



THE ROYAL AUSTRALASIAN  
COLLEGE OF SURGEONS

# SURGICAL NEWS

Vol:9 No:4 May 2008

## May Highlights:

### PAGE 8 TRAUMA CARE

“The Australasian Trauma Verification Program seeks to promulgate best practice in trauma care across Australia and New Zealand.”

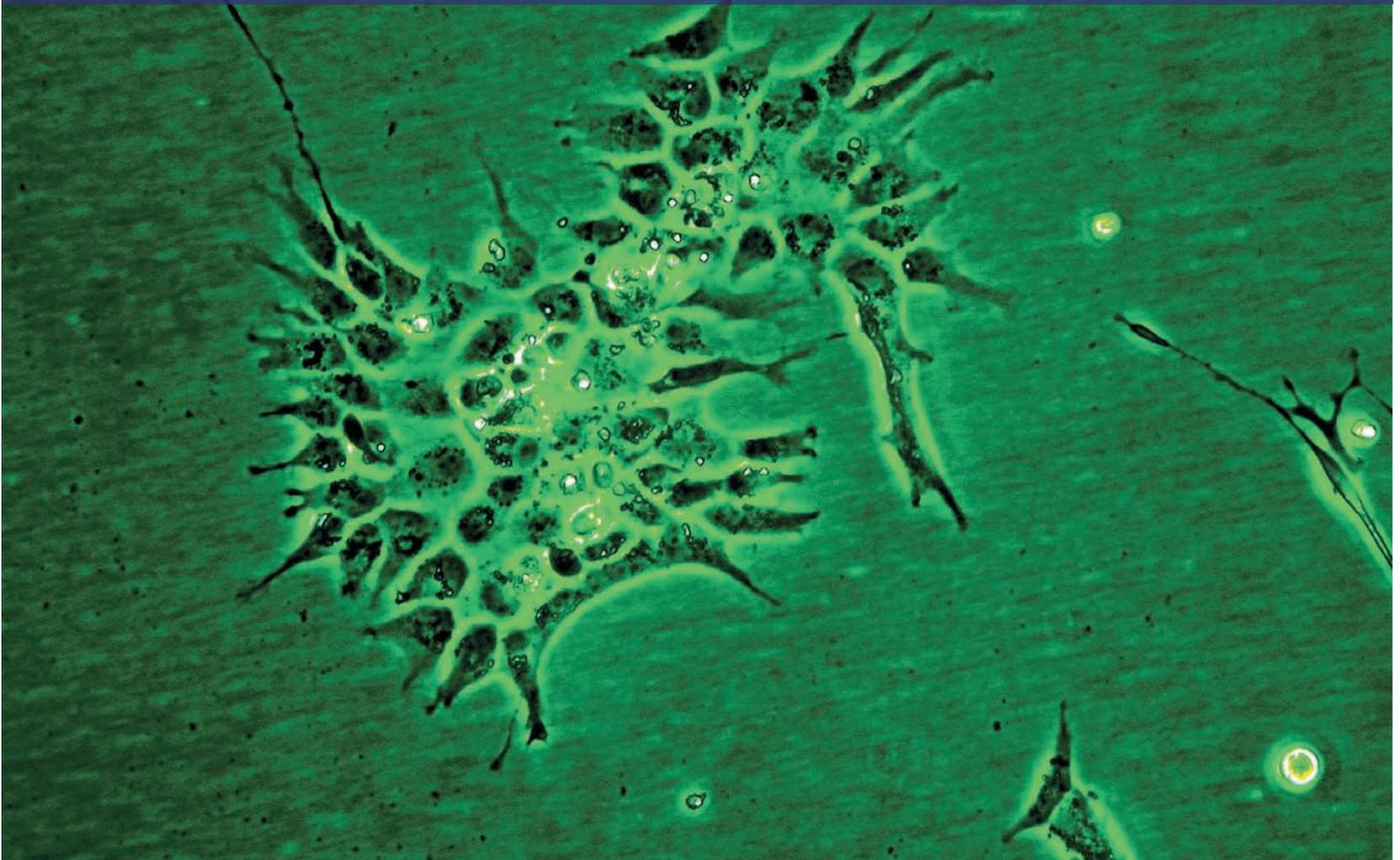
### PAGE 10 SURGICAL RESEARCH

The College is in the process of establishing a registry of expertise to allow potential scholars access to statistical information before they embark on their research projects.

### PAGE 30 INTERNATIONAL DEVELOPMENT

“The best network in the developing world is often through religious organisations because they have a central commitment to the care of the poor.”

Help the Foundation for Surgery, page 23



The College of Surgeons of Australia and New Zealand

## NEW WORKSHOPS FOR 2008

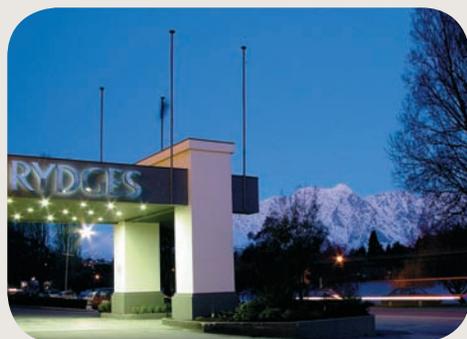
### **SURGEONS AS MANAGERS**

**DATE:** 4th–6th July 2008

**LOCATION:** Queenstown, NZ

Do you want to inspire and lead your team? Develop your management skills in the public sector or private practice?

Join your colleagues in Queenstown, NZ for the Surgeons as Managers workshop. Situated on Lake Wakatipu, this weekend retreat includes topics on management and leadership styles, hospital financial management, legal issues and effective practice management. Partners and family are welcome, with two nights accommodation for participants at the Rydges Lakeland Resort included. Proudly sponsored by Johnson and Johnson



### **PRACTICE MANAGEMENT FOR PRACTICE MANAGERS**

**DATE:** 3rd June

**LOCATION:** Melbourne, VIC

Practice Management for Practice Managers deals with topics relating to the unique challenges of running a surgical practice and covers practice systems, staff, HR issues, mitigating medico-legal risk and developing a patient-centred practice. Fellows are also welcome to attend this workshop with their practice managers and staff. Proudly sponsored by the Health Communication Network

### **WINDING DOWN FROM SURGICAL PRACTICE**

**DATE:** 14th June

**LOCATION:** Gold Coast, QLD

The workshop focuses on retirement issues such as when to wind down, career options, lifestyle changes, legal requirements for closing a practice, financial planning and superannuation. Proudly sponsored by Odyssey Financial Management

### **FROM THE FLIGHT DECK**

**DATE:** 13th–14th June

**LOCATION:** Melbourne, VIC

From the operating theatre to the skies, join your colleagues for an exciting and inspiring weekend that will challenge you as no other PD activity has before! Learn more about risk management and team dynamics including; an examination of the role active and latent factors play in aviation and medical errors; the SHELL and Reason models of error and their applicability to surgery; how to fly a 737 or Dash 8!

From the Flight Deck is a challenging and fun learning opportunity for any surgeon who wants to know more about minimising their risk and developing positive team dynamics.

### **WRITING REPORTS FOR COURT**

**DATE:** 21st June

**LOCATION:** Melbourne, VIC

Offering skills-based training in preparing medical reports for use in legal matters, this workshop gives participants valuable individualised feedback on their own medico-legal reports as well as an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective.

### **SURGICAL TEACHERS COURSE**

**DATE:** 3rd–5th July 2008

**LOCATION:** Perth, WA

Join your colleagues for an invigorating two-and-a-half day course to learn how to be a better teacher, leader, mentor and supervisor of trainees. Why not then take a few extra days to explore the wonderful Margaret River, Swan Valley and other acclaimed wine and food tourism regions? Hurry, places are filling fast!

### **EXPERT WITNESS WORKSHOP**

**DATE:** 19th July

**LOCATION:** Melbourne, VIC

Find out how to be an expert witness and master examinations in chief, cross and re-examinations through interactive role plays, seminars and discussions. This full day workshop is run by legal and surgical experts and provides a fantastic opportunity for any Fellow who wants to gain a better understanding of what to expect and what is expected of them in court.

### **FURTHER INFORMATION**

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

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

## PROFESSIONAL DEVELOPMENT CALENDAR 2008

### **VIC**

- 3 June - Practice Management for Practice Managers, Melbourne
- 13-14 June – From the Flight Deck: Improving Team Performance
- 21 June - Writing Reports for Court, Melbourne
- 28 June – Neurotrauma Workshop for Rural Surgeons, Melbourne
- 19 July - Expert Witness, Melb
- 22-23 Aug - From the Flight Deck: Improving Team Performance
- 8 Nov - Risk Management Foundation: Informed Consent, Melbourne
- 15 Nov - Communication Skills for Cancer Clinicians, Melbourne

### **WA**

- May 24, June 28, July 26, Aug 23 - Northern Australia Surgeons Network Videoconferences
- 29 April - Interviewer Training, Perth (by invitation only from Specialty Training Boards)
- 27 May - Beating Burnout, Perth
- 3-5 July - Surgical Teachers Course (STC), Perth

### **SA**

- 26 July - Mastering Difficult Clinical Interactions, Adelaide
- 19 Sept - Practice Management for Practice Managers, Adelaide

### **NSW**

- 7 June – Specialists as Teachers Course, Orange
- 29 July - Mastering Intercultural Communication, Sydney
- 8 Sept - Mastering Professional Interactions, Sydney
- 10 Oct - Winding Down from Surgical Practice, Sydney
- 23-25 Oct - Surgical Teachers Course (STC), Sydney

### **NT**

- May 24, June 28, July 26, Aug 23 - Northern Australia Surgeons Network Videoconferences

### **QLD**

- 24 May, 28 June, 26 July, 23 Aug - Northern Australia Surgeons Network Videoconferences
- 24 May – Specialists as Teachers Course, Townsville
- 14 June - Winding Down from Surgical Practice, Gold Coast
- 9 Aug - Mastering Difficult Clinical Interactions, Brisbane
- 3-5 Oct - Surgeons as Managers (SaM), Cairns

### **NZ**

- 4-6 July - Surgeons as Managers (SaM), Queenstown



Ian Gough, President

## New President for the College

I would like to thank both the Fellowship and Council for the honour of being the President

I look forward with enthusiasm to the next 12 months in representing our College in an increasing number of forums and also to have the opportunity to meet many of you at our regular meetings.

The recent work of Council has successfully positioned the College to be one of the more effective medical professional organisations. We have highly successful education and training programs and ongoing professional development initiatives. The College now works in ongoing partnerships with the Specialist Societies and Associations and other educational providers to ensure they are effectively delivered.

The past four years has seen the stronger resolve of the College to develop into the College of Surgical Specialties. This is a most important direction as the various Specialist Societies develop their own identity and autonomy. However, this also requires the College to ensure it defines clearly its ongoing role to provide value to the Trainees and Fellows. To progress this, the College Council underwent a strategic workshop focusing on the key things to achieve by 2015. The initial outcome of this is now being discussed with the various Chairs of the Regional Committees and Presidents of the Specialist Societies. I wish to take you through the major initiatives that have been proposed and will

be debated at Council. They will be refined and eventually developed into a strategic plan for distribution later this year. Feedback is welcomed.

### College purpose

**To be the unifying force for surgery, where FRACS stands for competence and quality in surgical care.**

Professionalism everywhere is under threat. We are at risk of fragmentation. The value of surgery and surgeons needs to be strongly promoted. As increasing surgical specialisation occurs, the College needs to ensure surgery is well represented as a substantial discipline in health care and the modern world of medico-politics. The College should not need to look to other organisations to represent the interests of surgeons or patients who require surgical care. Importantly, we must work with our various specialty groups to ensure their concerns and messages are well communicated to the broader community. We also need to represent the legitimate interests of subspecialty and interdisciplinary groups within the Fellowship. Underpinning our ability to advocate for issues will be the assurance that surgeons with the FRACS have demonstrated their competence and are able to perform at high levels of quality in delivering surgical care.

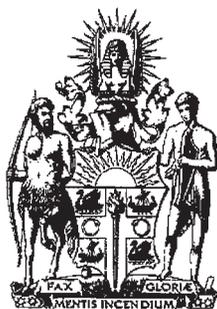
### College vision

**In 2015 the College will ensure the quality of surgical education and training programs, leading to FRACS, delivered by the College or a College accredited education provider.**

Our standing for quality surgery depends on the rigor and comprehensiveness of our education, training and evaluation processes. The College will remain highly involved with our educational activities although we may look to other providers to be accredited to provide components of the training. This will require successful partnerships with these providers and careful management of these relationships.

The College will serve the Fellowship by being relevant to all Fellows with professional development programs of such quality and value that they are universally accessed by all Fellows.

The College is progressively looking to all the specialist societies to provide professional development in the technical areas for Fellows of that particular area. Some of these will continue to be provided at the Annual Scientific Congress but increasingly the specialist societies also provide other venues for these activities. The upcoming General Surgeons of Australia (GSA) Conference on Surgical Oncology issues is a key example. The Australian Orthopaedic Association (AOA) and →



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## President's Perspective

“The College should always have a role in driving surgical excellence and a particular focus is on the growing success of our surgical scientist program...”

New Zealand Orthopaedic Association (NZOA) and other specialty society conferences have been providing this for much longer.

However, there is an expanding area of development opportunities that are of relevance to all surgeons that the College delivers either directly or through third party providers. These include opportunities like training in areas of medico-legal expertise and more recently has also included training for Fellows in the skills of supervising Trainees or management skills.

### **Be a leading advocate for the surgical health and well-being of patients**

The College is progressively moving into positions of advocacy on surgical issues and also stronger public advocacy on issues that affect the health of our patients. Fellows often reflect to me that the College should have been doing this some 20 years ago and that we are coming from a “long way back”. On the other hand, it was only about 10 years ago that the College moved to directly engage with government on relevant matters. Current College Office Holders now all anticipate

that they will need to be “media ready” and “media savvy”. The profile of the President has steadily increased with regular media events and presentations. This will be further developed and backed up by good quality position papers on issues that affect us all. Part of this will need to address access to the surgical workforce.

Many of the solutions that are currently provided by political fiat or Department of Health initiative can distort the system and eventually provide fewer incentives to train the surgical workforce of the future. It is important that problems relating to access are dealt with in a strategic and systematic way for the benefit of the community over the longer term.

### **Driving surgical excellence by promoting and supporting surgical research and evaluation of new technologies**

The College should always have a role in driving surgical excellence and a particular focus is on the growing success of our surgical scientist program and the increasing profile of the evaluation of surgical technologies and our commitment to audit. Whilst the College

contributes from our subscription base to this, there is also a significant contribution from bequests to the Foundation for Surgery or in the case of audit some direct support from Government bodies. Articulating the ongoing necessity of this will be most important as we grow the Foundation and its connections to both the corporate and philanthropic worlds.

Strategic planning should always re-invigorate the key activities of the College. Importantly the College needs to review its governance structures and processes to drive this. The College must embrace all surgical activities in its role as the unifying body. It must ensure that Collegiate surgical leadership with the attached responsibilities and opportunities is available to all Fellows.

As the incoming President I was delighted to meet with so many of you at the highly successful Conjoint Annual Scientific Congress that was just held in Hong Kong. As a Fellowship of surgeons sticking together and working together, we can look forward to a successful future.

## Results of 2008 elections to Council

The results of the 2008 elections to Council were tabled at the Annual General Meeting in Hong Kong on 15 May 2008. Congratulations to all successful candidates and sincere thanks to all candidates who nominated. The pro bono contribution of Fellows has been and continues to be the College's most valuable asset and resource.

We are grateful for their commitment.

### **General Elected Councillors**

There were five General Elected Councillor positions to be filled.

#### **Re-elected to Council are**

Ian Carnegie Dickinson, Queensland Orthopaedic Surgeon

Ian Ronald Gough, Queensland General Surgeon

Guy John Maddern, South Australian General Surgeon

Ivan John Thompson, West Australian General Surgeon

#### **Newly elected to Council is**

Philip Gregory Truskett, New South Wales General Surgeon

### **Specialty Elected Councillors**

#### **Otolaryngology Head & Neck Surgery**

Re-elected - Robert John Black, Queensland

#### **General Surgery**

Newly elected - Samuel Patrick Baker, Queensland

#### **Urology**

Re-elected - Helen Elizabeth O'Connell, Victoria

Thank you to the scrutineers Campbell Miles and Andrew Roberts.



Ian Dickinson,  
Vice President

## Political Processes

The College has long recognised the need for undertaking an active advocacy program

I am most honoured to have been elected Vice President of the College and to submit my first article to Surgical News regarding the Relationships portfolio.

I have been on Council since 2002 and filled a number of roles, including for the last three years being Chair of the Professional Development and Standards Board, responsible for the Fellowship portfolio. I am a Brisbane based orthopaedic surgeon and I am currently the Second Vice President of the Australian Orthopaedic Association.

In my first article, I would like to look at the College's engagement in the political process and the manner in which we will develop an advocacy strategy for surgical issues.

The College has long recognised the need for undertaking an active advocacy program on behalf of surgeons and surgical issues. It has been considered that other medico-political bodies, such as the Australian Medical Association, while advocating broadly for medical issues sometimes do not cover the specifics of issues affecting surgeons.

To reflect this, Council has determined that the Governance and Articles Committee (now the Governance and Advocacy Committee - GAC) will take the lead on the development of the College's advocacy strategy.

At the last GAC meeting a draft advocacy strategy was considered. One of the elements discussed was the concept of developing a "platform" or a series of position statements. These key public policy positions would form the core of what surgeons believe are important public policy matters to be brought to the attention of policy and decision makers.

While the College may develop a larger number of these position statements, the hallmark of successful public policy campaigns is focus by the organisation on a small number of achievable issues on which to work. It is better to achieve substantial change in a focussed number of areas rather than only incremental

*"We cannot expect to achieve change overnight, but only through setting focussed, achievable goals..."*

change in a larger number.

At the recent Council Strategic Planning Workshop, advocacy was extremely prominent and the subject of which issues to address were given some consideration.

GAC will advise Council in June on their views regarding which issues the College ought to focus on. Some under consideration include:

- access to care;
- improvements to acute care;
- clinical input into decision making;
- rural surgery;
- surgical workforce;
- safe hours;
- infrastructure.

In order to develop these core issues, it is important that they reflect the views of the broader fellowship. I would be very interested in your views about what you see as the priority issues for any college advocacy program. Feel free to contact me or the Director, Relationships & Advocacy ([vice.president@surgeons.org](mailto:vice.president@surgeons.org)).

The other important consideration in the development of our advocacy strategy is to ensure the engagement of the New Zealand and state governments through our regional boards and committees.

The Board of Regional Chairs (BRC) is the leading body within the College representing the views of Fellows in New Zealand and the various Australian states. The BRC meets monthly via teleconference and exchanges views regarding important matters in the nine jurisdictions.

