Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **MAY 2012**

The College delivers Competency Training Standards, p28

The College of Surgeons of Australia and New Zealand

Hearing the next *generation*

Important initiative from the Foundation of Surgery p22

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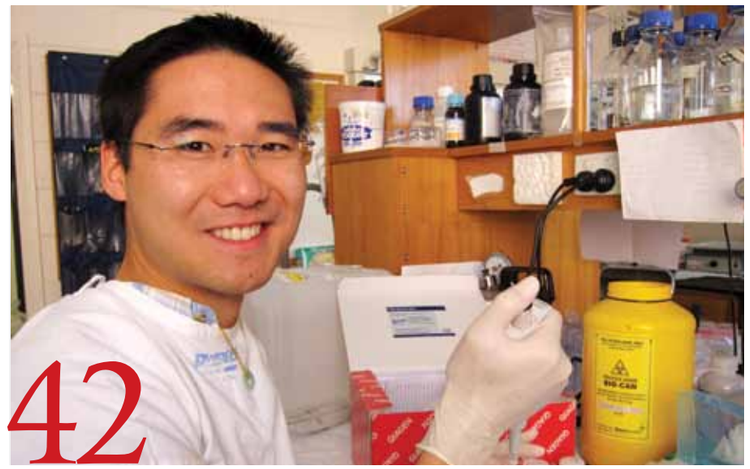

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Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

Letters to the Editor should be sent to: letters.editor@surgeons.org
Or The Editor, Surgical News, Royal Australasian College of Surgeons,
College of Surgeons Gardens. 250-290 Spring Street, East Melbourne, Victoria 3002

T: +61 3 9249 1200 **F:** +61 9249 1219 **W:** www.surgeons.org
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ON THE COVER:
An important initiative from the Foundation of Surgery p22

President's Perspective

Anticipation

An exciting few years are ahead of us

This President's perspective is being 'penned' just before the Annual Scientific Congress in Kuala Lumpur, Malaysia. It looks like being a terrific meeting. With a variety of top quality international speakers, a record number of submitted abstracts and an above average number of early registrations, the 2012 ASC should be an outstanding event.

Given that surgeons are somewhat notorious for booking late and even turning up without prior arrangement, as well as high levels of interest from our Malaysian Colleagues, the College is confident of an outstanding conference in a brilliant venue. I am personally aware of many people taking the opportunity of not only contributing in KL, but then using it is a launching pad for further travel. We are so much closer to many other destinations.

The ASC in 2013 is in Auckland and already arrangements are well in hand for a fantastic event there. By dint of circumstance, the ASC in 2014 is now being planned as a parallel meeting with the College of Anaesthetics. It will be held in Singapore. Martin Richardson, an orthopaedic surgeon from Melbourne will be the coordinator.

Although RACS was aiming to be in Melbourne and ANZCA in Sydney, circumstances beyond our control have colluded to enable parallel meetings – the first since 2000. One to keep free in the diaries! The ASC is the premier event for surgery in South East Asia and with an increasing number of multi-disciplinary groups now involved with the meeting, there is a very broad program in both the plenaries and the scientific sessions that appeals to all specialties within the broader 'surgical church'.

As President, I wish to acknowledge the outstanding commitment from my predecessor, Mr Ian Civil. His leadership of the College was exemplary, not only in the past two years as President, but in more than 20 years of service through courses, especially the EMST Program of which he was a "founding father" and CcRISP, Trainee selection and supervision, more committees than I can name, professional development and advocacy, and prior to being elected President, as Censor in Chief.

The 2014 ASC will now be in Singapore.

His contribution has been extraordinary in times that often have been demanding. He has purposefully steered the discussions between the College and the various Specialty Societies through troubled waters. The College's role in being the accredited body for training in surgery and awarding the FRACS is critical.

A new relationship between the College and the 13 specialty societies is being negotiated and will reflect the Societies' increasing role in all aspects of College activities, especially education. Seeing this incorporated in a principle based Memorandum of Understanding / Service Agreement needs to be bedded down over the next six months.

