributed significantly to BreastScreen Australia and was also highly regarded in the international arena. In recognition of his great love of teaching, the John Buckingham Travelling Scholarship has been established to encourage international exchange of information concerning surgical science, practice and education. It also aims to establish professional and academic collaborations and friendships amongst Trainees.

**Eligibility Criteria**

Due to availability of funding, applications for this Scholarship have been extended. They are open to current Australian and New Zealand SET Trainees. Applicants are expected to be a Member of or have applied for Resident Membership of the ACS with the intention of gaining Fellowship of the ACS in the future, and for Membership of the ANZ Chapter of the ACS.

This Scholarship is offered for short term travel. Applicants will be required to attend the ACS Annual Clinical Congress being held 6-10 October 2013, in Washington DC, USA, as well as the next Annual General Meeting of the ANZ Chapter of the ACS which occurs at the Annual Scientific Congress of the RACS.

**Applicants must supply the following in the application:**

- 1000 word dissertation outlining the proposed benefits of the Scholarship
- Current CV
- Supporting references from two referees

**Value**

The Scholarship is valued at AU\$3,000

**More Information**

Please read the Important General Information and the Scholarship Conditions prior to submitting your application. This information is available on our website by following the prompts to the Travel Scholarships at <http://www.surgeons.org/scholarships>.

**Please submit applications to:**

Mrs Sue Pleass,  
Scholarship Program Coordinator  
Royal Australasian College of Surgeons  
199 Ward Street, North Adelaide  
SA 5006  
**Ph:** 08 8219 0900  
**Email:** [scholarships@surgeons.org](mailto:scholarships@surgeons.org)  
Applications close Monday 5 August 2013.

**Indigenous Health**



**Foundation for Surgery**

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**The path to  
FRACS**

The 2<sup>nd</sup> Australasian Students' Surgical Conference – reflections by Indigenous medical students

The recent Annual Scientific Congress (ASC) in Auckland saw two Maori doctors celebrate their graduation as Fellows of the College. They join a very small group of six known Indigenous surgeons in Australia and New Zealand. On the Sunday prior to the ASC, the University of Auckland Surgical Society with active support from the Royal Australasian College of Surgeons, hosted the second Australasian Students' Surgical Conference in Auckland.

Thanks to thoughtful donations from Fellows made to the Foundation for Surgery, the College supported the attendance of five Indigenous medical students at the gathering. The aim of this forum is to inform aspiring surgeons of the current and future requirements of a surgical career and the training it will involve. It seeks to inspire students with specialty speeches and practical workshops and provide a platform for students to present their surgical research.

Three Aboriginal students and two Maori students were selected to attend by the Indigenous Health Committee in consultation with AIDA and Te ORA.

**Gordon Reid**

Gordon is a second year medical student at the University of Newcastle. A Widajuiir man from the NSW Central Coast his interests lie in the fields of plastic and reconstructive surgery and faciomaxillary surgery.

"This conference was a remarkable experience. It was interesting, engaging, fulfilling and exciting. It provided me with a range of tools necessary to begin my path to a career in surgery and beyond.



**This conference was a remarkable experience. It was interesting, engaging, fulfilling and exciting**

It also conveyed that, as an Indigenous medical student, surgery would provide me with an opportunity to work as part of a team, of both Indigenous and non-Indigenous peoples, to provide a service for the local community and Australia."

Gordon found particularly engaging the keynote address by Professor John Windsor, 'A Road Less Travelled – Critical Reflections on a Career in Academic Surgery' as it "offered an enticing view into a path of surgery that is rising in popularity and is essential for the development of new surgical techniques and treatment to improve the lives of many".

**Sean Lewis**

Sean is in his fourth year of medicine at the University of Otago. Like the others he found the individual specialty presentations insightful and informative.

"The initial talks from a surgeon of each specialty were highly valuable, as it is becoming increasingly clear that we really do not know what to expect from each area of medicine. It was nice to hear exactly what each specialty entails, not only what a normal week would hold, but also how a lifestyle can be moulded around each, and another interesting thing was to hear what each speaker thought about the down side to their job ... Having the actual path into a surgical career [explained] was also very beneficial ... knowing exactly what was needed, and also having been told the numbers that get through each year was really good. It was told to us in a realistic way that wasn't discouraging, just clear."

**Nicole Whitson**

Nicole is in her second year of medicine at the University of Newcastle. Nicole's ultimate dream is to be a cardiothoracic surgeon.

"Before this conference commenced, I was unsure as to the process of entering surgical training programs and the path into surgery. However, by its conclusion, I was not only aware of the preparations necessary to become a surgeon, I was definite in becoming a surgeon that is strong, independent and capable, one that is a role model for my people and my community."

For Nicole the highlight of the conference was the medical imaging and suturing workshops she participated in.