Regional issues can be raised through the

BRC so that a common response (if possible) can be developed across the jurisdictions. It provides an avenue to consult among Fellows and develop solutions that reflect Fellows' input and the broader policy platform.

It is also an important avenue through which the College can work with the states and New Zealand to ensure that the strategic advocacy goals are reflected across the College in our advocacy efforts. This is particularly important in Australia where healthcare issues often require both a federal and a state solution.

Through the BRC, Fellows will be able to work together to ensure we present our message coherently whether at a national or a state level.

The issue of a consistent and coherent message is an important one. Given that we often have limited opportunities with key decision makers or the media, it is imperative that we use these opportunities to maximise the potential of our message being heard.

The public relations department at the College will be working on "talking points" to ensure that we can all talk effectively about the key issues. As they are developed, these talking points will be available for download from the College's website.

We cannot expect to achieve change overnight, but only through setting focussed, achievable goals, building our profile, targeting our message to the right individuals and maintaining message discipline when speaking publicly.

Once again, I am delighted to have been elected Vice President of the College. The Relationships Portfolio has many challenges confronting it. I look forward to working with all of you to advance the interests of surgery and our College.

For further information or to contact the College regarding advocacy issues please email James McAdam, Director, Relationships & Advocacy at [james.mcadam@surgeons.org](mailto:james.mcadam@surgeons.org) or telephone +61 3 9249 1278.

## Surgical Mortality



Julian Smith, Research, Audit, Academic Surgery & External Affairs

# Surgical Mortality

Using secure web technology to review mortality

In recent years, the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) and the Audit Department of the Research, Audit and Academic Surgery (RAAS) Division of the College have developed several online systems which use the internet to securely harvest health information for analysis and storage in modern databases. These include the National Breast Cancer Audit, the College's upcoming Trainee logbook system and the web-based system developed for the Australian and New Zealand Audit of Surgical Mortality (ANZASM).

Web-based systems provide an excellent way of collecting information on a national or bi-national basis. As broadband coverage continues to expand into regional and remote areas of Australia and New Zealand, this allows regional surgeons to participate in such initiatives in an identical manner to their metropolitan counterparts.

The online banking industry has been at the forefront of developing this technology, which is required for the secure transmission of information over the internet. This experience has been utilised by our system developer,

Alcidion Corporation ([www.alcidion.com.au](http://www.alcidion.com.au)), during the construction of the ANZASM web system known as the Bi-National Audit System or BAS. Increasingly secure transfer of information is used routinely for everyday practices such as purchasing items online, business banking and downloading music purchases.

At present, the BAS system is used by two audits within ANZASM: the Victorian Audit of Surgical Mortality (VASM) and the Queensland Audit of Surgical Mortality (QASM). Plans are underway to migrate the other state-based audits from their pre-existing Microsoft Access databases to the industrial strength BAS system within the next few months.

The ANZASM audit is a linear process, involving a set number of steps from the initial notification of a death occurring during a surgical admission to completion of a surgical case form by the treating surgeon, first-line assessment and, in some instances, escalation to a more thorough second-line assessment of a case. The BAS system has two main components. The first is a database layer into which data forms can be entered and securely stored. The second layer is Alcidion's workflow engine (now known as Miya), which acts as

the system "brain", automatically generating the required letters and reports needed at each step and providing audit staff with reminders when certain tasks need to be completed. For example, Miya automatically generates reminder letters for any case in which the surgical case form has not been received back by the audit office within 30 days. Reports can also be automatically generated if a particular step within the audit cycle has been reached.

In future, the BAS system will expand to provide an interface that will allow surgeons to enter their surgical case forms online rather than the current situation in which cases are entered at each state's project office. Once such an interface is available, it will also present an opportunity to provide surgeons with more 'up-to-the-minute' information about their reviewed cases as well as summaries of the clinical incidents reported. The BAS system provides an interesting example of how emerging internet technology can be used to improve surgical care across Australia.

For further details about the ANZASM web system, please contact Julian Smith, Chair, Research, Audit, Academic Surgery & External Affairs (+61 8 8363 7513; [wendy.babidge@surgeons.org](mailto:wendy.babidge@surgeons.org))

## DEFINITIVE SURGICAL TRAUMA CARE COURSE (DSTC)

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) is pleased to announce the courses for 2008.

The DSTC course is an invigorating and exciting opportunity to focus on surgical decision-making and operative technique in critically ill trauma patients. You will have hands on practical experience with experienced instructors (both national and international).

The DSTC course has been widely acclaimed and is recommended by the Royal Australasian College of Surgeons for all surgeons and Trainees.

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.



Please register early to ensure a place!

To obtain a registration form, please contact Sonia Gagliardi on 02 9828 3928 or email: [sonia.gagliardi@sswahs.nsw.gov.au](mailto:sonia.gagliardi@sswahs.nsw.gov.au)

### 2008 COURSES:

Sydney: 23 & 24 July 2008, Military Module 22 July 2008  
Auckland: 28-30 July 2008  
Brisbane: TBC  
Melbourne: 17-19 November 2008



I.M.A Newfellow

## Does the ASC make a profit?

This is a straightforward question with a complex answer

It's a simple enough question: Does the Annual Scientific Congress (ASC) make a profit? This was the first question that I had ever asked during the Resources Section of the Council meeting. I plucked up the courage and asked (with heart thumping in case I had asked a really, really dumb question). No one sneered, there were no guffaws of laughter. Our ever patient Honorary Treasurer explained that this was not a simple question and in fact he said it was a good question (was there a faint hint of condescension on his face or was it just my paranoia?).

As the Honorary Treasurer was starting his reply my mind wandered to something our President has said on several occasions - that of the Senior Office Bearers, only the Treasurer is "Honorary". Why? All other officer holders and office bearers are also unpaid. I have thought about this and have an explanation. All the other positions in the College do not require special professional skills - anyone can be a President or Vice President provided they are politically smart and have their minds around a huge number of complex surgical issues.

However, to be a good Treasurer professional financial and accounting skills are needed. This is where the financial advisers and the staff in the Finance Department come in. The Honorary Treasurer is more of a figurehead and carries the "Honorary" title to

indicate that he is an amateur in finances and not paid a professional fee. Possibly it is also a reminder to him to keep his fingers out of the till. Sorry, I have wandered yet again.

Apparently if you look purely at the ASC income from registrations and trade displays and also consider costs such as venue hire, speaker costs, audio-visual costs, food, etc, it does make a profit. In some years the black writing has been as good as \$300,000. However, nothing is that simple in the accounting world. Because resources at the Spring Street premises are used for the ASC there is a charge allocated to the ASC for the use of these facilities (such things as the office space for the Convention Department, staff time spent on planning and executing the ASC). This is the allocated costing model that has so befuddled me (and other Councillors, judging by their questions).

Out of the financial mists, it became clearer that the ASC certainly covers its own direct costs and the costs of the Conference and Events department. That was good to know. However, it appears that the complexity of the ASC and its requirements to be in different locations mean that it is not ever going to be a substantial money spinner, which does seem fair in the balance of all things.

However, it is still not that simple. There are costs that are associated with the ASC that are termed "Collegiate" costs, such as visiting

dignitaries, the Convocation Ceremony and staff costs to attend and support the many business meetings. These are costs incurred at the ASC but are not part of the ASC costs.

However, (yet again) things are even less simple. Council determines each year that there is an allocation to many scientific meetings to improve the quality of the programs. This is the RACS visitor program. Sometimes they attend the ASC and sometimes they attend other specialty meetings. A few years ago the latter group had the remarkable name of "ASC visitors not attending the ASC" but our wise President, when he was the Honorary Treasurer, changed that contradiction.

I readily admit that I am a simpleton when it comes to finances (Mrs Newfellow agrees with me here). I adhere to the financial model of Mr Wilkins Micawber, from Charles Dickens' novel *David Copperfield*.

"Annual income twenty pounds, annual expenditure nineteen nineteen six, result happiness. Annual income twenty pounds, annual expenditure twenty pounds ought and six, result misery."

As the discussion became more detailed about Collegiate costs, allocated costing models and RACS visitors not attending the ASC, I was almost wishing our Honorary Treasurer was Mr Micawber. But then his answer to my question would have been "sixpence".



Rural  
Surgical  
Training  
Program

### Royal Australasian College of Surgeons

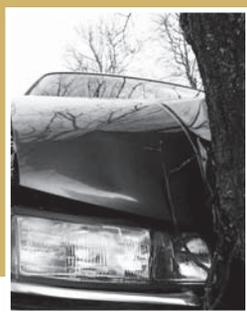
*Are you interested in Rural Surgery in Australia?*

Have you applied to the Surgical Education and Training Program in General Surgery this year? Or are you a current General Surgery Trainee? The program enables trainees to undertake flexible training, which includes hands-on, broad surgical experience and responsibility in regional and rural hospitals. The program also offers access to College facilities such as the RSTP Mentoring Program, and financial assistance to attend courses, conferences and workshops relevant to your training.

For more information about a surgical experience in rural Australia please logon to the Fellowship Services web page at [www.surgeons.org](http://www.surgeons.org) and select Rural Services.

For enquiries please contact Sabina Stuart, Project Officer Rural Services on +61 3 9276 7407, email [rural@surgeons.org](mailto:rural@surgeons.org)

Supported by the Commonwealth Department of Health and Ageing.



*Arthas Flabouris, Chair,  
College Trauma Verification  
Sub-Committee*

# Australasian Trauma Verification Program

## The purpose

The Australasian Trauma Verification Program seeks to promulgate best practice in trauma care across Australia and New Zealand. Following its inception in the late 1990s and at the recommendation of the College's Trauma Committee, the Program has evolved into a dedicated peer review process of evaluation of hospital trauma systems, from pre-hospital care through to rehabilitation services and everything in-between. Trauma Verification is primarily focused upon the trauma patient's journey, evaluating in detail the strengths and weaknesses, quality and efficiency of the care given to injured patients, from the moment of injury through to discharge from the hospital and subsequent rehabilitation. Trauma Verification is a quality tool that is applicable to individual hospitals, regional trauma systems and adult or paediatric patients. Trauma Verification Programs are active in the USA, Canada, Australia and New Zealand and one has been proposed for the United Kingdom.

The benefits of trauma verification include:

- Decreased length of stay of the trauma patient;
- Independent peer review of the quality of care for seriously injured patients;
- Decreased morbidity and mortality rates;
- Enhanced regional trauma systems;
- Defining specific education needs;
- Literature exists regarding the benefits of Trauma Verification and impact on patient outcomes.

Through an external multidisciplinary approach the Program seeks to identify the strengths and weaknesses of a trauma service. Institution to benchmark its own trauma services against predetermined criteria and to identify areas for future enhancements. The Trauma Verification process does not convey accreditation status nor does it seek to "pass" or "fail" the trauma service.

## The history

The development of the program flowed from a key recommendation of the 1993 report of the Working Party on Trauma Systems National Road Trauma Advisory Committee. Utilising a seeding grant from the College, a multidisciplinary working group was formed to develop the program. The program undertook four pilot reviews in 2000 and 2001 and since then has undertaken a further 17 successful reviews across Australia and New Zealand. Reviews have taken place at a number of Level 1 trauma centres as well as across area health networks and in both adult and paediatric hospitals. The reviews can be initiated and remunerated by individual institutions, area health networks, boards and jurisdictions as well as by organisations dedicated to excellence in care of the traumatically injured patient. The Australasian Program is based on the model operated by the American College of Surgeons and drew on the American system for concepts, policies and processes. Joining the College on the Australasian Program is the Joint Faculty of Intensive Care Medicine, the Australasian College for Emergency Medicine and the Australasian Trauma Society.

## The process

There are two levels of visits offered – consultative and formal. A consultative review enables an institution to benchmark its trauma resources and service provision against the current Model Resource Criteria (MRC) and so establish the institution's current readiness and any future improvements necessary for a formal review. It is a review undertaken by a small team over a period of a day or a day and a half.

A formal review ascertains a hospital's adherence to the MRC, its strengths and its weakness, and formulates recommendations for improving verification of trauma care delivery. Verification status will be awarded according to the level of a hospital's adherence to the MRC. A hospital can be awarded formal veri-

fication status if it satisfies all requirements. In the event that formal verification is not given, provisional verification may be granted, which will include recommendations the hospital should fulfil in order to be granted full formal verification. The Program seeks to assist hospitals to attain formal verification, and works closely with hospital staff throughout.

The Trauma Verification Sub-Committee strongly recommends to all hospitals seeking verification that they undertake a consultation review prior to proceeding to a formal review and that the period between a consultation and a formal review be no more than two years. The program also recommends re-verification every three years following formal verification. An essential element of the Australasian Trauma Verification Program is that it is a long term commitment allowing ongoing re-evaluation and benchmarking over an extended period of time. This is how to gain maximum benefit and cost-effectiveness.

The verification team consists of experienced trauma surgeons, intensivists, emergency physicians and trauma nurses. Members are trained in the verification process, including hospital visits. Care is taken to avoid potential conflicts of interest.

The verification team conducts a thorough document-based review via a Pre-Review Questionnaire (PRQ). The PRQ is completed by the institution before the site visit and the responses are compared against the MRC and then qualified during the visit. The documentation review is used as a benchmarking tool, as an information delivery system between the hospital and the review team and as a reporting tool for consultative visits. For example, the Program seeks to gather data and information on the institution and the current state of its trauma system. The data is then compared against the College's standards, translated into the requirements of the trauma service and validated by the site review team during the visit.

During the site visit the multidisciplinary team also meets with key hospital personnel to conduct an audit of randomly selected records of care for traumatically injured patients, trauma education and quality activities.

Once the site visit is completed the team aims to deliver within three months of the review.

One trauma surgeon commented “Thirty-five weaknesses in our Major Trauma Service were identified from the Verification Report, most of which have since been corrected. Verification has been the single most helpful and practical exercise I have undertaken in my experience in Trauma. It is the most effective tool to improve and upgrade a trauma service – both in terms of the relatively low-cost to the hospital and as a practical guide to problem solving.”

### The data

Data gathered on the program over the past eight years show some important trends in relation to Trauma Verification and the outcomes that verification delivers.

However the 17 individual institutions that have undertaken some form of Verification review over the last eight years, only four have returned to the program for further review and three have undertaken and completed the formal verification process. The poor uptake of formal verification review creates challenges for Trauma Directors, Clinicians and Hospital Administrators who must attain the standards of trauma care, clearly documented within the Trauma Verification Program as determined by a multidisciplinary group of trauma clinicians.

“Along with education, formal verification forms one of the two pillars of trauma care,” says Danny Cass, Chair of the Trauma Committee. “Verification is one of the most effective ways to improve the patient’s journey and assist with loop closure.”

The Program has matured to the stage whereby it will be developing future measurable performance benchmarks upon which hospitals will be evaluated. Throughout its history the Program has collected and collated performance measures from a range of hospitals. These measures have proven to be highly variable and highlight the challenges the program and Trauma Services face in

Trauma performance measures

Measure*	Value Median (range)
Patients entered on Trauma Registry (n=11)	1123 (279 – 4048)
ISS > 15 per year (n=11)	283 (118 – 396)
Trauma laparotomy within 4 hours (n=7)	43% (25% - 85%)
Craniotomy for head injury within 4 hours (n=8)	55% (13% - 78%)
Compound long bone fracture fixation within 6 hours (n=8)	74% (26% - 85%)
Nurse trained at TNCC level (n=11)	29% (0% - 100%)
EMST training (n=11)	
Registrar staff	
- Anaesthesia	60%
- Intensive Care	52%
- Emergency Department	50%
- Surgery	84%
Trauma Fellow	100%

the development of future performance measures. The Australasian Trauma Verification Program has made it a key objective to develop, propose and seek broad input into such future measures.

Measures shown are derived from de-identified subset of hospitals that have participated in the Program. The number of hospitals from which data is derived is given as the value “n” for each measure.

Currently, the low level of preparation and readiness for hospitals to be formally verified has made it difficult for the Australasian Trauma Verification Program to firmly demonstrate any collective benefits arising from the Program. There have been attempts at evaluation of Trauma Verification Programs from overseas, in particular the United States, but they also have only been able to derive data from a limited number of sites. Anecdotally, effective trauma systems within hospitals that include champions of trauma within key positions such as a Trauma Director, Trauma Nurse Coordinators, nominated trauma leaders from allied specialties such as anaesthesia, emergency medicine, intensive care, radiology and rehabilitation (including allied health services), a functional trauma bed card and functional and collaborative quality and educational programs that involve measures of performance and loop closure are consistent features that Trauma

Verification Programs have determined to be key components of robust trauma systems.

### The challenges for the future

The challenges for the Program moving into the future are the following:

- To continually engage Trauma Directors, Clinicians and Hospital Administrators through an ongoing involvement with the Trauma Verification Program;
- To develop and promulgate, through multidisciplinary input, standardised performance measures in addition to the existing MRC and PRQ information;
- To measure and report upon change that impacts directly or is indirectly attributable to the Program – ideally this would include both trauma system and trauma patient outcome measures;
- To maintain the Model Resource Criteria as a living and evolving resource that becomes ever more closely aligned to best evidence and practice.

*For more information and to register for a Trauma Verification hospital visit please contact the: Australasian Trauma Verification Program Officer on +61 3 9276 7405 or [alistair.finlay@surgeons.org](mailto:alistair.finlay@surgeons.org)*

*You can also view the program’s website and access important resource material such as the MRC, the PRQ and useful links at [www.surgeons.org/traumaverification](http://www.surgeons.org/traumaverification)*



*Pictured: Helen O'Connell,  
Chair, Surgical Research*

## New registry of expertise

The College has worked hard to develop a surgical research milieu that promotes the passionate quest to expand our surgical knowledge

**D**r Helen O'Connell, Clinical Associate Professor, University of Melbourne, took over the Chair of the Board of Surgical Research (BSR) in June last year. Her background in research started as a medical student, her Master's degree was completed in her residency and Doctorate as a Consultant Urologist.

"Higher degrees require dedication and persistence, not just by the candidate. The supervisor is critical to the process, particularly in the setting up and writing up phases. But it is the process of writing up that gives our research findings meaning", said Dr O'Connell.

"It is a tough discipline but it has the potential of turning research work into public knowledge. The infra-structure required to ensure that surgeons and surgical Trainees in Australia and New Zealand can effectively perform research takes careful nurturing and support. The ANZ Journal of Surgery recently highlighted many of the issues faced by academic surgeons and the obstacles to research excellence in our countries".

"Scholarship values have increased in recent years to provide a realistic living wage to improve the chances that a scholar will focus exclusively on their research for the life of the scholarship. Most of our scholarships are pegged to enrolment in a higher degree."

### **Co-funding of our Scholars with Other Research Entities**

Many of our research scholars have been awarded grants by other key funding bodies such as the NHMRC and the Foundations of the Specialty Societies in addition to their College funding. This combined funding allows the College to increase the number of scholars it funds. It is also an index of the calibre of our scholarship winners.