In the Council strategic planning weekend, held just before Easter, two clear messages were apparent. The first was to emphasise the role of advocacy in College activities. We need to explore every opportunity to promote surgery and surgeons. The politics of health is very complex with no ready solution that will be acceptable to all stake-holders. Nonetheless, our perspective needs to be heard in the corridors of power, be they at jurisdictional level or through the workplace.

There is no reason why surgeons should not contribute in a meaningful way to the development of health policy, particularly where it pertains to us. This will be a challenge as we have less expertise and are looked upon with caution by many. This is not a reason not to progress this issue, however.

The second message from the strategic planning weekend was the importance of the College moving our CPD program into a more meaningful space. Almost all of us attend enough educational activities to fully comply with the educational requirements. What needs more robust monitoring is our commitment to audit both of our practices and within an in-depth peer-reviewed methodology.

This can be achieved in a number of ways including good quality morbidity and mortality meetings. The College has worked incredibly diligently with numerous stakeholders to ensure our Mortality Audit function has progressed to being well regarded and surgeon friendly.

However, we must be doing more than that. CPD and audit of our practices is not an option for the community. They demand it and rightfully demand that the professional bodies like the College ensure it. If the College does not assume this responsibility it will be imposed upon us by an outside body with models that will not fit, and not work to improve standards, and certainly will not be surgeon oriented.

Other areas discussed at the strategic planning weekend were Council Governance and the fiduciary responsibility of Councillors, the College business model and where surgery might be in the next decade.

So my term as President has just started. I look forward to meeting you at the many meetings of the College and the Specialty Societies that I hope to attend. I am sure together we can progress these three key goals in the coming months.

Mike Hollands
President

Cementing our place

The College will be firm on its healthcare agenda

At the last meeting of Council I was honoured to be elected Vice President. I am aware that I assume the responsibility of this position at a time of significant change, both within the College and externally.

Working parties are reviewing both the College's governance arrangements and the way in which our education programs are delivered. It is too soon to say with any certainty what models will emerge from these processes, but they will be different from those currently in place.

Externally there are significant changes occurring in public health, particularly in Australia where the Federal Government is endeavouring to bed down the changes flowing from the centralisation of the registration and accreditation processes. The Australian Health Practitioner Regulation Agency and its medical arm, the Medical Board of Australia, seem daily to issue consultation papers addressing the detail of healthcare delivery. The College has been and will continue to be very active in advocating for surgeons. (I urge Fellows to look at the advocacy page of the College website to see just how many we have responded to over the past few years.)

There is of course one constant, in both our countries – increasing demand, yet increasingly limited resources with which to perform sophisticated surgical procedures safely. The ageing of the population is but one of many challenges. Elective surgical waiting lists are a "thorn in the side" of all governments. The stated desire by governments to eradicate elective surgery waiting lists is welcome, but unrealistic in the absence of additional resources.

In New Zealand some public patients are denied elective procedures which are deemed unnecessary even though their quality of life is profoundly compromised without them. This has given rise to charity trusts which, with the assistance of volunteer surgeons, perform these procedures without charge.

In Australia some states have been forced to begin implementing cuts to public health services, to rein in health budgets which threaten to consume all government revenue within a couple of decades.

It is in this context that the work of advocacy becomes increasingly important. The College's Governance and Advocacy Committee, or GAC, is charged with overseeing the crucial task of advocacy and is chaired by the Vice President. I would like to acknowledge the fine work of my predecessor, Keith Mutimer, who writes elsewhere in this issue of *Surgical News* of the committee's achievements over the past two years.

Your College, rightly in my view, sees one of its major roles as advocacy. Effective advocacy requires the issue be identified and a constructive position determined. Individual Fellows of the College have an important role in these processes – what needs to be said? The input of Fellows helps to identify issues and shape the College's responses. As surgeons we are primarily concerned with doing the best we can for the individual patients we care for, but increasingly we have a wider responsibility – to become active in what might be termed the politics of health.