"These workshops have taught me some great skills that I will be able to use as a junior doctor as not many medical students have the opportunity to learn the different suturing techniques before they start their practical work. I was extremely amazed in myself to be able to catch on quickly to the suturing techniques that the presenters were showing us."

Nicole was pleased that female surgeons were among the speakers. "As a female hearing these women talk about their transition into a surgical career and being able to juggle being a mother and wife was extremely encouraging.

It was inspiring to see that these strong women were able to accomplish all of these roles, both in their career as a surgeon and as a matriarchal figure in their family, and that they can be done without compromise."



**Improving Indigenous representation**

The strategy to promote and improve Indigenous representation in the surgical profession is an objective of the College Strategic Plan 2010-2015 and a commitment outlined in the Indigenous Health Position Paper. The Indigenous Health Committee (IHC) is working with the Australian Indigenous Doctors' Association (AIDA) and Te ORA the Maori Medical Practitioners Association of Aotearoa New Zealand to provide opportunities for students interested in surgery to explore training requirements, develop professional networks and source opportunities to engage in surgical related research, projects and forums to aid professional development.

**Guy Dennis**

Guy is a proud Wiradjuri/Worimi man from Nelson Bay in NSW, and is a third year medical student at the University of New South Wales.

“My journey to medicine began with my experience with health, illness and surgery within my family growing up. This gave me the initial spark for wanting to pursue a health profession, specifically around surgery. The conference helped create a foundation of knowledge for me that I will need to help make this dream come true in the future.

“I found it highly rewarding to be able to hear the surgeons give their presentations and then mingle with

them afterwards ... I learnt that yes, it is not an easy path, and yes it requires a lot of hard work and then some, but it will not seem like work if I pursue the right field, as I will be doing what I love ... Knowing the logistics of how I could become a surgeon gave me a timeline to develop in my mind of when I would need to start submitting applications and really playing with what field I may pursue. I found that the speakers who had children gave me good ideas as to how I may balance a family while being a surgeon. They also gave me an idea of the diversity of locations one may live in as a surgeon and how this may differ for each specialty.”

**Sophie Stevenson**

Sophie is in her fifth year of medicine at the University of Otago. Being more advanced in her studies and clinical experience, Sophie found value in other parts of the program.

“I really enjoyed the student presentations on research that they had been involved with, as I found it relevant and tailored to the audience. There are very few opportunities throughout the year where we are exposed to new research that is easily accessible to students. It is really nice to acknowledge peers who are out there doing extracurricular research. I think that raising the awareness of this also creates

“ **My journey to medicine began with my experience with health, illness and surgery within my family growing up** ”

more interest to undertake research ... The academic surgery workshop was very interesting and informative. The speakers were both surgeons who were finishing their PhDs, which was definitely an area of surgery I was less aware of. I enjoyed the smaller group sessions as they were less formal than the whole group presentations which allowed for more discussion of the topics. I think I took the most from this workshop, and research is definitely something I would look at doing now and later in my career.”

The conference was a success on many fronts. All the students were grateful for the chance to connect with other Indigenous

medical students, make new friends or catch up with old classmates. One student summed up the conference as, “making friends for life, in an environment that was both fulfilling and educational, is a fantastic experience that I will never forget”

The Indigenous Health Committee is very grateful to the Foundation for Surgery for its commitment and ongoing support for Indigenous health, and appreciates the tremendous work that it is doing to raise funds to help the College achieve its ambitions in respect to the health of our Aboriginal, Torres Strait Islander and Maori people.

**Kelvin Kong**  
Chair, Indigenous Health Committee




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James Cook University School of Medicine and Dentistry in association with The Cairns Surgical Society and The Northern Clinical Training Network invite you to join

**“The Anatomy of Surgical Exposure Course”**

November 1st to 3rd, 2013 at James Cook University, Smithfield Campus, Cairns, Queensland

This cadaver based dissection course will instruct surgical trainees and younger surgeons in the techniques of exposure commonly used in open surgical operations. The course is open to a maximum of 20 participants with two candidates allocated to each of 10 stations and a faculty of experienced surgeons in attendance to supervise. RACS accreditation is being sought. Course fee \$1200 includes manuals, instruments and attendance at the course.

For more information [www.anatomyofsurgicalexposure.wordpress.com](http://www.anatomyofsurgicalexposure.wordpress.com)  
Enquiries [Lisa.Jones1@jcu.edu.au](mailto:Lisa.Jones1@jcu.edu.au) or +61(0)7 40421311