### **Functions of the Board of Surgical Research**

The Board comprises representation from each of the nine surgical specialties, the Censor-In-

*"Each year, the College provides up to \$1.4 million in grants to fund more than 20 annual scholarships covering all specialties."*

Chief and a representative from the Surgical Research Society. The primary function of the Board is the evaluation of the scholarship applications by standardized scoring of the written applications and interviews. Three Board members evaluate each written application and then shortlisted applicants are interviewed by a further three Board members. It is a rigorous process to which the Board members generously donate their time and energy.

### **Special Purpose Grants**

"Our goal is to foster a research milieu among surgeons and Trainees and also to promote surgical research. The annual scholarship budget of over one million dollars is funded from money raised and managed by the Foundation for Surgery and Fellows' subscriptions. Changes to a scholar's plans at short notice can make funds available for a special purpose grant", said Dr O'Connell.

In late 2007 an opportunity arose to offer a Surgical Service Delivery Research Grant for projects that would be likely to improve access and quality of surgical services. This relatively small grant (\$40K) attracted applications from many leading researchers in Australia and New Zealand. For budgetary reasons there was little time between advertising of the grant and its allocation. The speedy response and the extremely high quality of the proposed research showed the potential for our researchers to take advantage of such opportunities. It also highlighted the potential

for a greater output if a larger pool of funding could be made available for our brightest and most experienced surgical researchers.

### **Statistical Support for Surgeon and Trainee Researchers**

"The research needs of the Fellowship also drive the agenda for the Board. An academic surgeon from Sydney recently queried whether there is adequate statistical support for Fellows and Trainees to work up research ideas and to increase the probability that research funds will bear fruit. Surgeons and Trainees depend on links with universities to provide such support, though it is unclear whether there is equity of access provided through these links.

"The Board has responded by developing a registry of statistical experts who would be willing to provide such assistance. It is proposed this registry would be available on the College website."

### **BSR Governance**

"What struck me when I joined the Board was the clear and clean nature of its governance. It does not run effectively and smoothly by accident. Previous Chair of the Board, Professor Guy Maddern has led the refinement of the College's scholarship process and direction for several years. The work of managers, Nicola Robinson and Rosemary Wong is very responsive to all stakeholders, particularly the applicants", said Dr O'Connell.

"Underpinning the scope of the BSR is its funding base, largely provided by the Foundation for Surgery. A vigorous philanthropic arm of the College to support the research activities of surgeons is needed.

The College has a well established infrastructure for the selection and distribution of research funds. Increasing the resource base is an area where Fellows and their families could contribute. For if we don't contribute, how can we ask others to."



*Hung Nguyen, Chair,  
Tasmanian Regional  
Committee*

## Tasmanian news

Anatomical knowledge is essential and important to all medical practitioners. It is used continuously throughout their career

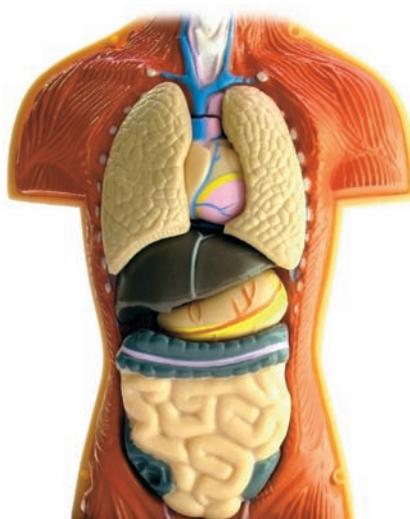
The Tasmanian medical school has begun its five-year undergraduate course. It is best described as a hybrid between a case-based learning and the traditional course and we receive some reassurances that anatomy teaching remains a core part of the curriculum.

Anatomical knowledge is essential and important to all medical practitioners. Furthermore, anatomy is of vital and primary importance to those destined to become a proceduralist or an imaging specialist, the growing lists of which include surgeons, obstetrics and gynaecologists, rural and procedural GPs, dentists, non-interventional and interventional radiologists, interventional physicians such as cardiologists, gastroenterologists, thoracic physicians, intensive care specialists and emergency specialists.

It is often argued by opponents of a formal anatomy course that it is more important to teach a method of learning rather than the content of a subject that is going to be outmoded by the time our graduates finish their course. This argument does not apply to anatomy teaching.

While there are rapid and enormous changes in the fields of immunology, physiology, pharmacology, biochemistry, infectious diseases and pathology, there has been comparatively little change in anatomical factual content even though the teaching methodology might have evolved. It would take the undergraduate about the same amount of time to learn acceptable knowledge of anatomy now as it would have taken 100 years ago. Any reduction of anatomy teaching would inevitably result in a reduction of anatomical knowledge.

To argue "as mastery is no longer possible ... it is essential students identify and satisfy their own learning needs"<sup>1</sup> is to simply say, "if we can't teach it all, it is acceptable to teach less than we did and the students can learn what they like." It is akin to saying that because there are such rapid developments in mathematics, it is perfectly acceptable to do less arithmetic at



*"Practicing surgeons affiliated with clinical schools have certainly noted a reduction in students' knowledge of anatomy in the last 10 years."*

school. While knowledge of the other subjects may not be of any use to a doctor 20 years from now, the same anatomical knowledge would arguably last the longest distance.

Practicing surgeons affiliated with clinical schools have certainly noted a reduction in students' knowledge of anatomy in the last 10 years. While there is a lack of measurement of anatomy learning outcome, the total time spent in formal learning classes, be it in a block of anatomy courses in second year or throughout the course in contextualised cases, is the yardstick of how much anatomy is imparted. The reduction of the only yardstick we have to measure anatomy teaching cannot be recommended. In our rush to embrace the new ways we must recognise that we are at risk of throwing the anatomical baby out with the bath water.

It is simplistic and condescending for any educator to state that students who study anatomy earlier in their "traditional" course will progressively forget that knowledge during their clinical years, as if they do not have the desire and initiative to relearn, revise and reapply their anatomical knowledge in the clinical years. Would the same memory-fade apply to the problem based learning (PBL) cases of the systems learned in the first few years of the integrated curricula? Do they get forgotten in later years?

In order to achieve the highest possible standard of anatomy teaching, care must be given to retain the hours spent in learning anatomy in any curriculum of any medical school, be it in a formal block or in progressive blocks. The time spent teaching, and the outcome, must be measured formally so that evidence based changes can be made. Too often, reforms are embraced for the sake of change without any study of the outcomes. Intuitively, as with education of young children, the time spent and the emphases in a subject matter speak the loudest about the standards expected and the importance of that particular subject.

The importance of communication skills and its teaching to future graduates cannot be overemphasised. However, this involves selection of undergraduates and training of already selected graduates and is a separate issue from anatomy teaching and should not be at the expense of anatomy teaching.

"Traditional" and PBL teachings both have their strengths and weaknesses, their proponents and detractors. The arguments will, no doubt, continue for some time to come, but anatomy teaching should not be diminished in either curricula. Better anatomy does not make better doctors, but it does make safer proceduralists.

### Reference:

1. "The Future of Undergraduate Anatomy Teaching", by J Epstein and SL Elliott *Surgical News* Vol 6, No 2, March 2005, page 13



Rob Atkinson, Chair, Correct Patient, Correct Side & Correct Site Surgery Working Party

## Correct Patient, Correct Side and Correct Site Surgery

The Correct Patient, Correct Side and Correct Site Surgery Working Party continues to promote the College's Implementation Guidelines for Ensuring Correct Patient, Correct Side and Correct Site Surgery.

The guidelines encourage Fellows to adopt protocols utilising multiple, complementary strategies and promote flexibility between surgeons, specialties and hospitals.

A full copy of the guidelines can be accessed on the College website: [www.surgeons.org](http://www.surgeons.org).

The Implementation Guidelines will be reviewed again in September 2008 after consultation with the Specialty Societies, Regional Committees and other bodies. The working party welcomes all feedback on the guidelines.

In addition, the College is collaborating with the various medical defence organisations to share de-identified case studies of correct patient, side and site issues. Included in this article is a case study from The Medical Insurance Group (MIGA).



### Correct Site Surgery Case Study: Spinal Surgery – 'Prone' to errors

Mr X, a 45-year-old man, had undergone previous spinal surgery and required extensive revision.

The planned procedure was a revision decompression at L3/4 and L5/S1 with a posterior stabilisation and fusion at two levels.

It had been identified that at one level (L3/L4) he had bilateral pathology but unilateral symptoms on the left side, so the intention was to operate to relieve those symptoms.

Prior to surgery the patient had marked his left leg, indicating the correct side. It is unclear if the surgeon was present at the time of the marking.

Once in theatre, the patient was turned onto his front and placed in the prone position in preparation for the procedure.

The surgeon had in her mind that it was the right side that needed to be operated on when in fact it was the left.

When Mr X reported that there was no improvement in his symptoms it alerted the surgeon to the error. The surgeon openly and

honestly discussed the error with the patient and it was decided that he would return to theatre.

Mr X returned to theatre five days later and the correct side was operated on with no complications. He was discharged four days later.

Despite the fact that the patient's long term recovery was not affected, his hospital stay was extended by two days and he underwent a further unnecessary general anaesthetic.

Would the error have been avoided if the Implementation Guidelines for Ensuring Correct Patient, Correct Side and Correct Site Surgery had been followed?

If a final verification or "Team Time-out" had taken place, during which the surgeon, anaesthetist and nurse had conferred and agreed on the side that was to be operated on, it is likely that the error would have been avoided.

It should also be considered that, in cases where the patient's position is changed immediately prior to the procedure that the system for marking takes this into account. In the case of Mr X, had the marking also been placed on the posterior aspect of the leg, confusion may have been avoided.

### ANZHPBA 2008 ANNUAL MEETING 19 – 22 October 2008 Hyatt Regency, Coolom Queensland SURGICAL CONDITIONS OF THE LIVER: ASSESSMENT, MANAGEMENT, AND OUTCOMES



ANZHPBA presents a multidisciplinary symposium with emphasis on surgical conditions of the liver. The scientific committee has put together a comprehensive and balanced academic programme.

Leading specialists from around the world, and faculty from Australia and New Zealand will address:

· Evidence in Liver Surgery, pathology, advances in imaging, chemotherapy, techniques, laparoscopic, management of colorectal liver mets, approaches to hepatocellular cancer, transplant, and novel approaches to new problems.

International Faculty consists of:

- Professor Markus Buechler, Heidelberg
- Mr Myrddin Rees, United Kingdom
- Professor James Garden, Edinburgh
- Dr Paul Greig, Toronto
- Dr Ibrahim Dagher, Paris
- Dr Nigel Hacking, United Kingdom

The symposium will be of great value to all practicing HPB Surgeons, General Surgeons, Surgical Trainees, Gastroenterologists, and Oncologists. This event should not be missed. Any further questions please contact the Secretariat at [anzhpba@gmail.com](mailto:anzhpba@gmail.com). Updates and registration form will be on the website [www.anzhpba.com](http://www.anzhpba.com)

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Donald MacLellan, Patrick Cregan, Brian McCaughan, Tony O'Connell & Katherine McGrath

# Clinical Process redesign methods

Applying clinical process redesign methods to planned arrivals in New South Wales hospitals

Lack of focus on the need to balance the hospital resources required for both emergency and planned demands often leads to emergency patients taking precedence in being admitted, and the resultant cancellation of planned admissions. This had been the situation in the New South Wales health system for many years. The interminable increase in the waiting list size is the inevitable consequence.

Over the past few decades, advances in technology in both surgery and anaesthesia have facilitated shorter lengths of stay in hospital for patients undergoing planned procedures. Many patients require only a few hours in hospital, or a stay of less than 24 hours. Much of the growth in demand for surgery could be accommodated by more use of day-only or extended day-only models of care.

The previous article in the supplement discussed redesign solutions for unplanned arrivals at hospitals.<sup>1</sup> Here, we will consider the application of the Clinical Services Redesign Program to planned arrivals in NSW hospitals.

## Diagnosing the problems with planned arrivals

A number of factors contributing to the problems resulting from planned arrivals have been elucidated in the diagnostic phase of the redesign method. They are discussed in the following sections.

### Pattern of planned arrival flows

Unplanned hospital demand is predictable over time, and the degree of randomness or variability is relatively small.<sup>1</sup> On the other hand, analysis of the planned hospital demand over time commonly shows large variability in the patient flows on a daily basis.

Planned arrivals are largely scheduled to suit clinician preference rather than being spread evenly across the full working week. The result is a high planned patient load early in the week and a lighter load at the end of the week.

Unfortunately, the unplanned demand also peaks at the beginning of the week because of a reduced discharge rate at weekends.

Smoothing out the variability in the scheduling of planned arrivals will reduce this potential source of capacity stress in hospitals and will improve the overall ability of the hospital to deal with the natural variability of arrivals.<sup>2,3</sup>

### Managing planned arrivals

NSW hospitals have lacked a purposeful approach to managing the demand for planned surgical procedures. An essential component of managing any system is information about internal and external influences to make it possible to track and predict changes in demand. To date, good management information (eg, waiting list profiles, theatre session utilisation lists) has not been readily available to managers or staff.

### Waiting list control and management

Categorising patients on the waiting list requires more precision than has previously been used. The categories used are: Category 1 (admission desirable within 30 days); Category 2 (admission desirable within 90 days); and Category 3 (admission desirable within 365 days). Placing large numbers of patients in Category 1 (considered "urgent") places considerable stress on the system to schedule their surgery within 30 days; this inevitably increases waiting times for patients not in the urgent category.

Patients are prioritised on a waiting list in order of urgency, but they frequently have their surgery performed in a more random order based on clinicians' preferences related to their operating theatre (OT) lists. This queue jumping leads to longer waiting times for many patients.

In NSW, the number of patients waiting more than 12 months for planned surgery had continued to increase between 1995 and 2004, reaching an unacceptable level of 10 551 patients in January, 2005.

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## Abstract

- Competing demands of planned and unplanned arrivals present major challenges for hospitals.
- Applying clinical process redesign methods to the planned patient journey allows management to recognise the blocks and inefficiencies in the journey and facilitates the development of solutions for improvement.
- Redesign of the planned patient journey in New South Wales has promoted the expansion of the extended day-only model of care, reformed the waiting times policy, standardised patient preadmission assessment and preparation, and targeted operating theatre use.
- Improved performance management at Area Health Service and local facility levels has accompanied the redesign of planned arrival processes.
- The results in redesign of surgery undertaken by the Area Health Services in 96 NSW hospitals have been impressive, with results within two years of commencing the clinical services redesign program showing:
  - a 97 per cent reduction in the numbers of patients in Category 1 (admission desirable within 30 days) whose surgery was overdue, from 5308 in January 2005 to 135 in June 2007; and
  - a 99 per cent reduction in the number of patients who have waited > 365 days for surgery, from 10 551 in January 2005 to 84 in June 2007.
- Improved surgical service efficiency, safety and quality justify the continuation of the redesign program.

*MJA* 2008; 188: S23–S26

### 1 Gains from improving efficiency of operating theatre use

In one Area Health Service, it was determined that the total operating theatre (OT) time unused or poorly used because of late starts, delays and overruns was approximately 11 600 hours across all their facilities. It was estimated that if this waste was decreased by 10%, there would be sufficient sessional OT capacity to halve that Area's waiting list without increased staffing or resources. ●

### Operating theatre and procedure room utilisation

Efficient preadmission and OT processes are necessary to avoid cancellation of planned procedural or operative interventions. Cancellation rates resulting from bed unavailability, patients being medically unfit or not arriving, and emergency surgery load were 10 per cent – 15 per cent in some facilities. The resultant financial cost to the system of a fully staffed and equipped OT remaining idle is considerable, and patients and their families bear a significant social and financial burden (Box 1).

### Applying clinical services redesign to the planned patient journey

There are multiple steps in the redesign of the journey for a patient being admitted for a planned procedure. The main components for the redesign of the planned patient journey, whether for a short stay or a more prolonged admission, are shown in Box 2. This simple schema covers the patient journey from referral through to discharge.

### The redesigned planned patient journey

The main components of the planned patient journey, once redesigned, will facilitate the man-

agement of an efficient, costeffective, safe and high-quality service. Integrating the components requires that management take responsibility for the whole patient journey, avoiding multiple managers and multiple interfaces. The components of the patient journey are described below.

#### Planned surgery

An essential component in managing planned arrival demand is ensuring that the capacity of the system, including beds, staff, equipment, and OT sessions are matched with the demand. Inhouse software programs have now been developed to provide managers with the ability to estimate future planned and unplanned demand based on trended demand data for the state and for individual hospitals. An additional inhouse software program monitors the waiting list and forewarns managers about patients nearing their maximum waiting time at facility level, and ensures that patients on the waiting list have a planned admission date.

#### Waiting list management

Waiting list management should ensure that all patients have their procedures in an appropriately prioritised and timely manner. In NSW, major changes were made to waiting list processes as part of the Clinical Services Redesign Program, and resulted in the 2006 publication of NSW Health's Waiting times and elective patient management policy.<sup>4</sup>

In addition to this policy, specific guidelines for prioritisation of urgent conditions have been developed, and only patients with these diagnoses are automatically placed in Category 1 by booking-office staff.<sup>5</sup> An opt-out system is in place and altered priority categorisation can be organised through the Area Director of Surgery, who is a surgeon. The Area Director makes the final decision, usually after consultation with the clinician concerned.

A patient is not placed on the waiting list if his or her surgeon does not have sufficient OT time available to do the surgery within the

required timeframe. Instead, discussions are held with the surgeon to determine how additional OT time could be made available, or the patient is referred to a surgeon who can perform the surgery within the timeframe.

Implementation of this policy ensures that the patient is admitted in the shortest time within their priority category and prevents queue jumping.

#### Preadmission processes

The Pre-Procedure Preparation Toolkit (PPPT)<sup>6</sup> is an essential determinant for success and defines the processes to prepare the patient medically, socially and administratively. In the Clinical Services Redesign Program, it was recognised that patients should not be required to visit the facility for anaesthetic assessment unless absolutely necessary. Thus, a triage system has been adopted which uses a standardised patient health questionnaire — this is an internationally accepted practice.