Guiding principles

By way of initiating debate, let me outline the guiding principles that I believe should fashion the College's advocacy into the future.

> Patient welfare remains paramount.
> There needs to be greater clinician input into the formulation of health policy and into the management of our hospitals.

"There have been some very positive achievements over those two years and several projects which are well advanced"

> Decreasing the size of and streamlining health and hospital bureaucracy should be a major efficiency drive.
> Existing resources can be spent more effectively.
> Government initiated changes should not compromise patient care.

And we must confront once and for all the tired argument that we are somehow a closed shop. This College puts no cap on the number of surgeons it trains. The number of surgeons in training is limited by the number of surgical training posts in our public hospitals – a reflection of governments' unwillingness or inability to invest in public health. Last October, the College issued a media release warning of a looming crisis in surgeon numbers in Australia. Modelling currently being finalised by our Workforce Assessment Department seems likely to reach similar conclusions about the surgical workforce in New Zealand. These are hardly the actions of a closed shop.

But our insistence that Australasian surgeons be among the very best in the world is not something we should ever compromise on, or apologise for. Again, it is a reflection of our commitment to the patient. While it may be the view of Government that any surgeon is better than no surgeon, as surgeons we know that this is rarely if ever true.

I will endeavour to attend as many specialty society meetings and regional ASMs as I can, and I would welcome the opportunity to hear your views on the issues you consider important. I can always be contacted through the College.

The next few years will undoubtedly be challenging. But, unlike governments which seem not to see past the next election, our advocacy will be aimed at improving the delivery of surgical care in the decades ahead.

I look forward to working with you.

Michael Grigg
Vice President

Obesity getting bigger

Obesity surgery is on the rise and has prompted the establishment of an Australian and New Zealand registry to monitor safety and patient outcomes.
The registry, currently piloted in Victoria, will track the use of devices such as lap-bands as well as inform the risks for the future. Professor Guy Maddern believes that the registry is important to evaluate the effectiveness of procedures. And despite surgery being effective, prevention is always better than cure. "Surgery still is the most effective way of reducing people's weight… but clearly it's not one we should be aspiring to."
***Adelaide Advertiser*, 12 April.**

Skin in demand

A shortage of skin donors in Victoria has meant that lives could be at risk in the event of a major catastrophe such as Black Saturday. Despite the increase of organ donation, Victoria, which originally had Australia's only skin banking facility, is now backed by a Queensland unit. Director of the Alfred Hospital's adult burns unit, Heather Cleland said that the skin allows the patient to recover when they don't have enough of their own in initial stages. "The problem is that once you've got a patient who needs it, they need a lot of it."
***The Age*, 9 April.**

WA will get worse before it gets better

The severe shortage of specialists in Western Australia (WA) will only get worse in the coming years, and has been likened to 'global warming'.

James Aitken, Clinical Director of the WA Audit of Mortality has said that the issue of a medical workforce has largely been ignored in recent times and may affect patient care for up to 15 years. "This increase is more akin to global warming in that the demand will rise and stay, and go up to a new higher level."
***West Australian*, 11 April.**

Appendectomies on the way out

An article in the British Medical Journal claims that operations to remove an inflamed appendix should be abandoned.Researchers at the Queen's Medical Centre in Nottingham (UK) studied four trials of more than 900 patients in which patients took a course of antibiotics to treat the infection. In two-thirds of cases the antibiotics were successful. They claim that the 47,000 appendectomies carried out in England last year are driven by tradition rather than evidence.
***Canberra Times*, 7 April.**

Do you need to be registered?

The Medical Board of Australia has opted not to change the definition of practice and released a statement to guide those uncertain as to whether they need to be registered

Fellows will recall that the College recently participated in a consultation process, conducted by the Medical Board of Australia (MBA), aimed at defining medical practice and thereby determining who did, and who did not, have to seek medical registration. The College's submission can be viewed on the advocacy page of the College website.