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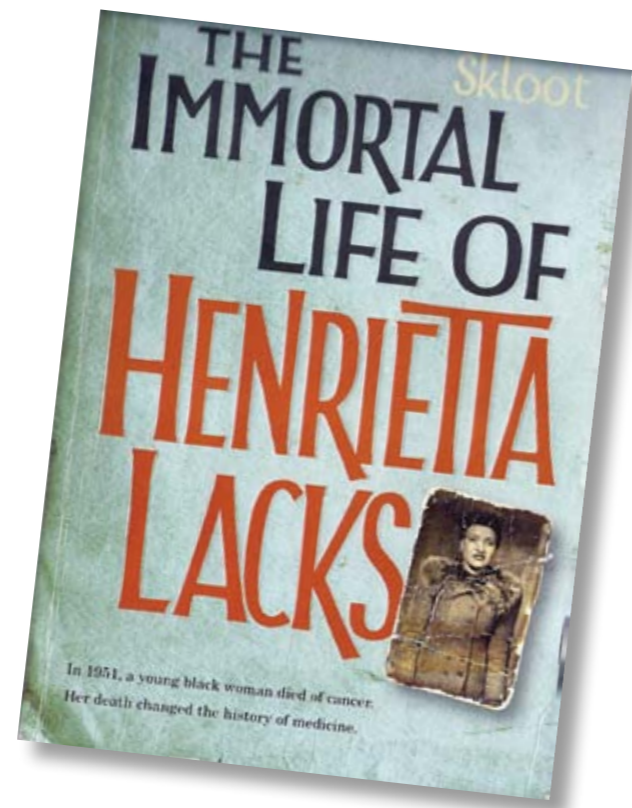
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# HeLa cells: The Story of Henrietta Lacks

A fascinating read of ethics and science

Recently my daughter reviewed for her university science course 'The Immortal life of Henrietta Lacks', a book written by Rebecca Skloot.

I was intrigued by the title of the title and flicked through it, eventually going on, aided by a glass or two of red wine, to read it cover to cover.

Most doctors have heard of HeLa cell cultures used in research around the world. I recall being taught that the abbreviation HeLa came from Helen Lane, the patient who first provided the cells.

In fact "Helen Lane" was a pseudonym for Henrietta Lacks, a black American woman who died of advanced cervical cancer in 1951.

During her illness tissue was taken from her cervix and used by Dr George Gey of Johns Hopkins Hospital, Baltimore, to create cell cultures.

Previously cell cultures had been

difficult to maintain, but the Lacks cells were particularly robust, and grew readily in culture media. They could be stored and maintained, even frozen and transported elsewhere and were soon greatly in demand by researchers worldwide.

HeLa cells became the work-horses of laboratories everywhere.

The person of origin, for privacy reasons was referred to as Helen Lane, or sometimes Helen Larson.

In 1952 HeLa cells were used to test the new Salk vaccine for the poliomyelitis epidemic of the time. The virus could invade the HeLa cells and the vaccine then tested for efficacy and safety, and eventually was to virtually eliminate poliomyelitis in Western countries.

This seminal use of HeLa cells led to a succession of experiments, and investigations of the effects of all types of environments on cells, including

thermal injury, radiation, phototherapy, high altitude, and a myriad of drugs including antibiotics and anti-cancer chemotherapy agents.

Studying the cell lines also led to major contributions in the science of genetics and chromosomes.

HeLa cell cultures are still maintained worldwide, 60 years later, and have given Henrietta a kind of immortality.

But what of Henrietta Lacks?

She was born into a poor tobacco-farming family in southern US at a time of segregation and discrimination against black, or coloured people, as they were then known. Henrietta's cancer was not diagnosed until late and undoubtedly access to medical care was limited at the time. She was admitted to the "coloured" ward at Johns Hopkins Hospital (many hospitals would not take black people at all).

Henrietta's case was considered too

advanced for surgery, and she was given a radium implant and external beam X-ray therapy, probably the only other available treatments of the day.

She had advanced cancer with local invasion and metastases, eventually dying of uraemia secondary to urinary tract obstruction.

Her cancer was originally diagnosed as squamous carcinoma, but later reclassified as adenocarcinoma, a less common but more aggressive type of cervical cancer often diagnosed later.

Henrietta was not told of the terminal nature of her disease. This was the time of "benevolent deception" in medical practice, no doubt altruistically motivated.

Additionally, her family were not told that her cells had been taken and were being used in research and it wasn't until the 1970s that family members, when contacted to take part in research projects, found out about this.

Note: Human experimentation now is governed by the Nuremberg code, and later Declarations of Helsinki and Geneva with informed consent a central tenet.

Henrietta's daughter Deborah, who was an infant when Henrietta died, eventually was shown rows of frozen HeLa cells in test tubes; handling them was a very emotional experience for her.

As the information came out, there was confusion in the family about the "immortal" descriptor that was frequently used in the media. They queried whether Henrietta could be cloned (of course the HeLa cells are cancer cells, not normal human cells).

Henrietta's family never received any financial compensation even though the HeLa cell cultures had become a multimillion global dollar industry; however, Rebecca Skloot has set up the Henrietta Lacks Foundation to help family and descendants.

There have been a number of written media pieces and television documentaries about the issue. An episode of the NBC TV drama 'Law and Order' entitled 'Immortal' is based on the HeLa story, with fictional characters.