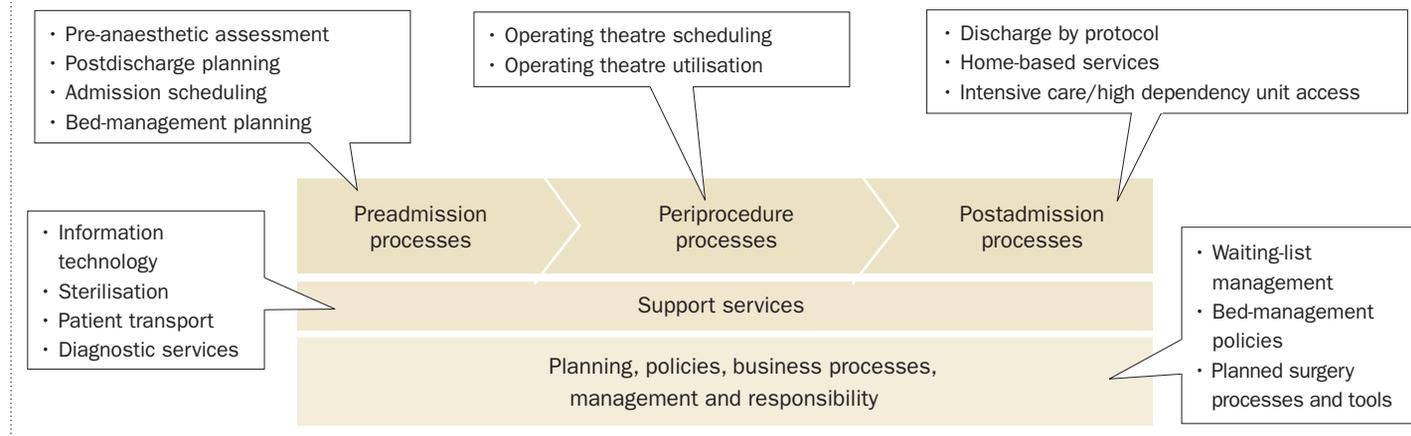
The preadmission process is also used to assess patients' postdischarge needs and to ensure that appropriate plans and resources are in place when patients are ready for discharge after their procedures (eg, home-based rehabilitation following hip replacement surgery, home help, etc).

#### Bed management for planned procedures

The number of beds needed for planned procedures is relatively small if the advances in technology that reduce the length of inpatient stay are applied effectively.

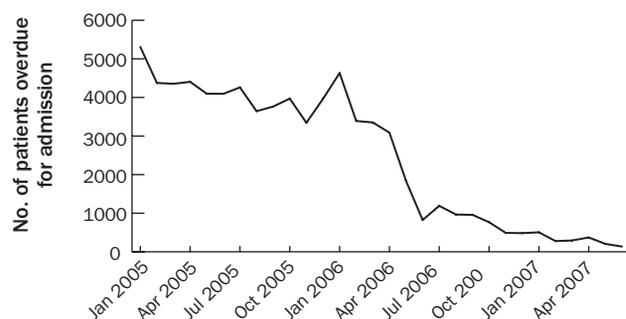
One way of ensuring that planned demand requirements are met is to use admission configurations more suited to the planned arrivals than the unplanned arrivals. The extended day-only (EDO) model mandates a stay of less than 24 hours with patients being managed according to agreed protocols. Under the EDO model, patients are less likely to have their procedures cancelled and discharge is predetermined by a specific protocol.<sup>7</sup> →

### 2 Schema of the main components for the redesign of the planned patient journey



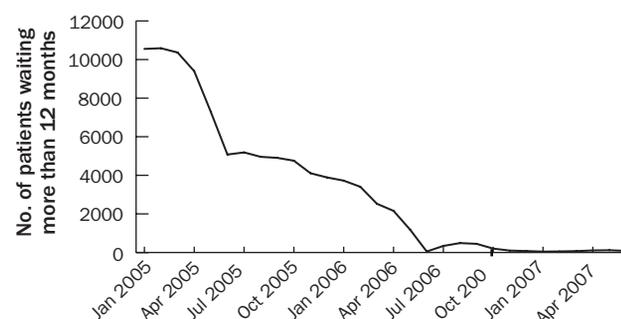
## Clinical Processes

**4 Numbers of Category 1 patients\* waiting > 30 days for surgery in New South Wales hospitals. January 2005 to June 2007**



\*Admission desirable within 30 days

**5 Numbers of patients waiting > 365 days for surgery in New South Wales hospitals, January 2005 to June 2007**



### 3 Simple solution to improve operating theatre efficiency

Sydney South West Area Health Service (AHS) successfully improved efficiency by planning an increase of one procedure per operating theatre in every second session. Across the hospitals in that AHS, this would increase the number of procedures by 7000 per annum without changing the number of sessions or the amount of staffing. Coupled with better defined processes concerning surgery start time, they also successfully reduced overruns. ●

In NSW, the identification of diagnosis-related groups (DRGs) suitable for the EDO model, together with policy support, has led to a significant increase in these designated DRGs going through as EDO admissions in line with the expectations of reaching the 80 per cent target.

#### Theatre utilisation

It is well recognised that efficiency in managing planned procedures relies heavily on OT efficiency. Cancellation rates increase as OT efficiency decreases, with resulting costs to the system and to patients and their families. Late starts and overruns are acknowledged to contribute significantly to a lower level of OT efficiency.

Since the Clinical Services Redesign Program was implemented, theatre staff have been working with surgeons to improve the accuracy of theatre lists so that the number of cases listed is appropriate for the time available (Box 3).

Moving appropriate procedures (eg, endoscopy, flexible cystoscopy) out of the operating suites reduces competition with major surgical procedures for a limited number of sessions. Where possible, patients undergoing these procedures should continue to recover in the OT recovery suite for efficient use of resources.

#### Postprocedure processes

The emphasis on protocol-based management of patients throughout their journey provides significant benefits to both patients and staff in terms of certainty of purpose and the perception of a well organised experience. Discharge planning and protocol-based patient management are part of the PPPT, and are essential components of the EDO model of care.

#### Support services

Information technology is required in the OT environment to provide the necessary data for information management. Planning of sterilising services, transport services and radiological services, to name a few, also need to be integrated into OT scheduling. The management of OTs has been hampered by the variable quality of data management systems, thus making review of OT utilisation difficult. The electronic medical record scheduling system currently being rolled out across NSW will improve the quality of OT scheduling, and the improved information technology support will assist in more automated and integrated data collection.

#### Results from redesign of planned arrivals

The initial results from the clinical process redesign of planned arrivals are impressive. Within a relatively short time there has been a significant increase in more timely patient access to treatment. It is anticipated that the redesign processes will continue to improve the delivery of services for planned arrivals. The results of the redesign are summarised below.

- The total waiting list has been reduced from 68 451 in January 2005 to 56 640 in June 2007.

- A 97 per cent reduction in the numbers of patients in the Category 1 (admission desirable within 30 days) whose surgery was overdue, from 5308 in January 2005 to 135 in June 2007 (Box 4). This improvement was sustained through the winter period.
- A 99 per cent reduction in the number of patients who have waited more than 365 days for surgery, from 10551 in January 2005 to 84 in June 2007 (Box 5).
- Between January 2005 and June 2007, average waiting times for patients on the waiting list in categories 1, 2 and 3 decreased: Category 1, 70 days to 12 days; Category 2, 141 days to 72 days; and Category 3, 226 days to 122 days.

#### Conclusions

Applying clinical redesign methods to the planned patient journey has successfully allowed management to recognise the blocks and inefficiencies, and to facilitate the development of solutions for improvement. The redesign solutions require committed clinician support and strong managers to ensure their implementation, and a robust performance management system for sustainability. With these in place, the improvements are unquestionably impressive, not only in terms of efficiency, safety and quality gains but also for enhancing patients' experiences.

#### Acknowledgements

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#### Competing interests

None identified.

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## North West Private Hospital



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# Fellow in Breast & Endocrine Surgery

This fellowship in Breast & Endocrine Surgery is to be offered again in 2009. It is for one year at North West Private Hospital. The fellow will also work in the Centre for Breast Health at the Royal Women's Hospital & in the Endocrine Surgery service at the Royal Brisbane Hospital. This fellowship offers an outstanding opportunity for training in breast & endocrine surgery with a substantial clinical workload in dedicated outpatient clinics, operating sessions & weekly multi-disciplinary meetings. The holder of the fellowship will also be encouraged to participate in clinical research programs & will be offered the opportunity to initiate clinical/collaborative research study.

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**Further information regarding the Fellowship & application requirements may be obtained from:**

**Professor Ian Gough** – Suite H, Ramsay Place, North West Private Hospital, 137 Flockton Street Everton Park QLD 4053

**07 3870 2450**

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Email: [goughmed@bigpond.com](mailto:goughmed@bigpond.com)

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Royal Australasian College of Surgeons

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Michael Gorton,  
College Solicitor

## The medical profession and the Trade Practices Act (Part two)

In Part one we examined the affect of the Trade Practices Act (TPA) on individual medical practitioners. This Part two looks at the TPA and its implications for the medical colleges, and the training and education of specialists.

### Does the TPA apply at all?

The Australian Competition and Consumer Commission (ACCC) clearly believes that the TPA applies to the medical colleges and, in previous years, has issued allegations against the College and the Australian Orthopaedic Association (AOA), in relation to the conduct of the specialist surgical training programme.

It should be noted that the allegations made by the ACCC were never tested, and were certainly always denied by both the College and the AOA. The suggestion that the College conducted a “closed shop” was strongly resisted, and credible arguments given by the College disputed that decisions on numbers were made by the college – rather the number of training places available for the training of surgeons were dictated by Government decisions, hospital resources and available funding. In any event, the College sought “authorisation” from the ACCC allowing it to conduct the training program without the TPA applying to it – effectively giving the College immunity from action under the Trade Practices Act. In January 2007 the College allowed the authorisation to expire.

A recent decision, *Shahid v Australasian College of Dermatologists* (2007), records a decision of the Federal Court in WA that the TPA may not apply to the medical colleges at all. That decision has determined that the medical colleges can be “trading corporations”, to which the Trade Practices legislation could apply. But the Court then had to decide whether the conduct of the college was “engaged in trade and commerce” for the particular provisions of the TPA to apply in this case.

The Court noted the role of the colleges as an educational and training body, and that its activities were not substantially commercial. The Court noted:

“None of the conduct in question is of a trading or commercial character. It is not enough that it is directed to the wider activity of the respondent to promote and develop dermatology, when it itself is devoid of the requisite character.”

In my view it cannot be found that any of the conduct in question here was a professional activity ... it was not “in trade or commerce ...”

The particular provisions of the Trade Practices Act in this case involved whether the College had made false or misleading representations or statements. It should be stressed that the relevant provisions considered in this case were not “anti-competitive” provisions of the Trade Practices Act considered later in this article.

The *Shahid* case is on appeal, and there is at least some suggestion that the ACCC may intervene in the appeal, to deal with the trade practices issues.

### Issues for Medical Colleges

The TPA provisions are likely to apply to medical colleges, to the extent that they are involved in:

- 1 Price setting, or setting recommended fee scales, which are invariably adhered to.
- 2 Imposing restrictions on advertising by members.
- 3 Imposing restrictions on the ability of members to associate with other professionals.
- 4 Imposing any restrictions or obligations in relation to the additional acquisition or supply of goods or services.

However, it is clear that the major areas which will apply to the medical colleges are:

- 1 Disciplinary procedures.
- 2 Barriers to entry/control of training, and accreditation.

### 1 Disciplinary Procedures

The ACCC has previously indicated that it would review the rules and constitutions of medical colleges to the extent that the disciplinary provisions may apply to restrict a member’s right to operate professionally in the health sector market. That is not to say that a college cannot discipline a member for any range of legitimate reasons, including professional incompetence, unethical behaviour, etc. However, where the disciplinary procedures are applied to control a member’s practice in such matters as fees, advertising, dealings with other professionals, etc., then they may potentially breach the TPA.

### 2 Control of Training and Accreditation

The primary role of most medical colleges is to control training, develop standards and supervise admission to the specialty. In the economist’s jargon, these are “barriers to entry” into the health care “market”. Clearly, the medical colleges control the opportunity for doctors to become recognised surgeons, anaesthetists or other specialists in Australia and New Zealand.

Where that control is used by a college to manipulate the number of doctors admitted to their specialty in order to control the numbers in the profession, the ACCC has indicated that it would clearly regard it as an anti-competitive practice contrary to the TPA.

Clearly, the control of training, accreditation of training posts and limitation of admission numbers all have the potential to be seen as anti-competitive. However, in many cases, there are good reasons for limiting numbers of admissions such as funding restraints, limitations on the ability to supervise training positions, constraints imposed by hospitals or government, the need to maintain professional standards, etc. In most of those cases, the reasons would not be regarded as creating “anti-competitive” practices.

“The control of training, accreditation of training posts and limitation of admission numbers all have the potential to be seen as anti-competitive.”

However, the concern for medical colleges is that Section 45 of the TPA applies in relation to arrangements or agreements which have the purpose or effect (or likely effect) of substantially lessening competition in the market. Thus, the purpose alone of the conduct of the medical college is not the only factor. If the conduct of the medical college also has the effect of substantially lessening competition in the market, it could potentially breach the TPA. This clearly requires further analysis.

The terms “substantially lessening competition” and “market” in the TPA have developed certain legal and economic meanings. In looking at the elements of Section 45 of the TPA, there must be:

- 1 “An agreement, arrangement or understanding between competitors”. The ACCC will regard the rules and constitution of the medical colleges, insofar as they apply to members, as sufficient to constitute a contract, arrangement or understanding between business professionals – the members of the College being the competitors.
- 2 The conduct or arrangement must have the purpose or effect of “substantially lessening competition”. This requires an economic analysis of the actual effect in the market place of the relevant conduct. There must be an objective assessment made of the effect on the ability of professionals in the health care sector to compete against each other, with its effect measured against the ability to control pricing, the numbers permitted to enter the market, the ability to conduct business in the market, etc. Clearly, control of the number of admissions to the training programs by the medical colleges could be regarded, in many circumstances, as “substantially lessening competition”. Clearly, if more trainees were admitted to the programs, competition within the speciality would be increased. Such economic analysis must be reasonably sophisticated in order to conclude that competition has been substantially lessened. However, it is clear that control of admissions will be one matter that the ACCC would review keenly.
- 3 The relevant conduct or agreement must also take place within a “market”. The

market will not just be all surgeons in Australia, or all anaesthetists in Australia. A “market” is an area in which the particular goods or services are relatively interchangeable and competitive with each other. Thus the relevant market may only be anaesthetists in Victoria, or even anaesthetists in Melbourne only. It could be ophthalmologists in Newcastle, if it is clear that most patients do not travel to Sydney for these services and rely on the ophthalmologists in the Newcastle region only. It is probably likely that each of the major capital cities would be regarded as a separate “market” in their own right, with the potential for sub-markets.

- 4 It is also potentially the case that “markets” exist in relation to the separate specialities. For example, intensivists may be regarded as a separate market from the general broader market of anaesthetists. Additionally, orthopaedic surgeons would clearly be a “market” in their own right, as compared to other surgeons.

Thus, when analysing Section 45 of the TPA, the economic analysis of whether particular conduct or agreements have the effect of substantially lessening competition, must be done in relation to each of the relevant markets. Whilst it may be possible to argue that the medical colleges’ training scheme does not substantially lessen competition across Australia, it may nonetheless be possible that the conduct of the colleges’ training scheme does substantially lessen competition in a particular “market”, such as a particular state or a particular speciality or sub-speciality. Clearly, the analysis can get very detailed and confusing.

### Implications for Medical Colleges

There is a significant risk that the ACCC would review college training programs, constituting as they do “barriers to entry”, as to whether they are contrary to Section 45 of the TPA, as having the effect, or likely to have the effect, of substantially lessening competition in a “market”. The ACCC certainly made this allegation in relation to the College.

Therefore, the training programs may be open to attack, not only by the ACCC but

also by individuals who failed to gain admission or other interested parties.

To the extent that the training programs can be demonstrated to have a clear public benefit and are not structured or intended to operate on any anti-competitive basis (i.e., they operate to maintain standards, they are constrained by funding and the requirement for supervision, they do not operate on the basis of unreasonable standards and there is no assessment of the numbers of entry to the training program – which are based on the desire to maintain numbers for the profession generally), then it would be possible for the medical colleges to seek authorisation from the ACCC, as the College has previously done. However, this is a time consuming and certainly expensive process.

An authorisation review by the ACCC involves it closely examining the practices and procedures of the medical college, and invites comment from other interested parties, including government, other professionals, hospitals, insurers, etc. All other sectors will have the opportunity to comment on the college’s training program and its potentially anti-competitive effect. They will also be able to comment on the claim by the medical colleges that the training program has clear public benefits.

Any authorisation granted by the ACCC is likely to be for a limited period of time, say two-to-five years, and would be reviewed at the end of that term.

In most cases, the medical colleges do not actually “select” trainers. They merely accredit posts or hospitals at which training can be carried out. The College is different in this regard, since it actually carries out a selection process for trainers to enter its training program.

### Conclusion

The TPA continues to loom large over the medical colleges. Accordingly it is important that all College board members and executive staff are fully aware of all aspects of the application of the TPA to their activities. Appropriate training and risk management systems should be undertaken and implemented.

*Michael Gorton, Partner,  
Russell Kennedy Solicitors*



Royal Australasian College of Surgeons

## Specialist Re-Entry Program

Are you interested in re-entering the Workforce after a period of absence from Clinical Practice due to illness, retirement or sabbatical?

### Who is eligible?

The program aims to assist those Fellows of the Royal Australasian College of Surgeons who have an Australian Medical Board registration and who want to resume clinical practice in Australia after having taken a break. Such specialists may include those who have left the workforce for family or health reasons or have a desire to return to clinical practice after working in a non clinical role .

For more information about the specialist re-entry program please contact Sabina Stuart, Project Officer Rural Services on +61 3 9276 7407, email rural@surgeons.org

Supported by the Commonwealth Department of Health and Ageing.

## Notice to Retired Fellows of the College

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

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

We will acknowledge your donation and place your name on the gown, if you approve.

If you would like to donate your gown to the College, please contact Jennifer Hannan on +61 3 9249 1248.

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

The College would like to acknowledge the following people for generously donating academic gowns:

- Dr Katharine Drummond FRACS
- Mrs Evelyn Gray on behalf of her late husband, Dr Franklin J. Gray OAM, FRACS
- Dr Raymond Hollings AM, FRACS
- Mr Frederick Niesche FRACS

## CLINICAL FELLOW IN UPPER GASTRO-INTESTINAL SURGERY

**Applicants are invited to apply for the position of Clinical Fellow in Upper Gastro-intestinal Surgery for 2009 at Royal North Shore and North Shore Private Hospitals, St Leonards, Sydney.**

*This is a busy clinical Fellowship during which the Fellow will be exposed to a broad range of benign and malignant oesophago-gastric disease. The successful applicant will be expected to participate in our programme of clinical research and the opportunity for laboratory based research is available. Previous exposure to advanced laparoscopic surgical techniques and a track record of clinical research are desirable. Applicants should be a Fellow of the RACS or hold equivalent qualifications.*

**Applications close 31 May 2008.**

**All applications, CVs and enquiries should be forwarded electronically.**

**Please direct all inquiries to:  
Garett Smith MS FRACS  
Email: garettsmith66@gmail.com**

## CLINICAL FELLOW IN HEPATO-BILIARY AND PANCREATIC SURGERY

**Applicants are invited to apply for the position of Clinical Fellow in Hepato-Biliary and Pancreatic Surgery at Royal North Shore and North Shore Private Hospitals, St Leonards, Sydney.**

*This is a busy clinical Fellowship during which the Fellow will be exposed to a broad range of complex Hepato-Biliary and Pancreatic surgical problems. There is a heavy laparoscopic component and an opportunity for involvement in complex radiological and endoscopic procedures, if desired. There is also ample opportunity for both clinical and laboratory based research during this 12 month appointment. Successful candidates can expect to prepare and submit a minimum of 2-3 scientific papers during their 12 month appointment. Applicants should be a Fellow of the RACS or hold equivalent qualifications.*

**Applications close 31 May 2008.**

**Please direct all inquiries to:  
Ros Rutherford  
Upper GI Surgical Unit  
Tel: 61 2 9926 8525  
Fax: 61 2 9926 5226  
Email: rrutherford@nsecahs.health.nsw.gov.au**



*Ian Incoll, Orthopaedic  
Craft Group Representative*

## Losing Professional Standards, not gaining ‘National Registration’

The federal government’s introduction of “National Registration” of health professionals is nothing more than a Trojan Horse, allowing the destruction of the current system of maintenance of professional standards.