The MBA has opted not to change the definition of practice and released a statement to guide those uncertain as to whether they need to be registered.

For the information of Fellows, those parts of the MBA's statement pertaining to registration are reproduced below.

Fellows who remain uncertain as to the need for registration are advised to visit www.medicalboard.gov.au under Contact us to lodge an online enquiry form or to call 1300 419 495 (within Australia) or +61 3 8708 9001 (overseas callers).

The Medical Board's advice on who should be registered:

The Medical Board of Australia provides the following advice, based on the objectives of the National Law, to guide practitioners' decisions about whether or not they should be registered. Any practitioner who is qualified and meets the applicable registration standards may apply for registration.

As the primary purpose of registration is to protect the public, medical practitioners should be registered if they have any direct clinical contact with patients or provide treatment or opinion about individuals. As well, other state and commonwealth legislation provides that registration is required to enable prescribing and in order for a patient to be eligible for a Medicare benefit for a medical service.

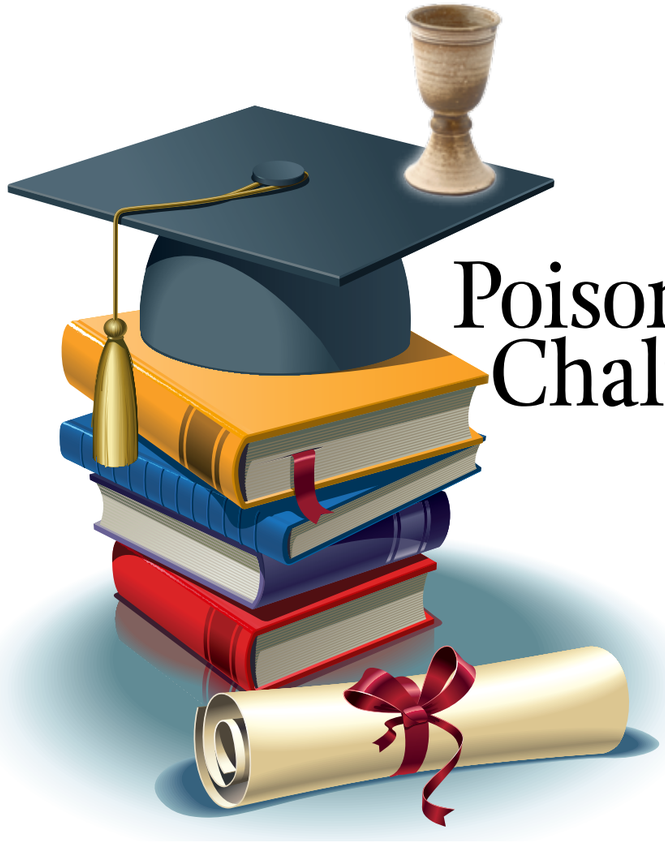
For roles beyond direct patient care, the Medical Board of Australia advises practitioners to be registered when:

1. their work impacts on safe, effective delivery of health care to individuals and/or
2. they are directing or supervising or advising other health practitioners about the health care of an individual(s) and/or
3. their employer and/or their employer's professional indemnity insurer requires a person in that role to be registered and/or
4. professional peers and the community would expect a person in that role to comply with the Board's registration standards for professional indemnity insurance, continuing professional development and recency of practice and/or
5. they are required to be registered under any law to undertake any specific activity.