There is talk of a Hollywood film arising from Skloot's book.

Skloot estimated that at the time of publication of her book, at least 160,000 scientific papers relating to HeLa cell studies had been published and were continuing to increase by 300 publications per month.

The development of successful cell cultures arguably can be ranked with the discovery of penicillin in terms of advancing medical science and treatment.

Skloot's book describes a very significant part of medical history and explores a number of social and ethical issues. It is educational and compulsive reading.

**Randal Williams**  
SA Fellow

#### References

Skloot, Rebecca; *The Immortal Life of Henrietta Lacks* Picador Edition 2010 by Pan Macmillan Australia Pty Ltd, Sydney.



## James Ramsay Fellowship for Provincial Surgeons

Sir John Ramsay was one of the College Founders and an original signatory in 1927 on its formation. The James Ramsay Fellowship was established following donations made in 1986 and 1993 by his son Mr James Ramsay, AO, and subsequently through the generosity of Mrs Diana Ramsay, AO. Due to available funding, applications are again invited for this Fellowship. Travel may be taken in 2013 or 2014.

**Who can apply** - This fellowship is only available to provincial surgeons in Australia or New Zealand and is designed to enable such surgeons spend time developing their existing skills or acquiring new skills away from their provincial practice. The fellowships can be taken for a period 1 – 12 weeks (between \$2,500 and \$30,000).

The fellowship grant is intended to contribute substantially to the return airfares to city/cities of choice and the daily living allowance (travel, meals, accommodation, ongoing practice costs). No additional amounts are payable for travel or accommodation for family, insurance or any other unspecified costs.

The applicant must spend a major part of each week at the appropriate institution and give a guarantee to continue in practice in his local area on completion of the fellowship.

**How to apply** - There is no application form. A letter of application should be forwarded to the Scholarship Program Co-ordinator at [scholarships@surgeons.org](mailto:scholarships@surgeons.org) including the following information:

- The intended fellowship duration
- An outline of the experience or skills you aim to gain through the fellowship and how this will benefit your current practice/hospital
- The locations to be visited in order to achieve your aim
- A written confirmation of your visit from the institution(s) where you are to gain your skill or experience
- A brief outline of the costs associated with acquiring the skills and experience
- Two written supporting references.

Applications close Monday 5 August 2013.

For further information please email  
the Scholarship Program Coordinator as  
above, or telephone 08 219 0900.

# Congratulations on your achievements

The Council of the Royal Australasian College of Surgeons admits from time to time distinguished surgeons, scientists and other persons to Honorary Fellowship of the College in recognition of their contributions to Surgery, Surgeons and the College. The purpose of the award is to recognise significant work of eminent individuals in any field of endeavour.



award  
winner

**Ms Beverly Lindley**  
*Honorary Fellowship*

Beverly Lindley served this College tirelessly for 24 years as the manager of the NSW Regional Office. At all times she believed in the unifying role of the College, its importance to the Fellows and its role in society as the guardian of surgery and the high standards it sets. The College could not have had a more passionate advocate. While Beverly worked with 12 chairmen, a constant theme over the years was to ensure that the Committee was relevant to the everyday life of NSW surgeons.

During her time with the office many different challenges arose and were dealt with in a timely and professional manner. The choice of an appropriate home for the Committee was an early challenge for Bev, and she guided the purchase of the stately building in Albion Street, Surry Hills. This was to be the focus of State activities for much of her time and it was a place where surgeons always felt welcome and comfortable to drop in. She set up a first class administrative structure that enabled the Committee to help rebuild the confidence of NSW surgeons after the bitter dispute of the late 1980s. Beverley's last challenge was to facilitate the move to the current modern office that is more suitable in this day and age.

Beverley was a passionate believer in maintaining close relationships with rural surgeons and from the early establishment of laparoscopic workshops, to the holding of meetings in rural centres, to the later review of rural surgical services these links were maintained. The relationship with the surgical specialties was also important to Bev and she always made sure that the specialty representatives were informed about Committee activities and were suitably involved in meetings. She also encouraged young surgeons to be part of Committee activities.

She had previously worked as personal

assistant to Prime Minister William McMahon and she understood the importance of maintaining relations with politicians and appropriate government departments. This ensured that regular meetings were held with the Deputy Director General of Health and these links helped to facilitate successful negotiations over the medico-legal crisis of the early 2000s and acceptance of the surgical services taskforce. The College view was always available to the State bureaucracy.

Each chairman with whom Bev worked had her total support, but was also challenged by her to reach their potential. She taught them the importance of a first class manager in allowing them to achieve what they wanted, while reminding them at all times of the responsibility of serving the College.

Bev's family was always very important and her two children are a credit to her. Her role as grandmother is helping to ease her into retirement.