Calling this process “National Registration of Health Professionals” is like propaganda calling the Gulag “re-education”. The title deliberately misinforms and misdirects, drawing attention away from the real agenda – government control of doctor standards, training and placement.

In Australia, the standards by which doctor training and certification are judged have been maintained by the doctors themselves – those with the closest and most up-to-date experience of what “best patient care” means. This task is currently performed by the Australian Medical Council (AMC), a group of professionals independent of the government, and has led to world-class standards of doctor and specialist training in Australia.

The criteria a medical practitioner must possess to be licensed to practice medicine in each state is set by the State and Territory Governments and is the recognition of the national medical standards achieved by the profession. These standards have served Australia well over many years and are policed by the AMC.

One of the most dangerous aspects of “National Registration” hidden inside this Trojan Horse is the federal government’s plan to take over this AMC function and therefore gain control of the setting and maintenance of doctor professional standards as opposed to government recognising standards set by the profession in legislation.

This allows the government to direct the production of as many “doctors” as it likes, without concern for their level of training or competence, safety or ongoing education.

In the UK where this is coming from, there are 14,000 young doctors without future

career prospects and around 770 nurses who can’t get positions. Government meddling in workforce issues has created a fiasco.

Allowing government to take control of Australian medical standards will see medical and surgical specialists trained down to a quota, not up to a level of expertise and safety. This is because one of the current functions of the AMC is the accreditation of specialist training programs, such as the Royal Australian College of Surgeons. This government takeover would allow specialist standards and numbers to become politically controlled rather than based on competency and the safety of the community.

In most states and territories around Australia, we’ve seen what political control of bed numbers has done to the public hospital system.

Overseas trained surgeons, currently making news for the wrong reasons, are normally assessed for competency by the Australian Medical Council or its agencies. It was only when this process was intentionally bypassed by government that the problems began in Queensland. Similarly, problems with Australian trained surgeons occurred when quality assurance processes already in place and supported strongly by the profession were bypassed, i.e., ignoring safeguards is not justification for a greater faceless bureaucracy.

Another hidden agenda is the crippling of the current state Medical Registration Boards. These are the professional bodies that know the needs of each state and maintain a register of doctor competency. Despite the rhetoric, a national database was established in 1992 by a Labour federal government, called “The National Compendium of Medical Registers”. The federal government is reinventing the wheel, rather than just improving the current database.

A national database is an administrative and software issue that does not require a new bureaucratic empire to govern the medical

“Allowing government to take control of Australian medical standards will see medical and surgical specialists trained down to a quota, not up to a level of expertise and safety.”

profession and determine its standards.

Finally, if it is only your hip pocket that speaks (rather than your painful hip), an extra, overarching federal government department such as the one proposed, to maintain oversight of hundreds-of-thousands of health professionals will cost us hundreds-of-millions, if not billions, of extra dollars all paid for in charges levied by the new bureaucracy on you and others on the register.

A national database of medical practitioners that would facilitate portability of qualifications, plus separate state medical boards (talking to each other) with an independent AMC as the accreditor of standards and the continued role of learned medical colleges in training and standard setting is achievable at minimum expense to taxpayers and no cost to the continuance of Australian medical standards.

The Australian medical profession is a national asset. It has achieved great things and should be left to get on with the job of meeting the challenges of the future within the bounds of reasonable and sensible regulation. The Council of Australian Governments National Registration model is a threat to medical standards, not a support.

*Ian Incoll, Federal Council,  
Australian Medical Association  
National Director and Treasurer,  
Australian Society of Orthopaedic Surgeons*

# VOLUNTEERS NEEDED

## for PNG Voluntary Clinics in Kanabea 2008

John Ward, director on the Board of the Children First Foundation, is again asking for applications from volunteer doctors and nurses to do a clinic at Kanabea in the Gulf Province of PNG where the Kamea people live. The dates are 28th June to 15th July; and 4-21 October 2008. The 2009 clinics will be announced later in the year. The clinic will last 10-12 days with some extra time to visit other beautiful areas of PNG. Travel will be by Yarra Valley Conference Centre company aircraft, departing Lilydale Airport in Victoria. Experience in tropical medicine is preferable but not necessary. There are three volunteers on each trip. There is the possible option of doctors or nurses flying commercially direct to Port Moresby where they could be then flown direct to Kanabea for shorter periods of the dates above.

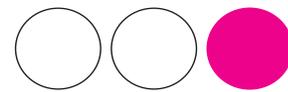
Email your details for more information  
(photos, full medical report from the '07 clinic etc.)  
to : [jward@yarravalleyconference.com.au](mailto:jward@yarravalleyconference.com.au)

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**Fifty** years ago operations such as coronary **artery bypass** surgery and hip replacements which prolong and improve the **quality of life** of thousands of people were little more than **science fiction**.

We live in a world where surgical techniques are rapidly advancing, specialisation is increasing and governments and the community are expecting surgeons to meet increasingly high standards.

In this environment we need to continue to actively nurture surgeon scientists in their ongoing search for knowledge that can both improve patients' quality of life and save lives.



The College recognises and actively supports surgical research through the **Foundation for Surgery.**

The Royal Australasian College of Surgeons





Bruce Barraclough, Chair,  
Foundation for Surgery

## The Scholarship and Fellowship Program

THE Scholarship and Fellowship Program offers over one million dollars in funding annually to the most academic and able surgical Trainees and Fellows. It funds research conducted for the greater good of the entire surgical and medical community, which saves patients' lives. One hundred per cent of the money donated to the Scholarship Program goes towards funding scholarships.

The Program offers two main types of awards: research and travel. The centrepiece of the Program is its research

scholarships and fellowships and these make up the majority of awards offered.

To help support the Foundation there are named memorial scholarships. For many people, a scholarship or grant provides a meaningful memorial to a lost loved one. Most of our donor and bequest funded scholarships are named either for the donor or for a family member as directed by the donor. Memorial scholarships offer a unique opportunity for you or your loved one to be remembered for giving back to the community now and for future generations.

## Foundation for Surgery Research Scholarship

UNDER the supervision of Associate Professor Joe Tjandra and Professor Richard Simpson, at the Ludwig Institute of Cancer Research, Dr Skandarajah's research looked at the use of proteomics to profile blood as a means of discovering biomarkers which may facilitate the early detection of colorectal cancer.

She said finding a way to detect changes in certain proteins in the blood was now seen to be the next advance from genetic screening.

"Colorectal cancer is the most common cancer in Australia with five per cent of the population developing the disease in their lifetime," she said.

"It can be cured if diagnosed at an early stage however most cancers present at an intermediate stage.

"(Therefore) early diagnosis of colorectal cancer by way of a simple blood test evaluating tumour markers would be ideal.

"Colorectal cancer results from perturbations in the normal signaling and/or transcriptional regulatory networks of the colonic cells and these perturbations manifest

themselves by altering the protein expression patterns of the tumour cells.

"We hypothesised that with increasing tumour load this will eventually alter the quantitative relationship of organ specific proteins in the tumour microenvironment constituting a blood fingerprint."

"Understanding and capturing the body's dynamic response to disease is clearly the best marker of a disease state but developing the science to allow for that is the challenge," she said.

"This research is very labour intensive and very expensive and the College Scholarship was enormously helpful."



**"Early diagnosis of colorectal cancer by way of a simple blood test evaluating tumour markers would be ideal."**

## Surgeon Scientist Scholarship

DR Michael Wong is working on what could be a world-first treatment for glioblastoma multiforme, the most common and aggressive brain tumour in the adult population.

Now in his third year of the scholarship, Dr Wong is working with a combined team of surgeons and scientists at the University of Melbourne and the Royal Melbourne Hospital on developing a novel targeted therapy for the cancer.

“The existing treatment for glioblastoma multiforme is not highly effective. Evidence shows that patient outcomes remain quite poor despite all the current treatments available including surgery, radiotherapy and chemotherapy. The median survival rate remains at only twelve months because the cancer is so aggressive,” he said.

“We believe our work is likely to change clinical treatment and hopefully extend that survival rate.”

He said the work was now gaining world-wide attention and that he would be presenting aspects of the research at both the World Federation of Neurosurgical Societies in



“We believe **our work** is likely to **change** clinical treatment and hopefully extend that **survival rate.**”

Japan and the American Association of Cancer Research in Singapore.

“While this is very rewarding work, we are not looking at finding the definitive cure for cancer. But what we are doing is developing a drug that could prove useful in conjunction with existing treatments to combat glioblastoma,” Dr Wong said.

“I think it is a great credit to the College that they fund and support one of the highest paid scholarships available in medical science. To have financial support from the College makes an enormous difference and sends a strong signal about the value of scholarship to our profession.”



## NZ Research Fellowship

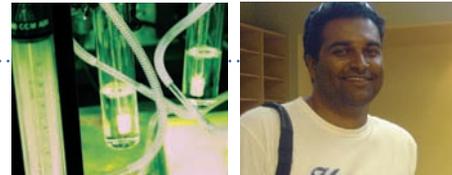
NEW Zealand surgical Trainee Dr Sachin Mathur, has used the funds provided to conduct world first research into the role of nutritional intervention for patients suffering catabolic illness.

Dr Mathur’s research is focussing on liver transplant patients who have signed up to be part of a double-blind randomised controlled trial at Auckland City Hospital. He said the study, designed and run by the Body Composition and New Zealand Liver Transplant Units based at Auckland Hospital, will determine what benefits arise from giving patients immunonutrition (omega-3 fatty acids, arginine and nucleotides) before surgery.

“Our research is unique in that it looks at manipulating their immune system via nutrition that potentially may reduce post-operative infectious complications or even episodes of rejection.

“We believe that there might be indications for giving liver transplant candidates omega-3 fatty acids before their surgery to increase body protein and therefore improve malnutrition.

“This is the first trial in the world to look at omega-3



“The fact that the College **supports Trainees** like me means more of us have an **opportunity** to conduct scientific research...”

fatty acids in liver transplantation and it is exciting to be involved in such a project.”

“When you take time out of clinical work and training there is always the fear about funding, and the fact that the College supports Trainees like me means more of us have an opportunity to conduct scientific research at the highest levels,” he said.

“Unless you have the opportunity to give it your entire focus you can’t get fully involved in the work and learn all aspects that research has to offer. I am grateful for the opportunity.”



Thank you

## Donations to the Foundation for Surgery



### Argentina

Mr M Gillespie

### Hong Kong

Mr K Tsui

### New Zealand

Dr M Hollyoak

### Singapore

Mr H Chng

### South Africa

Professor A Millar

### USA

Mr Y Lo

### United Kingdom

Mr M Terry  
Mr R Wilkinson

### Queensland

Mr A Ganko  
Professor Y Ho  
Associate Professor S Pillay

### Western Australia

Mr D Collopy

### New South Wales

Dr R Abraszko  
Mr A Collins  
Mr G Curtin  
Dr J Deves  
Mr P Grant  
Mr B Haymet  
Mr D Huber  
Mr P Kevin  
Dr A Lewis  
Professor D MacLellan  
Professor M Morgan  
Dr J Rooney  
Mr M Stephen

### Victoria

Mr S Chang  
Mr D Esmore  
Mr D Murphy  
Dr F Walker

.....  
**Total:**

\$4827.50

## Balancing Life

### Improving your working life – MABEL goes ‘live’

**M**ABEL (Medicine in Australia: Balancing Employment and Life) is a major new national longitudinal survey of doctors that is being sent to all doctors in Australia in May. MABEL is funded by the National Health and Medical Research Council (NHMRC) and is being conducted by researchers at the University of Melbourne and Monash University. The results from extensive piloting, which will be included in the results for the first wave, are promising. The responses were broadly representative of age, gender, Rural Remote Metropolitan Area (RRMA) and doctor type and

some further changes to the questionnaires have been made. We are striving for as many doctors to fill out the survey as possible, so please respond to our invite letter or register on our website [www.mabel.org.au](http://www.mabel.org.au) to participate. MABEL has now been formally endorsed by the Royal Australasian College of Surgeons and a number of other colleges, societies and postgraduate training councils.

*Anthony Scott,  
Professorial Fellow,  
The University of Melbourne*

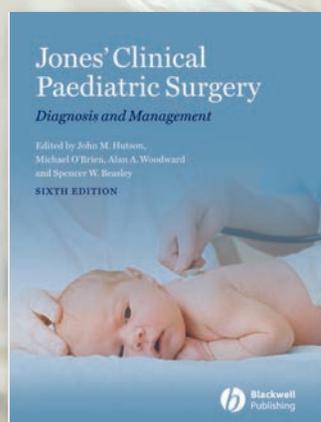


# The Surgeon's Book Club



## Welcome to The Surgeon's Book Club

Highlighted in this month's issue are recent and new titles from across the surgical spectrum available from John Wiley & Sons (inc Blackwell Publishing books).



9781405162678 April 2008 | PB  
A\$115.95 A\$92.76

### Book of the month 20% discount

**Jones' Clinical Paediatric Surgery 6e NEW**  
(ANZ Authors)

Edited by John Hutson, Michael O'Brien, Alan Woodward and Spencer Beasley

This unique book applies a systematic approach to explain the role of surgery in treating childhood diseases. Throughout the book key subject areas are supported by case vignettes as well as high quality photographs and illustrations. Building on the successful style of previous editions, this sixth edition of Jones' Clinical Paediatric Surgery is substantially revised exploring fundamental topics such as:

- Neonatal Emergencies
- Head and Neck
- Abdomen
- Abdominal Mass
- Urinary Tract
- Trauma
- Orthopaedics
- Chest
- Skin/Soft Tissues

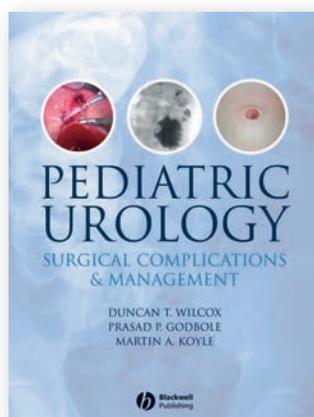
Jones' Clinical Paediatric Surgery provides paediatricians and surgeons with a straightforward and clear explanation of the surgical options available for the care of the paediatric patient.

### Pediatric Urology – Surgical Complications and Management

Edited by Duncan Wilcox, Prasad Godbole and Martin Koyle

This is a practical evidence based textbook with the following features:

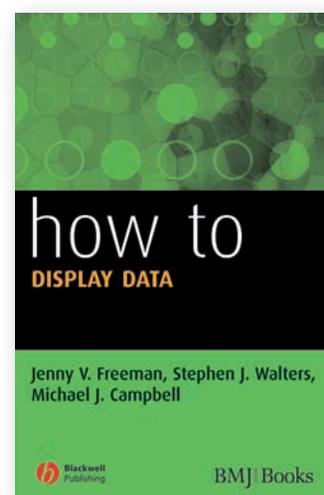
- World renowned editors and contributors offer personal experiences
- Clearly addresses common and rare complications in paediatric urological practices
- Details operative procedures and prevention of complications
- Enables reader to deal with principles and practice of audit



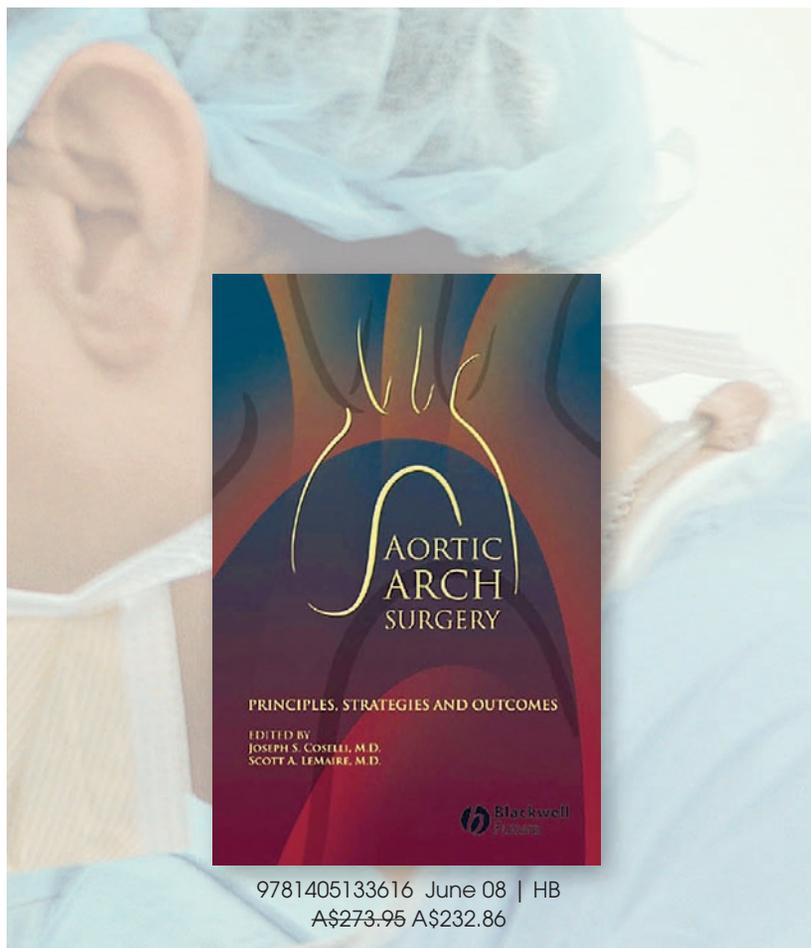
9781405162685  
May 2008 | HB  
A\$192.95 A\$164.00

### How to Display Data

Effective data presentation is an essential skill for anybody wishing to display or publish research results, but when done badly, it can convey a misleading or confusing message. This new addition to the popular "How to" series explains how to present data in journal articles, grant applications or research presentations clearly, accurately and logically, increasing the chances of successful publication.