Roles for which current practising registration may not be necessary

The Medical Board of Australia advises that practitioners engaging in the following activities do not necessarily require any registration or may choose to hold non-practising registration:

1. An examiner or assessor of medical students or medical graduates, when the student or graduate is not treating patients as part of the assessment, provided that the organisation on whose behalf they are acting believes that current practising registration is not necessary for the scope of activity.
2. A tutor or teacher working in settings that involves simulated patients or settings in which there are no patients present, provided that the organisation on whose behalf they are acting believes that current practising registration is not necessary for the scope of activity.
3. A researcher whose work does not include any human subjects and whose research facility does not require them to be registered.
4. A person who speaks publicly about a health or medical related topic and who will not be giving any individual patient advice.
5. A person serving on a board or committee or accreditation body, when their appointment is not dependent on their status as a "registered medical practitioner".
6. A person who may be using skills and knowledge gained from an approved qualification, but is not using a protected title, nor claiming or holding themselves out to be registered, such as a person in an advisory or policy role.
7. A medical practitioner who is registered overseas and is visiting for any role not involved in providing treatment or opinion about the physical or mental health of any individuals.



Poison'd Chalice

"I pledge to always act in the best interests of my patients, respecting their autonomy and rights"

- extract from RACS Pledge.

It had been a few years. So busy being a Clinical Director of one of the country's most challenged Surgical Services, that my attendance at the Annual Scientific Conference had been less than impeccable. This year I had made a point of going. I felt a need. My exposure to the vapours of accounting and corporate governance was becoming toxic.

A particular motivation was that some of my more promising Trainees were making the effort to go to the Convocation.

I had missed my own convocation having headed off to the UK as a young man – more intent upon the cut and thrust of surgical endeavour, not giving tradition and ceremony a second thought.

I looked at the Convocation booklet. There, with some prominence, was the 'College Pledge'. I read it carefully – I am sorry to say for the first time. The words of Hamlet resonate in my brain. 'The triumph of his pledge, Is it a custom?'

Mind you Shakespeare was not the source of great reassurance – most of the pledges he referred to were drunken toasts over 'Rhenish' wine. The Code of the Pirate Brethren also flashed into my mind with Captain Barbossa stating 'the code is more what you'd call "guidelines" than actual rules.' Geoffrey Rush is so good at Barbossa, but also Shakespeare…

The new Fellows were now convocating. It was an impressive sight. There were certainly more female surgeons than in my day, but still not enough. The breadth of cultural backgrounds was impressive and this was matched by the efforts of the Chair of the Court of Examiners in ensuring all the names were pronounced correctly. That was not an easy task, but one so important to do well. I looked at the words of the pledge again, 'I will be respectful of my colleagues, and readily offer them my assistance and support.' Yes, the diversity of surgeons is really important to support.

My Trainee, well to be honest, one of the many Trainees I knew reasonably now strode purposefully across the stage. I had been struck by her ability to stay calm in the middle of any clinical storm, offer compassion to patients, to staff and to her seniors when required. How she had juggled the demands of training with her family commitments had continued to defy description. She deserved all the accolades she received. I looked again at the pledge, "I agree to continue learning and teaching for the benefit of my patients, my Trainees and my community."

And there we were, all assembled. The Council, the newest Fellows and the older Fellows. We rose and recited the pledge together. I realised that I was feeling something that I had not felt in a long while. It seemed as if the constant "Brownian" activity of my world had paused. It seemed as if the ghosts of the great surgeons who had gone before were peering down upon us, listening to us affirming our commitment to ideals.

The Pledge ended with the words, "I accept the responsibility and challenge of being a surgeon." I looked at the new Fellows. They were smiling, content that they had achieved recognition, a place within the profession. Like myself, the older surgeons looked like they had just reaffirmed their pride in the profession that they belonged to.

As my mind drifted, it began to dawn upon me that there is a place and a role in society for ceremony and tradition. But maybe there is more to it than that. Maybe it is the way to start 'the revolution' I spoke so passionately for in my last reminisces. A pledge based revolution. A realisation that the best place for my loyalty, my efforts was not hospitals or institutions, but to the ideals that form the basis of my profession.

I thought of my current Trainee. Would he understand the pledge? A bit too much of Generation Me, I thought. Perhaps I was being unfair. I will need to challenge him and see what I can 'open up'.

Maybe the revolution is to make the pledge the custom, as Shakespeare would say. I think it will need to be for the next audit meeting; the topic will be 'Good and bad examples of acting in the best interests of my patients, respecting their autonomy and rights – two interesting cases'. I smiled; the revolution was afoot.