Beverley's contribution to this College through her role as manager of the NSW Regional office has been enormous. Even when extremely ill she returned to work sooner than expected or advised. We can be truly thankful for such devotion.

*Citation kindly provided by  
Richard Barnett*



award  
winner

**Dr A Brent Eastman FACS**  
*Honorary Fellowship*

Dr Eastman is President of the American College of Surgeons (ACS) and a general, vascular and trauma surgeon from San Diego where he has occupied the N. Paul Whittier Endowed Chair of Trauma at the Scripps Memorial Hospital since 1987. His surgical training was at San Francisco General Hospital and included a year as a surgical registrar in the UK. His greatest strengths and contributions have been as a Professional Leader and Health Advocate.

He has strongly served the ACS, including as Chair (1989-1994) of the Committee on Trauma (COT) and as Vice-Chair and Chair (2009-2010) of the Board of Regents. He has served on many other committees of the ACS and of other surgical organisations.

Dr Eastman's first involvement with the RACS was in September 1990 when, as Chair of the COT, his diplomatic skill and international understanding greatly assisted the maturation of a strong partnership in ATLS between

our two Colleges, through which EMST has flourished in Australia and New Zealand and has contributed strongly to the expansion and rigour of ATLS internationally.

In June 1991, he was invited to the developing trauma service at Westmead Hospital and its network of 14 hospitals in Greater Western Sydney, all of which he visited before sharing conclusions in an open symposium. This contributed to implementation of the metropolitan trauma plan in Sydney in 1992 and to the foundations of the Trauma Service that developed at Liverpool Hospital.

Dr Eastman returned in December 1992 as the keynote speaker for the annual RACS trauma seminar that helped to refine ideas for regional trauma care systems in ANZ and to prepare the surgical community for the 1993 release of the NRTAC Working Party report on 'Trauma Systems in Australia'.

He was a co-founder in the 1980's of the outstanding and internationally

respected San Diego County Trauma System. As an invited Expert Consultant, he has strongly influenced the development of trauma care systems in multiple countries. His leadership was recognised in his selection as the prestigious Scudder Orator of the ACS in 2009.

Dr Eastman's advocacy roles on state and national bodies (including a working group of the US Congress and leadership roles within the Centers for Disease Control) have focused on injury prevention and control, injury research, cost and effectiveness of trauma centre care, injury in the ageing population, trauma care education, professional workforce for emergency care, medical responses to natural disasters, and professional leadership in medicine, and have contributed to hallmark reports which have substantially influenced health systems in North America and internationally.

For his contributions to military trauma care, he was assigned the Distinction of Honorary Member of the United States Army Medical Regiment, by order of the Surgeon General.

Dr Eastman was a key resource to the RACS Trauma Committee in the establishment of the RACS programme of Trauma Service Verification in ANZ, which was adapted from the successful model of the ACS.

Dr Eastman's many friendships among RACS Fellows involved in Trauma and Emergency Surgery reflect shared vision and advocacy, his personal mentorship of us over many years, and our deep respect for his warm humanity, professional achievements and unique capacity for strong, inclusive and effective leadership.

*Citation kindly provided by  
Professor Stephen Deane*

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

The medal was created to honour and perpetuate the name of Sir Hugh Devine as he played a leading role in the original concept of the College, being one of the three signatories to the “foundation letter” of 1925. He achieved world fame for his surgical skills and originality of thought, and was knighted for his contributions to surgery.



award winner

**Mr Campbell Miles**  
FRACS  
Sir Hugh Devine Medal

At the time of Campbell Miles' appointment in late 2004 as coordinator of the Annual Scientific Congress (ASC) of the College, the continued existence of the meeting was under severe threat with the competition from specialty scientific meetings. By the time of his retirement from this position in 2012, the ASC, the College's foremost educational event, had established its own identity, its raison d'être – it had been reinvented, re-invigorated and continues to flourish. The Awards Committee of the College was unanimously of the opinion that the success that is the current ASC can mostly be attributed to the efforts of one individual – Campbell Miles.

Being a section convener or indeed chair of the scientific committee is no longer regarded as a poisoned chalice.

The procedures, processes and overall gentle guidance provided by Campbell in creating successful congresses have been universally appreciated. It is rare for a Fellow of our College to achieve accolades, admiration and respect from various States and Specialty Societies with nary a word of discontent, but Campbell has achieved this.

Campbell chose not to compete with specialty society conferences, but rather to complement them and offer an alternative experience to ASC attendees. His achievements required tenacity, tact and the courage to experiment. Time hallowed but effete elements of the program were dropped, the duration was reduced to four days and the plenary sessions revitalised to become “must attend” highlights of each congress reflecting generic elements of the theme of each congress. Campbell promulgated the principle that plenary sessions had to have relevance, interest and importance to every surgeon, no matter their specialty. Six new programs were begun including a specific program for our Trainees, electronic posters were introduced, the extraordinary Masterclass program commenced, audience polling technology purchased and the Virtual Congress with audio recording and PowerPoint presentations

established. A particular challenge was organising and running ASCs off-shore – firstly Hong Kong and more recently Kuala Lumpur – difficult, but popular with the Fellowship. Throughout Campbell has been, as he was with his surgery, meticulous. He has also been tireless in his efforts in extolling the virtues of the ASC, raising its profile and defending it when necessary.