9781405139748  
Jan 2008 | PB  
A\$46.95 A\$39.91



9781405133616 June 08 | HB  
A\$273.95 A\$232.86

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Wiley-Blackwell offers RACS Fellows discounts on All Wiley-Blackwell titles.  
A 20% discount is offered on the Book of the Month.  
15% discount on all other books.  
**You must quote Promo Code RCS08**

**Aortic Arch Surgery**

Edited by: Joseph Coselli & Scott Lemaire  
(Both Baylor College of Medicine)

Focusing exclusively on the surgical management of aortic arch disease in adults, this concise reference provides authoritative guidance on both standard and alternative approaches from internationally recognized experts.

Topics include:

- general principles of aortic diseases
- imaging techniques
- intraoperative management
- neurologic protection strategies
- options for aortic repair
- surgical treatment of specific problems
- complications

Abundant illustrations demonstrate significant imaging study findings and depict key techniques and strategies.

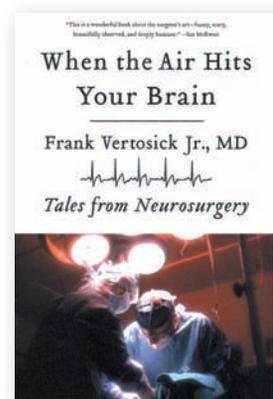
With its detailed descriptions and thorough explanations of a wide variety of approaches to imaging, brain protection and monitoring, and aortic reconstruction, *Aortic Arch Surgery: Principles, Strategies and Outcomes* gives practicing and prospective thoracic and cardiovascular surgeons access to the full armamentarium of management options. Anesthesiologists, perfusionists, neurologists, radiologists, and others who have a special interest in treating patients with thoracic aortic disease will also find this book an invaluable source of dependable information.

**Leisure Reading**

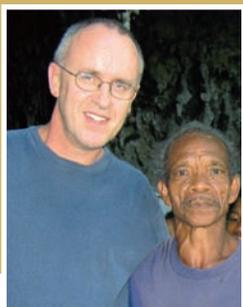
**When the Air Hits Your Brain:**  
**Tales from Neurosurgery**  
Frank Vertosick Jr., MD

Dramatic, moving, and utterly fascinating. —*New York Times* Book Review

With poignant insight and humor, *When the Air Hits Your Brain* chronicles one man's evolution from naïve and ambitious young intern to world-class neurosurgeon. In electrifying detail, Frank Vertosick Jr. describes some of the greatest challenges of his career, including a six-week-old infant with a tumor in her brain, a young man struck down in his prime by paraplegia, and a minister with a .22-caliber bullet lodged in his skull. Told through intimate portraits of Vertosick's patients and unsparing yet fascinatingly detailed descriptions of surgical procedures, *When the Air Hits Your Brain*—the culmination of decades spent struggling to learn an unforgiving craft—illuminates both the mysteries of the mind and the realities of the operating room.



9780393330496  
Mar 08 | PB  
AU\$20.95 A\$17.81



## Helping those in need

OSSAA builds trust and understanding with local people and medical counterparts in the developing countries where it works



Last year, a photograph was sent to Mr Mark Moore, an Adelaide plastic surgeon and vice-president of the Overseas Specialist Surgical Association of Australia (OSSAA). The image was of a young West Timorese woman who had severe burn contractures of the neck that had drawn her face down onto her chest. It had originally been sent to College staff by members of Oxfam asking for help.

Upon receipt of the photograph, Mr Moore showed the image to OSSAA co-ordinator Ms Ruth Boveington who felt a twinge of recognition. She hunted through old records of the service and found the woman pictured in an earlier photograph, then a child of only eight, also snapped in a plea for help because she had been born with a cleft lip and palate.

An earlier effort to bring her to Australia for treatment had failed and she had become

a recluse in her isolated village because of both the birth defect and the terrible consequences of the untreated burn.

“The picture was haunting. There was this pleading look in the father’s eyes and then to see her 15 years later still untreated and with worse physical suffering to endure was difficult,” said Mr Moore.

Now, that has changed. Mr Moore, through OSSAA and Oxfam, had the young woman, named Yanti, sent from her home in West Timor to the island of Flores where the first of many operations was conducted to treat the cleft lip and palate and then ease the severe burn contracture.

“There is a special little place on the island of Flores that was once a leprosy hospital where people with deformities can stay and be treated. The social stigma some of these people have

faced is as bad or worse in the developing world as it is here, but at St Damian Hospital they are treated with dignity and respect and some stay forever,” he said.

Mr Moore said the hospital had three new operating theatres and ward blocks and was run by the Sisters of the Holy Spirit, a world-wide order of nuns based in Europe.

“The hospital was established 40 years ago and the nun who set it up is still there. Many of the nuns undertake post-operative care and rehabilitation and show a deep commitment to the people of the community. Patients who go there for treatment are given places to stay but are also expected to work and they make shoes, splints, prosthetics, furniture and grow food,” he said.

“Hundreds of people live there, providing payment for their treatment through their work supporting the community, which

in turn gives them a sense of dignity and involvement when in some cases they had been rejected and ostracised for years by their local village community.

“It is a wonderful place, one of the most special places I’ve ever visited.”

Mr Moore said the first operation on Yanti was done in October to repair the cleft lip and release the neck burn contracture, with another visit scheduled for June for further surgery.

“One of the best aspects of St Damian Hospital is the ongoing patient support, which means that we can do the repair in stages. Obviously, the bigger the operation the bigger the risk, a risk that is magnified when the surgeons are only visiting,” Mr Moore said.

“Here, (Yanti) can stay and have physiotherapy and receive after-care until she is ready for the next procedure.”

Mr Moore has been involved in OSSAA since it took over the former Australia South East Asia Rehabilitation Service, set up by the respected surgical philanthropist Mr John Hargrave when he retired in 1999.

With up to eight visits a year, he travels through East Timor, West Timor and Flores, mostly conducting plastic surgery but also providing support for general, orthopaedic and ENT surgeons. He has worked in East Timor on 22 separate trips (the last seven years supported by the College’s East Timor aid program), and made 18 trips to Indonesia, working mostly in Flores.

He said the most important aspect of OSSAA’s work, based on Mr Hargrave’s philosophy, was that it was designed as a bottom-up aid programme rather than a top-down bureaucratic aid arrangement.

“A lot of international aid programmes involve surgeons visiting on just one or two occasions and while that is laudable it does not allow for a deep understanding of the community you are trying to help,” he said.

“Without developing trust with the local people and local medical counterparts it is at times impossible to know what skills are wanted, what facilities are available, what will happen when the surgeon flies home. We have seen some work on clefts by other surgeons with very bad results, as if they go to developing countries to train.”

Mr Moore said OSSAA works with local nurses or nuns or alongside young GPs sent by the Indonesian health system to remote areas for the first years of their careers.

It also sends younger Fellows of the College to West Timor or Flores to work along-

side young Indonesian surgeons.

“Surgery is expensive in Indonesia with most specialties only represented in the major cities so many people in remote areas totally miss out. You need to know what treatment is required, how to get the message to the people in need and how they will be cared for after you go,” he said.

“That is what makes us different. A lot of aid programs are based on a signed agreement in Jakarta and are designed to trickle down from the top to the bottom, but that often means that the aid doesn’t actually reach the people most in need. The best network in the developing world is often through religious organisations because they have a central commitment to the care of the poor.”

Mr Moore said there was a high incidence of cleft lip and palate in East and West Timor because it was more common in the Asian population and it was related to malnutrition and folate deficiency during gestation.

He said that some people born with the condition were often forced to wait decades for treatment even though they were unable to eat properly and were therefore malnourished and ill, unable to attend school and unable to contribute fully to their community. However, he said untreated burns were the cause of even more suffering.

“The frequency of severe burns injuries relates to cooking with kerosene, poor quality clothing and no trauma care. They are often little people so the burns are correspondingly large and many die,” he said.

“Many of those who survive and have healed without pain control, suffer severe contractures with arms fused to chests or chins to chests and some of it requires major surgery to treat.”

Mr Moore said Yanti had coped well with the initial surgery and was likely to return to her village when all procedures were complete.

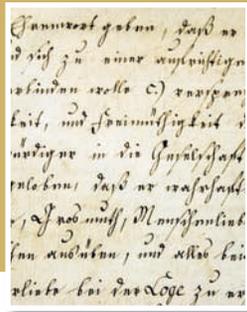
“She’s doing pretty well and like many people from this part of the world doesn’t complain about the surgery or what she has been through but when you think about what people like Yanti have endured, it is beyond our imagination.”

1. Children who have undergone plastic & reconstructive surgery having rice & vegetables for breakfast
2. Nusa Tenggara, Timor
3. A local girl recovering after her cleft palate operation
4. Yanti before the operation
5. Yanti after her first operation, with lip repair and some neck burn contracture release
6. St Damian Cancar Flores NTT

“One of the best aspects of St Damian Hospital is the ongoing patient support, which means that we can do the repair in stages.”



Dear  
Editor



## Letters to the Editor

### Road carnage

Worthy as is Rob Atkinson's suggestion in his article "You can help stop the road carnage" (*Surgical News*, Jan/Feb. '08), it is only picking at the edges of this major problem. It is the speed and power mind-set that has to be changed. No amount of fiddling with minor hot-spots is going to make much difference to this Australia-wide tragedy.

Everywhere one looks, there are advertisements for cars, the main appeal being performance, yes, even in the NRMA magazine *Open Road!* Motoring magazines abound, advertisements on television and radio and online emphasise the need for faster and faster cars. We frown at street racing but our attitude encourages it. Far greater numbers of Australians are killed and injured on our roads than in Iraq, Afghanistan or Vietnam.

I believe this subject sits alongside smoking and binge-drinking as challenges for this so-called advanced society. It took us a long while to deal with smoking, still not completely, but alcohol and the road toll are far more immediate in their effects and need to be dealt with far more urgently. Yes, it will hurt most of us, many in the hip-pocket, but let's not let vested interests undermine our resolve.

K. B. Orr

*Retired surgeon (including trauma)*

### Dear K. B. Orr

Many thanks for your reply and interest.

The College Trauma Committee is committed to cutting down speed with alcohol and driving and our track record does demonstrate this. In recent days we have managed to get the speed limit in the Northern Territory down to 130. The big advantages of tackling speeding and alcohol consumption is that it is measurable, can be legislated on and enforceable to some degree. In fact, enforcement is a weak point that needs a large amount of resourcing and we would be very keen to support any campaign in

this regard. Daryl Wall in Queensland is pushing this as fatalities in the Gold Coast have doubled over the last 12 months. If you stood out on the road with a hairdryer I am sure you could cut down some of the speed temporarily.

We have done our best, writing to motor vehicle companies as well as the program *Top Gear* to encourage them to look at safety, sustainability, economy, reliability and recognition of the impact on the environment. By chipping away we do change the culture to some degree and in fact the recognition of brain maturation has resulted in graded licensing being increased in Queensland, New South Wales and Victoria. We would like speedometers to only go to 130kph and have pushed this with no result thus far.

The aim of the Road Safety Watch Program is to generate a community engagement in order to change the culture and have ordinary people empowered to say they can do something to change the motor vehicle environment for good.

Even though a particular issue may be relatively minor it is a step along the path and the more the ordinary citizen realises that it is within their power to stop the killing then the more it may be we will see a change.

At this point everything tried seems to have reached a plateau and we cannot get below the 1600 deaths a year so a circuit breaker of some sort is needed.

I would see a cultural awareness and more powerful enforcement enabled by community support as a potential circuit breaker.

I totally agree that to change the mindset is the key. I will leave you with the old adage "How do you eat an elephant? Answer: One mouthful at a time."

Robert Atkinson, Chair,

*College Road Trauma Committee*

### Lessons from delayed diagnosis

I dare say most of us have experienced unfortunate cases such as that in Joseph Lizzio's

article "Lessons from a delayed diagnosis (*Surgical News*, March '08). Here are three more patients illustrating other ways for a serious diagnosis to be delayed:

1. A fit 80-year-old man had been put on the waiting list for a lesion on the right cheek by a colleague. I saw him some months later at follow up after a Highly Selective Vagotomy for chronic DU, as part of a series. His HSV had done well but I did not like the look of the lesion. I arranged for an urgent operation by my colleague. The lesion was an SCC with perineural infiltration; he died soon after of intracranial spread.

Lesson: Don't let your waiting list become a death list!

2. A middle-aged man had been in hospital for investigation of his cardiovascular system. Just before discharge, he had a test for urinary catecholamines. Some weeks later he was admitted with a coronary occlusion when it was revealed from the previous test that he had a phaeochromocytoma. Unwisely he underwent an attempted removal of the adrenal tumour from which he died.

Lesson: Never order an investigation without looking up the results.

3. An elderly man had a lesion removed from the right leg by his GP, who then went on holidays. The histopathology was filed, in his absence. Months later the man presented to the GP with hard lumps in the right groin. The original report was then shown to be a squamous-cell carcinoma. So was the groin lesion, which did not respond to radiotherapy.

Lesson: always follow up your histopathology. Enough said.

K.B. Orr

*Ed: these did not have medico-legal implications then but they would today. Nevertheless the clinical lessons are timeless.*



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**A/Professor Cathy Lazarus**  
**Professor Gregory Wolf**

Visit [www.surgeons.org/headneck2008](http://www.surgeons.org/headneck2008) for further information



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**Meeting Announcement**



**I.A.A.S.**

8th International Congress on Ambulatory Surgery  
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Meeting Announcement  
**GSA Annual Scientific Meeting**  
**"Acute Care & Oncology  
for the General Surgeon"**

26-28th September 2008  
Hyatt Regency Coolum, Queensland, Australia

**Program includes:**

- ◆ Exam 'demystifying' session for Trainees
- ◆ Trainees' Day & Trainees' Forum
- ◆ Educational day on "Principals of Surgical Oncology"
  - ◆ Ultrasound Workshop
  - ◆ Acute Care for the General Surgeon

**GSA Organising Committee**

Mr Philip Truskett  
Professor Bruce Mann  
Mr Graeme Campbell  
Ms Meron Pitcher  
Dr Mary Theophilus

**For further information contact:**

Kymerley Walta  
RACS Conferences & Events Department  
Tel: +61 3 9276 7406  
Fax: +61 3 9276 7431  
Email: [kymerley.walta@surgeons.org](mailto:kymerley.walta@surgeons.org)



**MEETING ANNOUNCEMENT**  
**PROVINCIAL SURGEONS OF AUSTRALIA**

**PSA 2008**  
**ANNUAL SCIENTIFIC CONFERENCE**

WAGGA WAGGA  
2 - 5 OCTOBER 2008

THEME: Updating General Surgery

**FOR FURTHER INFORMATION**

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FAX: +61 3 9276 7431



Philip Truskett

## RACS medal recipient Norman Fary

An educator whose work provided a cornerstone to the EMST and CCrISP programs

In the March edition of *Surgical News*, educator Norman Fary was recognised for his outstanding contribution toward the Care of the Critically Ill Surgical Patient (CCrISP) and Early Management of Severe Trauma (EMST) programs as the recipient of the RACS Medal. Unfortunately, the details of his citation incorrectly implied involvement in the inauguration of Advanced Trauma Life Support (ATLS) International in Nebraska in 1977.

### RACS Medal

#### Norman Fary Citation

The EMST and the CCrISP programs have been success stories of the Royal Australasian College of Surgeons. In an address to the Trauma Society in 1998, our then president, Bruce Baraclough, attributed the success of the EMST program to a small group of dedicated enthusiasts. Among those enthusiasts, he named Norman Fary.

Norman Fary has shared the role of educator for both the EMST and the CCrISP programs virtually since their launch in Australia and New Zealand. The role has included the design and delivery of instructor courses and the meticulous audit of course delivery.

Norman graduated from Melbourne University with a Bachelor's Degree in Commerce and Education. He then completed a Master's

of Education at Monash University before travelling to Nebraska to complete a PhD at the University of Nebraska.

Nebraska, of course, resonates with the ATLS/EMST program as it was the site of the tragic 1977 plane crash involving orthopaedic surgeon James Styner and his family.

The accident lead Styner to say: "When I can provide better care in the field with limited resources than what my children and I received at the primary facility – there is something wrong with the system and the system must be changed."

This was the beginning of the ATLS program. The most significant next step was to turn to the education faculty of the University of Nebraska to ask it to assist in designing a course to provide an appropriate education envelope to teach trauma care.

The more recently developed CCrISP course is modelled on this educational package. Norman's educational pedigree is therefore undoubted.

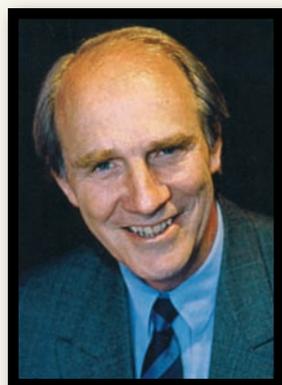
After the Nebraska experience, Norm continued his career teaching as an academic in both Australia and Britain. He completed his career as Principal of St Leonard's College in Victoria.

In 1988 he joined the College as an educator at the commencement of EMST and later embraced CCrISP.

His contribution as an educator has provided a cornerstone to the EMST and CCrISP program.

He has been previously honoured as a Fellow of the Australian College of Educators and was awarded the Hedley Beare Educator of the Year Award in 2000 for Educational Leadership.

## ASTRAZENECA UPPER GI RESEARCH GRANT RECIPIENT-2008



The College would like to congratulate Professor Glyn Jamieson, who is the 2008 recipient of the AstraZeneca Upper GI Research Grant. Professor Jamieson is the Dorothy Mortlock Professor of Surgery at the University of Adelaide. This grant will be used by Professor Jamieson to undertake a research project entitled 'Prognostic impact of micrometastases in oesophageal cancer – applying the sentinel lymph node concept'.

**The College wishes to thank AstraZeneca for its continued support of medical research in the field of Upper GI/HPB Surgery.**

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**ROYAL AUSTRALASIAN COLLEGE OF SURGEONS**  
**EXECUTIVE DIRECTOR OF SURGICAL AFFAIRS (New Zealand)**  
**PART TIME APPOINTMENT (0.5 FTE)**

**Key Direction Statement**

As a fellowship based organisation, the Royal Australasian College of Surgeons strives to ensure the highest standard of safe and comprehensive surgical care to the community through excellence in surgical education, training, professional development and support.

**Values**

- Service and professionalism – performing to and upholding the highest standards
- Integrity – upholding professional values
- Respect and compassion – being sympathetic and empathetic
- Commitment and diligence – being dedicated, doing one's best to deliver
- Collaboration and teamwork – working together to achieve the best outcome

The College invites applications from interested Fellows for the position of Executive Director of Surgical Affairs – New Zealand (EDSA-NZ) within the College. This position is located in New Zealand.

The primary objective of the role is to provide advice to the NZ National Board, NZ Fellows and the NZ Manager on professional surgical matters and to ensure that strategies implemented by the College will achieve the best outcomes for the Fellowship. The EDSA is responsible to the Chair of the National Board on professional matters and to the NZ Manager (on administrative matters).