Professor U.R. Kidding

Wattle and Fern – the new President's gown

A new gown will make things easier for future presidents

In the early months of Mr Ian Civil's tenure as President, he and his wife Denise travelled to Wewak in Papua New Guinea to represent the College at a medical conference.

In temperatures of more than 30 degrees and at a time of year when the country regularly suffers 90 per cent humidity, Mr Civil was required by protocol to don the heavy woollen travelling gown over his suit when acting in his official capacity.

It was, said Denise, unbearably hot and heavy so she decided to do something about it.

Upon their return to New Zealand, she went into design mode using her skills as an architect to combine form and function into sketches for a new light-weight official garment that would better serve future presidents in an era of increasing travel, particularly to the more sultry climes of South-East Asian and Pacific countries.

Now, after four months of effort, the new robe is complete and has already been given to the College.

Made of black silk with gold ribbons and embroidery, it is elegant, light and, of equal importance, represents the College symbolically.

"The President has two official gowns," Denise explained.

"One is only used in Melbourne and at the Annual Scientific Meeting. It is a very ornate robe modelled on a previous gown that is now in the College museum.

"The other is known as the Travelling Gown and given to the President for his or her use when they travel as representatives of the College.

"This one is also of heavy wool and, while embellished with decoration, had nothing symbolic of Australia or New Zealand. It is extremely uncomfortable to wear in tropical countries.

"I enjoy design and I have been making clothes since I was very young, so I thought a light, breathable gown could be our gift to future Presidents."

Previous President Ian Civil in the donated travelling gown with his wife Denise.

College Presidents have been donning a robe of office since the Presidency of Sir Henry Simpson Newland in the mid 1930s after a gown was ordered from Ede & Ravenscroft, the royal gown-makers in London.

Over time, each robe needs either to be replaced or undergo a major renovation, yet each time tradition has called for the heavy wool of its early English ancestor.

But as Australia and New Zealand – and the RACS – become increasingly engaged in the Asian region, Denise made the radical decision to ditch the wool of England for the silk of the tropics.

The new robe designed by Denise is based on the Standard College Gown and features stylish embroidered motifs on each sleeve – a Wattle for Australia and a Silver Fern to represent New Zealand.

"Made of black silk with gold ribbons and embroidery, it is elegant, light and, of equal importance, represents the College symbolically"

"I based the embroidered badges on the sleeves on a brooch donated to the College by Mr Bruce Barraclough at the end of his presidency," she said.

"That is also worn as an official ornament, in that the President's partner wears it when the President is wearing the Presidential Medal.

"The badges took quite a lot of work, about six weeks altogether, while all the ribbons were hand sewn to protect the silk and I just hope it makes life easier for future presidents in warmer climates and stands the test of time."

Mr and Dr Civil have already presented the gown to the College for the use of incoming President Michael Hollands while the brooch will be returned in May and passed on to his wife Dr Jane Young.

Denise described the experience of her husband's presidency as a wonderful time, which was one of the reasons she felt inspired to make life easier for those who followed.

"It was a true delight to travel to such interesting places and to meet wonderful people," she said.

"It also meant that I got to spend more time with my husband than has often been the case because we could travel together."

With Karen Murphy

Doctor BB G-loved *Mr N-destruct-able*

Cutting through the hard issues

My name is Doctor Double-Begloved. Yes, you read it right - it is spelt with a 'Double B' and a hyphen. I am g-loved to protect my identity, and allow me to share with you readers some experiences of surgeons as patients. I would like you to regard me as a confidante with your best interests and surgeons' health at heart. You can even write and I will respond. This column is offered in good faith and wishes you a long, healthy life. But first, you may find it disturbing.

Let's begin with a personal question. Do you have a family doctor? By this I do not mean, 'do the other members of your family have one?' Of course they do, otherwise they'd never survive waiting for you to come home and take their complaints seriously. I mean do you, the surgeon of the household, have a doctor whom you regularly consult and who coordinates your health issues?