Campbell came to the College having been recruited by John Masterton. He had been Head of the Vascular Unit, Alfred Hospital where he was encouraged to develop a strong interest in adverse event analysis. His education began in a one teacher rural school and progressed through Nunawading High School to Monash University.

Despite his appointment being only three half days per week, Campbell devoted his post clinical life to the role. The influence and interactions with Lindy Moffat, with John Collins and with David Hillis were of particular importance. His wife, Vivienne, has been a tireless support.

Campbell's contribution to the College has been immeasurable and vitally important. He is a worthy recipient of the Hugh Devine medal.

*Citation kindly provided by  
Professor Michael Grigg*



Lindy Moffat and team congratulate long-time colleague Campbell Miles on his award of the Sir Hugh Devine Medal

## On the sharp end

What I know now!



Mervyn Smith, FRACS of happy memory, was a senior registrar when he had an acute appendix that he reckoned taught him much more about this ubiquitous disease than anyone or anything else had. Muggins was his intern, and had to wait almost 60 years before confirming Mervyn's dictum in spades.

It began in mid-August with what looked vaguely like haematuria. A few days later there was no doubt: smoky urine preceded a clear stream. Ultrasound on August 21 revealed a golf-ball size mass in the left lower bladder. What to do? I'm my wife's carer, and somebody needed to take over while I was in hospital.

It happened that our Melbourne daughter's employers wanted her to take accumulated leave, and we have naming rights on her guest suite for the usual reasons, so we went interstate. But to see whom? A friend emailed Don Moss asking for advice. He was riding his bike along the Danube and said big ones tend to invade late; he named a urologist who saw me on August 27.

He agreed with Don and said he could TUR it next day if I pushed him, but he really had enough on his list already, so could I wait a week? I've been there too,

so happily waited until September 4 when he completely excised a high-grade TCC with surrounding CIS. It wasn't through the lamina propria, so I went home for the ritual six weekly doses of intravesical BCG. At review on January 15 he excised a recurrence, again not into bladder muscle. What now?

I'm pretty fit, but there was the small problem of a left ICA block, <70 per cent, but enough to give pause. When I realised the only way to be reasonably sure of cure was to have a radical cystoprostatectomy I lined up for it in my home city as soon as ACAT found respite for my wife.

My surgeon, a Trainee of the Melbourne urologist, was somewhat daunted by the prospect of performing such a major procedure on another surgeon, but did so on March 26. Extensive small bowel adhesions, a high caecum and a long retro appendix helped stretch it out to six hours. (The path: no residual bladder tumour and nodes clear. So unless it got away between September and January, I should be cured.)

I woke at midnight in absolute agony and couldn't believe I'd been inflicting such pain on others for 50 years; I reckoned if I'd had such an experience

“**Ultrasound on August 21 revealed a golf-ball size mass in the left lower bladder**”

early on I'd never have become a surgeon.

Next morning I was switched to PCA Fentanyl, very satisfied except that they changed it to Endone after 48 hours, a day early in my opinion. I blew up like a poisoned pup and told the nurses this was where we used a flatus tube in my time. Never heard of it. I refused Endone and took Panadol only; time and Colxyl fixed the wind problem; my urostomy behaved perfectly and at 10 days I was fit for rehab.

The nurses were as tenderly efficient as one could wish for and the stoma therapist was excellent, but the physios seemed brutal.

I thought I knew about pain relief, but this has been a vivid and unforgettable educational experience. A bit late when I've been retired almost 10 years. Pity.

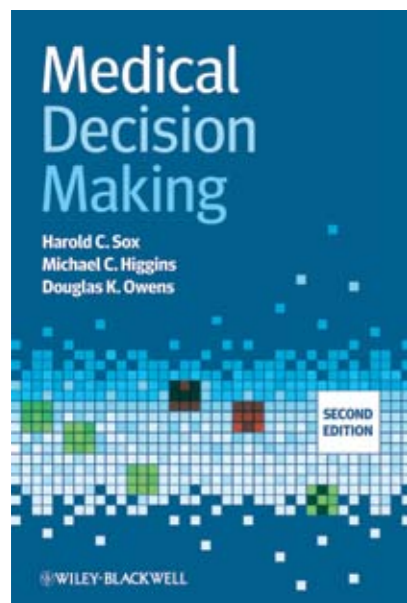
**Bernard Catchpole**  
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# Welcome to the Surgeons'