You should be a Fellow with previous experience of College committees and an involvement in the College's activities. Experience in research, policy development and / or consultation with professional groups would be advantageous.

For a detailed person specification and position description please contact [Monica.Carrarini@surgeons.org](mailto:Monica.Carrarini@surgeons.org) in the College's Human Resources Department, Melbourne

Applications for all these positions close at 5pm on Friday 6 June 2008 and should be addressed to the Chair, NZ National Board, Royal Australasian College of Surgeons., c/- Monica Carrarini at the email address above; or posted to Ms Carrarini at the College Head Office (Spring St, Melbourne, VIC 3000, Australia).



**Postgraduate Course in Clinical Anatomy**

The Monash University Departments of Anatomy & Developmental Biology and Surgery (MMC) are pleased to announce the Postgraduate Course in Clinical Anatomy for 2008. The Course will provide postgraduate training in anatomy for graduates wishing to advance their knowledge in anatomy. Though designed for trainees preparing for specialist college examinations, the course is open to graduates from any other health science discipline. In view of previous popularity, registrants are advised to enrol early.

The Course will be taught by anatomists from both Monash University, The University of Melbourne and relevant specialist surgeons. It will involve the use of the Museum and Dissection Room facilities at the Clayton campus. The Course will consist of 16 sessions on Monday evenings from 6.30-9pm and will cover the anatomy and surgical anatomy of the entire body. Participants in the Course will have access to the Anatomy Museum. Examiners for the College of Surgeons will give optional formative assessments if requested. The course does not involve cadaveric dissection, but will include examination of wet specimens.

Attendees will receive a CD of relevant software showing over 10,000 anatomical and surgical images and a 300 page syllabus. Each participant will receive a copy of the College approved anatomy text 'General Anatomy - Principles & Applications' (McGraw Hill 2007). Participants completing the course in 2008 will receive a Certificate of Attendance.

Further details of course are provided below:

**REGISTRATION IS DUE BY MONDAY JUNE 18.**

**Dates:** Monday 30 June to Monday 20 October, 2008

**Venue:** Department of Anatomy and Developmental Biology, Building 13C, Monash University, Clayton campus.

**Cost:** \$1,100 including GST and \$550 for part-time enrolment for Physiotherapists and Sports Medicine professionals only needing the limbs and spine component.

To register click on: <http://ecommerce.med.monash.edu.au/categories.asp?cID=1&c=245842>. If you have any questions please contact: [mira.petrzalez@med.monash.edu.au](mailto:mira.petrzalez@med.monash.edu.au); ph 03 95945500.

**FURTHER INFORMATION**

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Dr Gerry Ahern  
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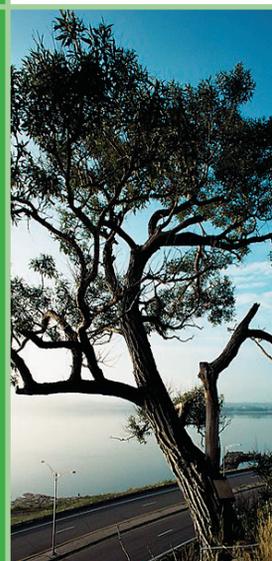


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Tobias Nebl

## Fuelling Visions

Fuel cell vehicles guarantee sustainable mobility, and Mercedes is a driving force behind it

The view from the fifth-floor window is idyllic. You gaze over a Middle Age fortress, lush forests and green meadows and the view encourages your thoughts to run free.

What better place to contemplate the vision of a hydrogen-powered future as outlined in Jules Verne's *The Mysterious Island*. It is fitting that the path towards zero-emission transportation should lead us here to Nabern, just outside Stuttgart.

The office with a view belongs to Christian Mohrdieck. The Director of Fuel Cell Drive Development at DaimlerChrysler since 2003, for the past two years he has also been the Director of Nabern's Fuel Cell Competence Centre. The centre employs some 400 people, all working to perfect the environment-friendly drive system of the future.

Fuel cells are the major focus here. Submarines use fuel cells to generate power, and this technology has long been standard in the space industry. But, as Mohrdieck says, "nowhere is the need for fuel cells greater than in automotive construction".

Mercedes engineers unveiled the world's first vehicle driven by hydrogen-powered fuel cells in 1994. Sir William Grove's 'gas voltaic battery' may have set the course back in 1842, but Mercedes' NECAR 1 constituted a genuine milestone. The technology underpinning this initial prototype occupied the entire load-bearing surface of the small van.

Two years later came the NECAR 2. Based on a V-Class, this test vehicle had a pair of hydrogen tanks fixed to the roof, with the fuel cell technology accommodated under the rear seat bench. Inside the NECAR 2 there was space to seat six passengers – fuel cell technology had graduated to the next level.

Not far from Mohrdieck's office, in Building 3, you pass through a steel door into an innovation gallery. Ahead of you is an enormous stack of several fuel cells. To the left, there is a twin-

ling display case of metal plates coated in various precious metals. There's an A-Class with a pioneering fuel cell motor, and a vehicle whose insulated tank can hold liquid hydrogen chilled to minus 253 degrees Celsius. The book may now have been closed on these particular vehicles, but not before they had helped identifying gaseous hydrogen as the fuel of the future.

Sixty F-Cell vehicles in operation around the world have demonstrated just how user-friendly this technology has become. Service teams from Japanese gas supplier Tokyo Gas now use Mercedes-Benz fuel cell vehicles, and these automotive pioneers can also be spotted on the runway at Frankfurt Airport.

The procedure is always the same: turn the key, wait for the 'OK' in the cockpit unit display and slide the selector lever into 'D'. The four-door car sets off with barely a whisper. Driving is like flying in a glider, almost skimming the surface of the road, but a press on the accelerator taps into 210Nm of torque, the top speed hitting 140km/h.

All in all, the converted A-Class works so seamlessly you can't help but wonder why it has yet to make the leap into the showroom. "So far we have not reached the stage where we can guarantee the standards you would expect of a Mercedes," Mohrdieck says.

He is referring, among other things, to the car's current inability to top 200km on a full tank, to the difficulty of starting the car in below-zero temperatures and the challenge of fitting the technology into vehicles, although the Nabern experts have already reduced fuel cells to a fifth of their size over recent years.

The A-Class cars in the F-Cell fleet have more than 400 fuel cells on board which, when combined into a stack, produce output of 72kW. The hydrogen that generates the power is sourced from two tanks fitted in the double floor section. A compressor ensures sufficient supplies of the fresh air essential for the exothermal reaction.

When the driver accelerates, the boost effect pushes him back in his seat. This can be explained as follows: the electric motor serves as a generator under braking, the recovered energy charges a battery, and that supplies the extra dose of power when the driver accelerates.

Nabern is also the hub of a sophisticated data network. Data such as the voltage levels in the fuel cells is transmitted automatically to a receiver in the network by the fleet of 60 F-Cell vehicles. A team of almost a dozen people evaluate incoming data on a daily basis.

There are also 'Flying Doctors' – a group of globally operating fuel cell specialists who spring into action when a local service crew cannot solve a problem. An array of sensors in the A-Class cars supply them with a wealth of information. This allows them, while still in Germany, to identify which components have developed a gremlin.

Some 15,000 fuel cell-specific spare parts can be dispatched around the clock through an external logistics centre. This investment of time and resources has paid dividends in the form of the more than three million kilometres of fuel cell vehicle testing carried out by Mercedes-Benz.

As well as the A-Class cars, this innovative fleet also includes two Sprinter vans and 36 Citaro urban buses. "No other manufacturer can match our level of experience in this area," says Mohrdieck. "We've racked up the equivalent of about 150,000 operating hours."

This experience has been channeled into the F 600 Hygenius test model, which offers a preview of the second-generation fuel cell vehicles. This next wave is already in the starting blocks in B-Class guise.

"It will be on the roads before the decade is out," says Mohrdieck, whose mind has already turned to third and fourth generations. "We expect the new car to take us a big step forward." The experts in Nabern are fine-tuning the development of a fuel cell car with an



“A fuel cell vehicle should not be significantly more expensive than a comparable standard car.”

operating range in the region of 400km.

This has been made possible by higher pressure in the plastic tanks, enveloped in a carbon-fibre casing, and more efficient fuel cells. The result is energy use equivalent to less than three litres of diesel per 100km. As well, the use of high-tech materials has allowed the water to be removed from the fuel cells. The system now even starts reliably at minus 25 degrees Celsius and damage caused by ice for-

mation is a thing of the past.

Reducing costs plays a particularly crucial role in Mercedes' development road map. “A fuel cell vehicle should not be significantly more expensive than a comparable standard car,” Mohrdieck says, citing the platinum used as a catalyst in the fuel cells as reducing much production cost. One target being doggedly pursued is therefore a cut in platinum content to a tenth of current levels.

So when will fuel cell technology become

our everyday reality? “That should happen within the next 10 years,” Mohrdieck says. “We are expecting to have technology at our fingertips sometime between 2012 and 2015 which can be prepared for the market.”

Mohrdieck is keen to be among the first people to drive a fuel cell car privately, an intention shared by every one of his colleagues at the Nabern facility.

*Reprinted with kind permission from Mercedes, from Mercedesmagazine, Autumn, 2008.*

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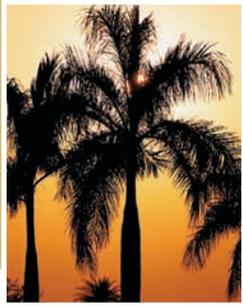
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Graeme Campbell,  
Chair, Fellowship Services

# Technology: a surgeon's best friend

Dedicated, user-friendly databases provide easy access to quality research and information

## Literature searches and Evidence-based databases

A good literature search involves searching several databases, as each one will include different information. With so many databases available to us, finding good quality evidence like systematic reviews, guidelines and randomised controlled trials (RCTs) can be a challenge.

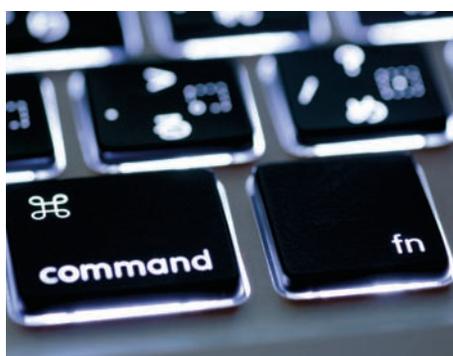
The online library of the College provides a selection of key databases, including OVID Medline and Evidence Based Medicine Reviews (EMBR). Within these databases you will find systematic reviews, guidelines and RCTs.

## Medline on Ovid

With Medline on Ovid, you have the choice of using "Basic Search" or "Advanced Search". In Basic Search, you can use natural language including phrases. The search results will be ranked by relevance, and within that by date so that the most relevant, most recent articles come first.

Under each citation in the list of results you can click to open and review the abstract without needing to leave the page of results. If you find an article exactly on your topic, there are also options to "find similar" and "find citing articles".

The default setting when you open Medline in the College's online library is Advanced Search. This allows combinations of search terms and phrases. You combine by choosing between the options "AND", "OR" or "NOT". As with Basic Search you can also limit the search results by date and other criteria including only EBMRs. When you enter a search term, you may notice "Map Term to Subject Heading" underneath the box. This means the system will look for the "official" descriptors of that term. This may help you get more specific results but you can also click to turn it off if you wish.



"The next time you are searching for systematic reviews, RCTs or guidelines, why not try one of these user-friendly, dedicated databases?"

## Evidence Based Medicine Reviews

EMBR is a package of seven, high-quality full text EBM databases including Cochrane's. These databases provide a very reliable coverage of current and past systematic reviews of topics, article reviews and access to definitive controlled trials. You can search EBMR separately or in combination with Medline.

## Free resources

Here are some other evidence-based databases that you may find useful:

- Turning Research Into Practice (TRIP) is a free international database, available at [www.tripdatabase.com](http://www.tripdatabase.com). The TRIP database includes systematic reviews, guidelines, clinical questions and evidence-based synopses, and provides links to any available free full-text. This database can also be used to locate other types of information including medical images, patient information handouts and textbooks. It also contains resources for

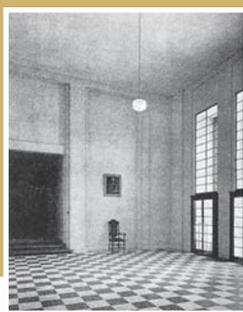
each major specialty, which can help you to retrieve relevant information.

- PubMed Clinical Queries is a free filter which searches PubMed and can help you to find higher levels of evidence. It is available at <http://www.ncbi.nlm.nih.gov/entrez/query/static/clinical.shtml>, or can be accessed through PubMed <http://www.ncbi.nlm.nih.gov/sites/entrez> by clicking on "Clinical Queries" in the blue bar on the left of the screen. You can use PubMed Clinical Queries to limit your search to systematic reviews and RCTs. Just like all your other PubMed searches, not all of your search results with PubMed Clinical Queries will be full-text, but the College library staff will be happy to provide you with the articles you need.
- Evidence Australia ([www.evidenceaustralia.net](http://www.evidenceaustralia.net)) is a new, free resource. It was developed at the Royal Melbourne Hospital and searches evidence-based Australian health sites. Its advantage is that it only retrieves Australian information, and is likely to return relevant systematic reviews and guidelines. Your search results are usually full-text, allowing you to quickly access the information you need.

The next time you are searching for systematic reviews, RCTs or guidelines, why not try one of these user-friendly, dedicated databases? Like many of the College online library resources, both TRIP and PubMed Clinical Queries are RSS-capable, so you can add your searches to your RSS reader and feel confident that you will stay up-to-date. For more information on RSS technology, please see the article on this topic in the April issue of *Surgical News*.

Please email [College.Library@surgeons.org](mailto:College.Library@surgeons.org) for further information including user guides

Anne Casey, Manager, Library and Website and  
Caryn Perera, Research Officer at ASERNIP-S.



Keith Mutimer,  
Honorary Treasurer

## The aspirator's inventors

Devised to assist in draining the pleural cavity, the aspirator soon became the maid-of-all-work

Aspirators were important in the days of rampant pulmonary tuberculosis and during the World Wars when they became a useful tool in the management of gunshot wounds to the chest

On display in the College of Surgeons Museum are two aspirators. One is a Potain's aspirator, the other a Dieulafoy aspirator. These closely-related aspirators were invented in the 19th century by two leading French physicians.

Pierre-Carl-Édouard Potain (1825-1901) was born in Paris. For most of his career as a cardiologist he was associated with Necker Hospital in Paris. He was an assistant to Jean-Baptiste Bouillaud (1796-1881), who was a major influence in his decision to study cardiothoracic diseases. Potain made several important contributions to the understanding of cardiovascular disease. Some of his tests included analysis of jugular venous waves, research into heart gallop and blood pressure testing. In 1889 he was credited for making modifications to the sphygmomanometer, a device used to measure blood pressure that had been recently invented by S.S.C. von Basch (1837-1905).

A man known and respected for his compassion and generosity, Potain was also a man of refinement who liked music, especially Beethoven, and literature, especially Racine and Châteaubriand. He was a close friend of the writer Alphonse Daudet. His voice was said to be deep and comforting, his hearing acute and his eyes, though bulbous and askew, held a keen gaze from which little escaped.

Potain's name is also associated with several eponymous medical terms, which are no longer in common usage. These include Potain's Disease (pulmonary edema), Potain's Solution (a diluent once used in a procedure to count



“A man known and respected for his compassion and generosity, Potain was also a man of refinement ...”

red blood cells) and Potain's Syndrome (dyspepsia with expansion of the right ventricle).

Potain invented his aspirator to assist in draining the pleural cavity (paracentesis thoracis), but it soon became a maid-of-all-work.

The standard Potain's aspirator consists of a graduated glass bottle fitted with a rubber cork pierced by a T-shaped tube with two stopcocks (no.1 and no.2). Both stopcocks are connected via rubber tubing: no.1 is connected to a syringe pump and no.2 to the aspirating needle. The air from the glass bottle is exhausted by the metal pump, while stopcock no.1 is kept closed. After the needle has been introduced into the abscess cavity, the stopcocks no.1 and no.2 are opened and the drained fluid/necrotic material enters the exhaust bottle by suction.

The aspirator on display is one of several in the College's collections. Unlike the others, which are housed in black cases lined with purple silk with “Aspirateur du Dr Potain” stamped in gold in the lid, this one is in a plain metal case and is intended for field use. There is an engraved dedication on the lid which reads “G.L.L. from W.K. 1912”. It is in very good condition, even though it has obviously been much utilised. It was donated by B.C. Milroy.

### Potain's principal publications

“Des mouvements et des bruits qui se passent dans les veines jugulaires”

*Bull. Soc. Méd. Hôp. Paris (Mémoires)* 2me sér. no.4 (1867).3-27

“Du rythme cardiaque appelé bruit de galop, de son mécanisme et de sa valeur séméiologique: note présentée à la Société médicale des hôpitaux de Paris” *Bull. Soc. Méd. Hôp. Paris (Mémoires)* 12 (1875-76).137-66

“Du sphygmomanomètre et de la mesure de la pression artérielle chez l'homme à l'état normale et pathologique” *Arch. Physiol. Nom. Path.*, 5 sér. no.1, 556-69

*Dernière leçon de M. le professeur Potain.* Paris, Gainche, 1900

*La pression artérielle de l'homme à l'état normal et pathologique.* Paris, Masson, 1902

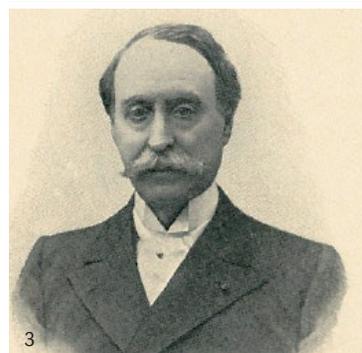
Paul-Georges Dieulafoy (1839-1911) was a physician and surgeon, born in Toulouse into a well-to-do family. One of his uncles was a surgeon. His younger brother Marcel-Auguste was to become a renowned archaeologist who is best remembered for his excavations at the ancient Persian cities of Susa and Pasagardae.

Dieulafoy studied medicine in Paris and gained his doctorate in 1869. He was Adjunct Professor at the Faculté de Médecine and phy-

sician to the hospitals in Paris, becoming chief of medical services at the Hôtel-Dieu. He worked on numerous topics including pleurisy, typhoid and Bright's disease, wrote a manual on pathology and was elected President of the Académie de Médecine in 1910. As a teacher Dieulafoy influenced many graduates, but he is best known for his gastrointestinal studies including acute appendicitis. He described its early symptoms and clinical manifestations in detail, most notably the collection of symptoms now known as Dieulafoy's triad, and was one of the first physicians to stress the importance of surgery in the treatment of this condition. He is also known for his description of Dieulafoy's lesion, a rare but well-recognised cause of life-threatening bleeding from the gastrointestinal tract, especially the upper tract, resulting from the rupture of an exposed submucous artery, and he did extensive research into hydatid disease and epidemic hepatitis.