Don't have a GP? Maybe you've never been seriously unwell? If you've got kids and dependants you're likely to have applied for life insurance. That's if your blood pressure is near normal, you don't have a threatening chronic disease, and the serology confirms you are HIV, HCV and HBV negative. But having undergone the life insurance medical examination is not the same as having your own GP.

Many of your colleagues are sailing in a GP-less boat. I am not touting for extra work; my own practice is too busy. But the AMC Code of Conduct to which we are all bound says all doctors should have their own GP.

Even your College's Code of Conduct has its Section 9 on Surgeons' Health which promotes the value of the same. Recently someone showed me your Competence and Performance Guide where under the competency of professionalism it lists as a pattern of behavior, "maintaining health and well-being". On page 17 of that guide, good behavior is described as: "has a personal general practitioner". Do you pass that test?

One recent case I recall was a surgeon, who though nameless, we shall call N-destruct-able. N-destruct-able was suffering severely from the complications of what was expected to be minor surgery performed at the end of their own operating day by another colleague, Mr Snip.

After the procedure N-destruct-able got off the operating table and went to do postoperative rounds. Complications ensued, caused almost entirely by a failure to rest and recover like any of N-destruct-able's own patients would have been advised and Mr Snip's patients were advised.

The old surgical adage, "sutured wounds do not travel well", was ignored or forgotten. For the next few days N-destruct-able persisted in operating, supervising Trainees, conducting ward rounds, whilst all the time feeling worse and worse, but not consulting anyone.

Bedbound over the weekend, nothing could deter N-destruct-able from loyally attending their operating list the next Monday morning. Fuelled by antibiotics (self-prescribed), anti-inflammatories (over-the-counter), best intentions and delusions of invincibility (self-imposed), N-destruct-able endured febrile episodes, swollen body parts, great pain and increasing lassitude.

Finally, in desperation, N-destruct-able consulted Doctor Double-Begloved. In fairness, N-destruct-able had once phoned (not consulted) Mr Snip who had opined the illness was unlikely to be related to the procedure. And now before me was a respected specialist, weak at the knees, lacking in insight, concerned about their schedule, reluctant to readjust their agenda.

What could I offer? Well though I listened with a half-sympathetic ear to all the things N-destruct-able really had to do, I was in reality heartless and brutal. I signed N-destruct-able off sick, forced the cancellation of the planned schedule, ordered some blood tests including blood cultures and changed the antibiotics to something with a far better spectrum of activity. N-destruct-able rested, slowly recovered and was advised to obtain a regular GP.

Those of you who have already learnt that you are as mortal as your patients have probably already got a GP. My advice to those who don't is: don't choose your best friend; and don't choose your wife, husband, father, mother, daughter or son.

Your GP should be someone you respect, and even be a little afraid of. My blood pressure always rises when I know I have to visit mine.

Why shouldn't we experience the same? Choose someone who will treat you like a patient, but who will also respect your medical understanding and need to be informed.

Dr BB G-loved

A surgeon's treasure

A maritime treasure of two surgeons has found a place in the public domain

As a boy growing up on a farm along the beautiful Bass River in Gippsland, the late plastic surgeon William Wilson felt a great love of country spreading from the farm itself, to the nearby river system and out to Western Port Bay.

Along the way, he also developed an affinity and fascination with the man who mapped that corner of the world and who left echoes of his presence from Gippsland to Tasmania – fellow surgeon and explorer George Bass.

Later, after having established one of the first private practices at the Cabrini Hospital, Mr Wilson made that interest manifest by travelling widely to collect objects and documents relating to the life of his boyhood hero.

He travelled to England to look upon and photograph his wedding certificate, collected early maps of the Western Port area, maps showing the charting of Bass Strait and gathered sundry artefacts connected to the intrepid naval surgeon, sailor and navigator.