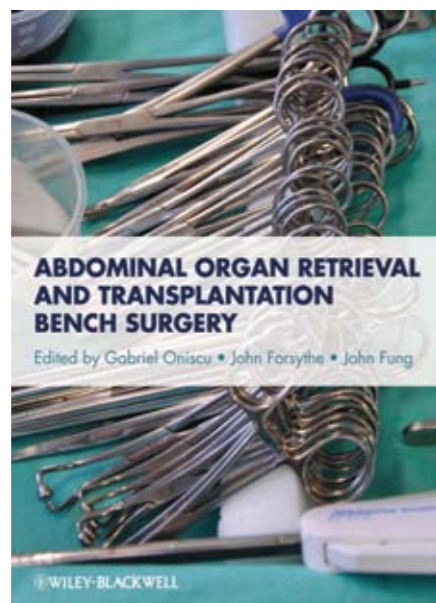
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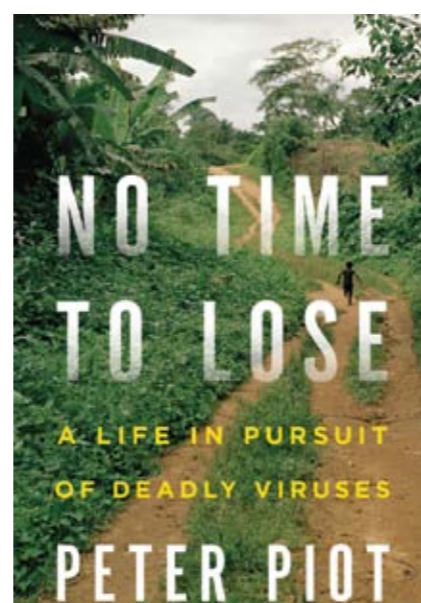
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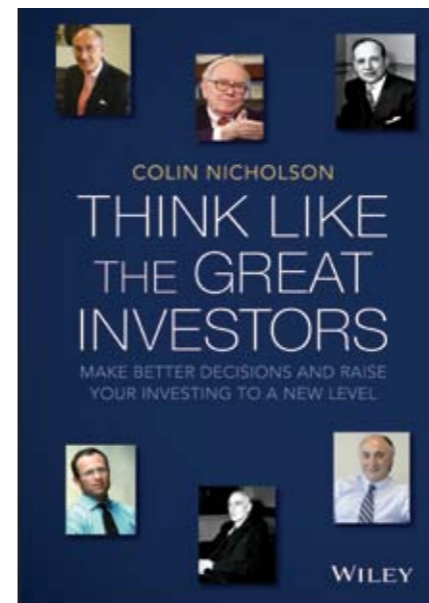
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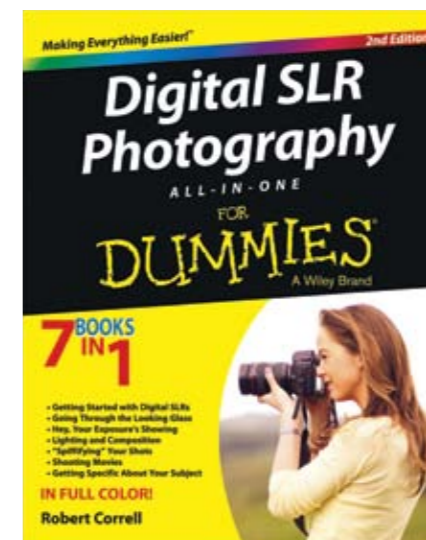
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**Medical Decision Making, 2nd Ed**  
Harold C. Sox, Michael C. Higgins,  
Douglas K. Owens  
9780470658666 | Pbk | 368 pages | July 2013  
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*Medical Decision Making* provides clinicians with a powerful framework for helping patients make decisions that increase the likelihood that they will have the outcomes that are most consistent with their preferences. This new edition provides a thorough understanding of the key decision making infrastructure of clinical practice and explains the principles of medical decision making both for individual patients and the wider health care arena. It shows how to make the best clinical decisions based on the available evidence and how to use clinical guidelines and decision support systems in electronic medical records to shape practice guidelines and policies. *Medical Decision Making* is a valuable resource for all experienced and learning clinicians. "There is little doubt that in the future many clinical analyses will be based on the methods described in *Medical Decision Making*, and the book provides a basis for a critical appraisal of such policies." - *Jerome P. Kassirer M.D., Distinguished Professor, Tufts University School of Medicine, US and Visiting Professor, Stanford Medical School, US*



**Abdominal Organ Retrieval and Transplantation Bench Surgery**  
Gabriel Oniscu (Editor), John Forsythe (Editor), John Fung (Editor)  
9780470657867 | Hbk | 192 pages | May 2013  
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This important new book covers all aspects of retrieval and bench surgery of the abdominal organs. Coverage includes organ retrieval logistics and organ preservation; retrieval and bench surgery of the kidney, liver, pancreas and intestine; in situ and ex situ liver splitting; multi-organ retrieval; paediatric age-specific aspects of retrieval and bench surgery; and more. Key features include:

- Practice learning points for each procedure
- Detailed colour illustrations of standard techniques
- Thorough guidance on dealing with anatomical variations

*Abdominal Organ Retrieval and Transplantation Bench Surgery* is the ideal guide for surgeons and donor retrieval teams alike. With its step-wise approach and practical orientation, it is a reference transplant professionals can trust to help them understand and excel at all aspects of abdominal organ retrieval, from managing potential donors and properly retrieving organs to minimizing the likelihood of common pitfalls.