He developed his aspirator, a modified version of Potain's, during his internship under Potain in 1865-69. Like Potain's, it was intended for draining the pleural cavity but quickly found other uses, including the draining of hydatid cysts and the suprapubic draining of urine from the bladder in cases of urethral stricture. Dieulafoy first described his aspirator and its method of use in *Traité de l'aspiration des liquides morbides* (1873), including an engraving of it at the end of the book. Its main variations from Potain's device are the syringe pump, which is glass mounted in a metal frame with graduations along its side, and a simpler spigot arrangement.

The College's example dates from about the end of the 19th century and was made by Collin & Cie, Paris. It is in a black case lined with purple material with "Aspirateur de Dieulafoy" stamped in gold in the lid. It is in excellent condition and belonged to the late Alfred Trinca FRACS. It was donated to the College in 1999 by Gordon Trinca FRACS.



1. Dieulafoy's aspirator  
2. Potain's aspirator  
3. Dr Dieulafoy  
4. Dr Potain

In 1878 Dieulafoy was honoured for his services to medicine. As the *Journal de Toulouse* noted on Saturday October 26:

"Par décret du 20 octobre, M. Dieulafoy, professeur agrégé à la Faculté de Médecine de Paris, médecin des hôpitaux, est nommé Chevalier de la Légion d'Honneur. - Inventeur d'un aspirateur très employé en médecine. Services exceptionnels."

### Dieulafoy's principal publications

*De la mort subite dans la fièvre typhoïde.*

Doctoral thesis, 1869.

*De l'aspiration pneumatique sous-cutanée.*

*Méthode de diagnostic et de traitement.*

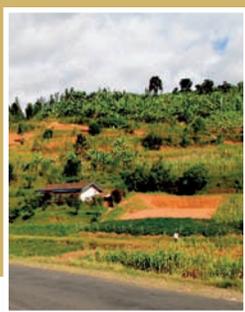
Paris, 1870; English edition published simultaneously in London.

*Du diagnostic et du traitement des kystes hydatiques et des abcès du foie par aspiration.* Paper, Paris, 1872.

*Traité de l'aspiration des liquides morbides. Méthode médico-chirurgicale de diagnostic et de traitement. Kystes et abcès du foie. Hernie étranglée. Rétention d'urine. Péricardite. Pleurésie hydatose.* Paris and London, 1873.

Manuel de pathologie interne. Paris, 1880-84.

"Exulceratio simplex. L'intervention chirurgicale dans les hématoméses foudroyantes consecutives a l'exulcération simple de l'estomac" *Bull. Acad. Méd.* 49 (1898).49-84



Paul Anderson, Co-founder,  
Hospitals of Hope

## Surgery in Rwanda – first you need a hospital

“The fact that nearly a million Rwandans died in one of the biggest acts of ethnic cleansing the world has witnessed remains a living testimony to our apathy and the Rwandans’ durability.”

This journey began in 2005 when I was challenged to take a surgical/medical team into Rwanda. It came about after talking to Russell Lee in Sydney. He is the organiser of the charity Operation Open Heart, which is dedicated to taking pediatric cardiac surgical teams into areas of need — in this case Kigali in Rwanda. The trip was to be part of a worldwide response to mark the 10-year anniversary of the genocide; a giant mea culpa for ignoring pleas from both UN commanders on the ground in 1994 and the people themselves — which if responded to in a courageous and timely manner may have averted much of the subsequent genocide. The fact that nearly a million Rwandans died in one of the biggest acts of ethnic cleansing the world has witnessed remains a living testimony to our apathy and the Rwandans’ durability.

My initial reaction to Russell’s challenge was that it was not something I was going to be comfortable dealing with — my previous experience of being badly wounded in a terrorist attack in Africa some years previous negatively coloured my feelings about the project. I thought my way out was to create an unrealistic expectation, so I indicated that if there were more than 10 people interested then I would offer serious consideration to being involved. Surely they wouldn’t get 10 people. My name was then put on the Hope Rwanda website and the response was overwhelming. More than 30 people with some kind of medical skill were so moved by the project that they offered to go to Rwanda — 30 people who were going to be led by a rather reluctant surgeon who was now, in addition to leading the team, going to have to confront ghosts from the not-too-distant past!

The medical surgical team comprised people from all over the world including England, South Africa, New Zealand, the US and Australia. Those who volunteered covered the medical spectrum — nurses, physiotherapists, occupational therapists, hospital administrators

and pharmacists. The response was such that it was decided that two medical teams would go to Rwanda under the Hope Rwanda banner. Since I was the only surgeon I led one team, with the other, coordinated by Dr Simon Wu from Sydney, allocated to a separate, more-northern, peripheral hospital. With the cooperation of the Rwandan government my team duly arrived and were allocated Gisenyi Hospital, which is in Rwanda but only just — it is 800 metres from the Congolese border.

Gisenyi Hospital is a 300-bed facility with a catchment area of approximately one million. It is staffed by five doctors who are all grossly overworked and draws not only from the Rwandan but also the Congolese side of the border. It was in a state of general disrepair, having been overwhelmed and overrun at the time of the genocide in 1994 with little done to repair it since. Its location is on Lake Kivu, which offers a contrasting scenic background and also provided great respite for the team as on its shores, amongst all the poverty, is a four-star hotel with good security and excellent food. One of the things about taking a team into Africa is you don’t want to spend a great part of your time treating your own team!

The hospital is situated on a dirt road leading into the town of Gisenyi. Further down the road is the congested Congolese border. Opposite the hospital is the prison, which is

full to overflowing. The hospital grounds are serviced by prisoners dressed in easy-to-spot pink — the HIV-positive ones are given retrovirals in return for their labour.

The real challenge for this team was where to start. There was a great lack of everything, with only one X-ray machine servicing the surrounding population of one million and the sole radiographer wearing a lead apron with all the lead at the bottom! We brought him a new one on the next trip but weren’t sure whether the large radiating smile was entirely due to gratitude.

The hospital has two theatres, only one of which was working. That theatre had electricity, but it was intermittent, and no overhead theatre lights, merely a stand-alone reading lamp with a 100-watt bulb (see the video on the Hospitals of HOPE Africa website). There is no diathermy and all anaesthesia is ketamine with a mask and oxygen. When the electricity cut out someone would have to leave the theatre, run down the hill and start the generator so there was enough light to continue.

Having said that, the first “operation” I was part of was a caesarean section. I had tried to prepare for that scenario by assisting at three caesarean sections before leaving Adelaide. That first caesarean section was unlike anything I had seen in Adelaide, and the fact that the neonate had an Apgar of two would probably indicate the degree of difficulty of the procedure. However, the fact that the neonate survived is probably a metaphor for Africa — that survival requires extraordinary strength and serendipity.

The challenges from a surgical point of view are multiple, and such are the conditions that one frequently questions whether such a mission can achieve any short term, or long term, good — a feeling the rest of the team experienced from day one. I had spent in total 10 years in Africa previously and memories were instantly rekindled so my adjustment wasn’t as great as for some. But for many in the medical team this was



Gisenyi Hospital on the Congolese border



Only the strong survive



Dr Anderson consulting



The team pursued 'small steps'

their first experience of these conditions.

Briefings and debriefings became a twice daily event. The conditions were totally foreign — hygiene was non-existent, sterilisers were broken, wash-up for theatre didn't work and a hand bowl and soap was used. Ventilator tubing had perished and was held together with tape. All such problems were potentially overwhelming to new recruits. It was a matter of constantly reassuring and re-evaluating what one hoped to achieve in a situation such as this when, in addition to the conditions, there was so little to work with and significant problems with language (French) and education.

Our approach became that we had to proceed with very "small steps". This became the title of the documentary made by Rachel and Sharon, two girls from Channel Seven who were travelling with us. It is available from the author or through the Hospitals of HOPE Africa website.

From a general medical/surgical team point of view, the small steps were as basic as going to the market and buying sheets, towels and bowls in which the patients could be washed, as well

as teaching basic hygiene to the nurses on the wards. Surgically listening for bowel sounds was a fascination.

The nursing encountered was more patient-watching and IV insertion. Very little hygiene exists with no barrier nursing and no isolation of infective patients — although HIV patients are in a separate ward. A significant amount of UN aid goes into the HIV programme. Nurses in Rwanda are graded A1 or A2. A1 nurses are the ones who have had some tertiary education, whereas the A2 nurses have generally just had two years of secondary schooling. This means the amount of nursing training is enormously variable and the nursing team found that basic principles of hygiene had either not been taught or were lacking implementation. They introduced a hand washing protocol to try and cut down the cross contamination, and instructed staff on how to look after, wash and prepare patients for surgical procedures.

There is no such thing in the hospital as a central kitchen, all food for patients is supplied by patients' families. Cooking facilities exist around the hospital in the form of open fires

where families bring food, which is then cooked for the patients. Most patients are malnourished and those who, through the genocide or other conditions such as HIV or malaria, have no family do not do well in hospital. Nutrition naturally became a team focus.

Surgically, I was able to do small procedures such as inguinal hernias and lumps, but I found advice was also sought on mastitis, goitres and on orthopaedic problems such as chronic fistulae secondary to osteitis.

What comes out of an experience like this is difficult to evaluate from a surgical viewpoint. I think one can end up being extremely disappointed that one can't contribute more from one's surgical experience. But the experience itself can also change your view on life, for here are a people so very grateful for anything that you can do for them. You end up thinking, what else you could possibly do to make some improvement in their lives?

It occurs with a bit of thought that there is much that can be done.

Visit [www.hospitalsofhopeafrica.org](http://www.hospitalsofhopeafrica.org) for more information



## Specialists Without Borders

The non-profit organisation that facilitates teaching visits to developing countries by Western specialists

Working in the third world, one can easily be amazed at the degree of skill that exists among people who have graduated with a basic degree in medicine and then been forced to become obstetricians, gynaecologists, urologists, orthopaedic surgeons and general surgeons as well.

As head of a Hospitals of HOPE Africa-sponsored medical team at Gisenyi Hospital on Rwanda's Congolese border, I was impressed that, given the circumstances and lack of hygiene, significant complications did not occur more often. Obviously this was difficult to assess as patients would leave hospital with little chance of a follow-up. Yet one assumes that if there were serious complications they would re-visit the hospital. Certainly none of the surgical procedures my team witnessed ended up with significant post-operative complications.

One of the things that concerns you when you are part of a medical team in a third world

country is whether you are actually doing anything that positively contributes. Two weeks after arriving, the medical surgical allied health team I headed at Gisenyi Hospital decided that a meeting needed to be held to evaluate the effectiveness of our intervention and decide what assistance or aid strategy to adopt.

It emerged at this meeting that several crucial things were needed. The first was a building or facility where healthcare could be distributed to the local community. The hospital in Gisenyi was barely functioning and was in great need of refurbishment and rebuilding. The second was the establishment of some kind of coordinated community healthcare programme. It was therefore decided that at subsequent hospital visits patients would be given a questionnaire to acquire data for a community healthcare programme to go with the new hospital. The third need identified was for education at both the most basic levels and also at the levels of the graduate staff.

As mentioned, what impresses in Rwanda from a surgical point of view is that you have doctors coming through a system without specialist training who end up with general specialist expertise, which can be quite daunting when compared to that of a Western surgical model. The doctors who were designated surgeons in Gisenyi Hospital were able to provide a wide range of expertise, from orthopaedics and gynaecology to general surgery and urology. These doctors expressed a strong desire for postgraduate teaching and out of this desire and need Specialists Without Borders has emerged. Like Hospitals of HOPE Africa, Specialists Without Borders is a non-profit organisation. It aims to take medical, surgical, nursing and allied health specialists into areas of need for one-to-two week periods of teaching, primarily using the SCIM module

Hospitals of HOPE Africa was established to work in conjunction with the Rwandan government and philanthropic groups to



“The hospital in Gisenyi was barely functioning and was in great need of refurbishment and rebuilding.”

achieve the best African hospital and community health care plan. This organisation has now established a website which details the undertaking and it actively seeks both individual and corporate sponsorship.

The result so far in terms of interest and pledges of support has been surprising. Contact has come from many areas indicating a global interest in contributing to something that has the potential to positively impact the lives of many below the global poverty line. The logistics of undertaking something as audacious as a 300-bed hospital need to be coordinated, especially since the organisation has already been granted land, the design has been donated by a New York architect and the project has a Rwandan supervisor doing logistical work such as sourcing building supplies and labour. Inter-

est has so far been from larger corporate groups, including the Clinton Foundation.

The first Specialists Without Borders workshop/conference is scheduled to be held in the Rwandan capital of Kigali in July. To date, five surgeons and two anaesthetists have committed to be part of a structured clinical instruction module, which will be trialled for the first time in an African setting. This is basically utilising the specialists to create their own teaching modules in areas indicated by the third world country as being areas of educational need. These can be as simple as inguinal hernias or appendicectomies or more advanced such as rectovaginal fistula and treatment of burns and skin grafts.

Hopefully, the establishment of a website for Specialists Without Borders will allow third world countries to register their educational

needs and then globally match them with the availability of participating specialists.

It was felt that this was the best way that people with medical expertise across the whole spectrum could contribute in the most positive manner. While it still remains to be evaluated, the feedback so far has been extremely positive and interest from surrounding African countries enthusiastic.

It is also hoped that, with the establishment of a facility with the potential for quick medical and surgical care, both undergraduates and graduates will be interested in spending some time at the hospital to increase their knowledge of tropical medicine and surgery and in doing so contribute to the ongoing education of the facility's personnel. Hopefully, a serviced house in a secure compound will be established nearby the new hospital so that visiting medical staff will have a secure and cheap place to stay.

The other potential arm of this endeavour is to identify African personnel who could benefit from a College scholarship or fellowship that would allow them to upgrade their skills in a Western country then return to impart those skills to their colleagues.

Visit [www.specialistswithoutborders.org](http://www.specialistswithoutborders.org) for more information.

Paul Anderson, Co-Founder, Hospitals of Hope



**Surgical Conference / Kigali — Rwandan School of Medicine, Department of Surgery**  
June 30th — July 6th 2008

*The treatment of Surgical Emergencies —traumatic and non traumatic*

Volunteer surgeons needed to teach : structured clinical instruction module( SCIM)

- Principles of primary care of the injured
- Intestinal obstruction
- Laparotomy and abdominal wound management
- Peritonitis and abdominal sepsis
- Appendicitis
- Acute surgical problems in Africa
- Burns
- Resection and anastomosis of bowel
- Thoracic injuries
- Ano- rectal abscesses and wounds
- Urgent amputations
- Emergency treatment of closed and com
- pound fractures of the extremities

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SWB is an educational not-for-profit Christian-based organisation



## Congratulations on your achievements

### **Dr Albert Shun – ESR Hughes Award**

Dr Albert Shun has been awarded the ESR Hughes Award to recognise his distinguished contribution to surgery, particularly in the field of Pediatric Liver Transplantation.

Dr Shun has been the sole Pediatric Surgeon of the Australian National Liver Transplantation Unit for the last 20 years being on call for transplants 24 hours a day, seven days a week, 52 weeks a year. He has also dealt with the complications of transplantation, an ongoing, unrecognised and onerous task. The mortality and morbidity figures for the patients under his care are comparable with the best in the world.

Another big contribution has been his annual visits to PNG for the last eight years, six in conjunction with the College. His role in PNG is very much that of teacher and mentor, actively passing on his skills.

For many years Dr Shun was one of the surgeons of the Burns Unit at the Children's Hospital, this being the Statewide Pediatric Burns Referral Unit. His skill in liver resection is widely recognised, and he performs or is involved with all major liver resections in the hospital. Albert is one of the three surgeons who deal with complex biliary problems such as biliary atresia and choledochal cyst. He is recognised by all his colleagues as being one of the most widely read and academic surgeons in the hospital, an example of which is an excellent knowledge of endocrine and metabolic diseases.

Dr Shun was Head of the Department of General Surgery before the increasing load of transplant work forced him to step down. He is an enthusiastic teacher, numerous trainees having had the benefit of working with him.

### **Professor Franklin Sim – Honorary Fellowship**

Professor Franklin Sim is Professor of Orthopaedics and Chief, Orthopaedic Oncol-

ogy Service, at the Mayo Clinic, Rochester, Minnesota, USA.

Born in Nova Scotia, Canada, Professor Sim graduated from the University of Dalhousie, Halifax, with great distinction and was accepted into residency training at the Mayo Clinic. Professor Sim completed his training in orthopaedics and was immediately accepted onto the staff of the Mayo Clinic as one of the youngest and most capable consultants in their history.

Professor Sim has served as a consultant for almost 40 years and during this time was instrumental in the development of the specialties of hip arthroplasty, sports surgery and musculoskeletal oncology. Because of his relative youth when he started at Mayo, many of the modern masters of orthopaedic surgery have since passed through the Mayo Clinic, not only as his students, but also as his residents, fellows and subsequently his colleagues. It was in the field of musculoskeletal oncology that Professor Sim is best known and in which he has had perhaps the greatest impact.

Professor Sim's influence over the development of musculoskeletal oncology in Australia is profound, with key units in Melbourne, Brisbane and Sydney. His Asia-Pacific impact extends well beyond the shores of Australia where his disciples now lead prestigious units in Singapore, Japan, Taiwan, China, India, Pakistan and Korea. His prolific list of publications attests to his global recognition and certainly establishes him as one of the giants of this highly specialised discipline.

### **Associate Professor Bruce Waxman – RACS Medal**

The RACS Medal has been awarded to Associate Professor Bruce Waxman in recognition of his singular contribution to the College. Bruce has worked tirelessly on behalf of patients, surgery and surgeons and is a great role model for Trainees and future Surgeons.

Currently, Bruce is the Director of the Monash University Academic Surgical Unit and is Director of General Surgery and head of the



Colorectal Unit  
at Southern Health  
in Victoria.

He has been involved in numerous College activities at both State and National level. During the 1990's Bruce was a member of the Victorian State Committee, the EMST regional director for Victoria and Tasmania and chaired the Regional Board of Surgical Training. His multiple generic College tasks have included membership of the EMST, CCrISP, Ethics and Women in Surgery Committees. Bruce has been a course director and instructor of both EMST and CCrISP.

Associate Professor Waxman was a very valuable member of College Council for seven years until 2007. He was a member of the Court of Examiners, served on the Board of Basic Surgical Training, the Professional Development and Standards Board, the Education Board and has been Chairman of the Board of Specialist Surgical Training. In addition, he has chaired the Section of Academic Surgery and was instrumental in developing the SATSET (Supervisor and Trainer course for SET).

Bruce is noted for his selfless service to the community at large. He has had a long association with the Scout Association of Australia. He holds the rank of Squadron Leader in the Air Force Reserve and remains heavily involved with the Royal Flying Doctor Service where he serves as the Director and Chairman of the AeroMedical Wing.

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