**No Time to Lose: A Life in Pursuit of Deadly Viruses**  
Peter Piot  
9780393063165 | Hbk | 304 pages | May 2012  
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In the 1970s, Peter Piot was sent to Central Africa as part of a team tasked with identifying a grisly new virus. Crossing into the quarantine zone on the most dangerous missions, he studied local customs to determine how this disease - the Ebola virus - was spreading. Later, Piot was in the field again when another mysterious epidemic broke out: AIDS. Candid and engrossing, *No Time to Lose* captures the urgency and excitement of being on the front lines in the fight against today's deadliest diseases.



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**Digital SLR Photography All-in-One For Dummies, 2nd Edition**  
Robert Correll  
9781118590829 | Pbk | 672 pages | May 2013  
**AU\$47.95 | AU\$35.96**  
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The bestselling guide to DSLR photography - now updated for the latest technology and tools! This new edition gets you up to "shutter speed" on the latest camera technologies, including the new consumer-targeted full-frame models and pro-features that are now incorporated in consumer-focused units. Veteran author and professional photographer Robert Correll walks you through how a camera works, what lenses to use, how to set exposure, and how to capture the shots that define a portfolio. Fully updated to cover the latest generation of cameras and boasting more than 700 pages, this must-have resource explores the latest in tools and offers additional content, including video and interactive tools so that you can enhance your photography knowledge. Covers the basics of DSLR mechanics and explains how settings affect the final photo. Reviews lenses and walks you through choosing and applying the right lens for your situation. Discusses how aperture, shutter speed, and ISO combine to determine how your photo will look.



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# Serving the Community

The new Outstanding Service to the Community award has been presented

The new College award to recognise Fellows' work in the community was part of a regional presentation in May. Mr Stephen Clifforth received the award for his tireless work for the people of the Western district. Recommendations can be forwarded by colleagues, administrators, patients or members of the broader community for consideration.

Stephen Clifforth is a surgical supervisor and an advocate of providing rural surgical training education. Currently he sits on the Board of Academy of Surgical Educators and is a College representative on the Victorian Surgical Consultative Council.

During his career Stephen has also held a role as an Executive member on the Victorian State Committee. His other committee roles have included Victorian Road Trauma Committee, Victorian Trauma Committee and he is currently Course Director for Care of the Critically Ill Surgical Patient (CCrISP) and has been a faculty member of many Emergency Management of Severe Trauma (EMST) courses over the years at the Royal Australasian College of Surgeons.

Noteworthy comments on his service were:

"Throughout his 27 years of service to healthcare in the Western District of Victoria, Mr Clifforth has become a much loved and respected figure to his work

colleagues and many patients. He is known for his empathy, care and surgical skill."

"He is always conscious of the fact that he lives in our community and that today's patient may well be tomorrow's neighbour, friend or social contact and thus brings a human empathetic touch to his practice and teaching."

Mr Michael Wilson was the first recipient of the Award in April at Kilmore, with the inaugural presentation at the Kilmore and District Hospital.

Mr Wilson has served his community for 25 years and during that time the increase in specialist services has been several fold. He ensures patients in the district are well cared for even with further appointments at Northern Hospital.

Community Awards are for those surgeons who have worked tirelessly within their community and not received any acknowledgement for their commitment. It is the College's wish to ensure these people are given the recognition they deserve.

Recommendations noted: "We believe he is well deserving of any award that recognises his contribution to medicine in the context of giving that little bit extra, beyond that which is usually expected."

Awards are only given to surgeons who have been nominated by their community members with a minimum of two

**“He is always conscious of the fact that he lives in our community and that today's patient may well be tomorrow's neighbour, friend or social contact and thus brings a human empathetic touch to his practice and teaching”**

recommendations and the College then asks a local dignitary to acknowledge the surgeon at a community event and the Victorian Regional Committee Chair presents a Certificate of Community Service on behalf of the College.

If you know a Fellow who has done outstanding work in their community, nominate them by contacting your Regional Committee Office.

Pictured Top: Federal Member for Wannan Mr. Dan Tehan, Victoria Regional Chair Robert Stunden and Stephen Clifforth.

Above: CEO WDHS Mr Jim Fletcher, Stephen Clifforth, and Federal Member for Wannan Mr. Dan Tehan.



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