But of all these, his great delight was the pocket compass and sundial used by Bass in the first European expedition to explore Victoria's coast, a gem he acquired at a Christie's auction.

Described as an item of unique national significance to the early maritime exploration of Australia, Mr Wilson treasured the compass, taking it to historical society meetings and lending it for display to institutions such as the Melbourne Maritime History Museum and the Mitchell Library, which had purchased a number of George Bass' letters.

But now, following the death of the widely loved surgeon known as "Willie" Wilson in 2009, the pocket compass has found a new permanent home after a decision by his daughters to donate the treasure to Museum Victoria.

His daughter, Dr Meaghan Wilson-Anastasios, described the artefact as her father's pride and joy.

"Dad cherished the sundial and compass, but in his will he made no mention of it or where he wanted it to go," she said.

"However, given that he loved it so greatly it didn't feel right to sell it. My sisters and I then decided that what did seem right was to put it in the public domain for public enjoyment.

"We also thought it the best way to associate dad's name with the name of his lifelong hero, George Bass."

Described as one of the most remarkable and significant maritime expeditions in Australia's early history, George Bass sailed almost 2,000 kilometres from Sydney Cove in an open whaleboat with a crew of six volunteers and provisions for six weeks.

During the course of the epic journey, he named Westernport Bay, made the European discovery of Wilson's Promontory and proved that Tasmania was an island, all by navigating his way through unknown waters using only a quadrant and the portable compass and sundial.

According to Museum Victoria, the compass and sundial is made of brass and steel, has a glass lid, a blue coloured dial and has a moveable arm hinged to the top of the compass.

However, despite the fact that it was manufactured in London by eminent optical instrument maker Peter Dolland, it was far from perfectly suitable for the purposes of the voyage.

Said Museum Victoria curator Martin Bush: "This was one of the most remarkable and significant maritime expeditions in Australia's early history.

"Bass navigated his journey with a quadrant and this portable compass and sundial made in London.

"Yet, although the sundial could be adjusted for latitude differences, the compass was actually weighted incorrectly for use in the southern hemisphere."

George Bass, naval surgeon, arrived in New South Wales in 1795 at the age of 24 on the same ship that carried Matthew Flinders.

Within five years, Bass and Flinders had explored the coast south of Sydney and circumnavigated Tasmania.

Flinders named Bass Strait in honour of his friend's heroic whaleboat voyage.

Dr Wilson-Anastasios said it had been that courage and adventurous spirit that was always the great appeal of George Bass to her father.

"I think it was the combination of them both being surgeons and both sharing a hunger for adventure that was at the heart of Dad's affinity with Bass," she said.

"Dad was quite a trail-blazer himself in plastic and reconstructive surgery, with a particular interest in hand surgery, and trained under John Hueston who was the pre-eminent plastic surgeon in Melbourne in the 1970s.

"Therefore it always made sense to us that he would have such an interest in a fellow explorer surgeon."

Dr Wilson-Anastasios said that even though Mr Wilson had security concerns regarding the safety of the precious object over the years, he could never let it out of his possession for long.

However, she feels sure he would be happy with the family decision.

"Dad treasured the object so much that even though he loved sharing it with people, he could never quite bring himself to part with it," she said.

"But I think he'd be thrilled to see it on display at Melbourne Museum now – in a cabinet with his name forever associated with the name of George Bass."

Mr Wilson, who worked out of the Royal Melbourne Hospital and Western General Hospital, had a particular flair for hand surgery. He conducted original research which improved surgical outcomes for those suffering hand injuries and became a Foundation member of the Australian Hand Surgery Society.

With Karen Murphy

Pictures courtesy of Museum Victoria

The late Fellow William Wilson had a passion for the George Bass story and his compass.

"Everyone in PNG knows someone who has been affected by cervical cancer so the most common reaction even from the boys is: How can we protect our sisters and our mothers?"

For the next generation

A surgeon's goal to deliver the HPV vaccine in PNG will reduce cervical cancer

Clockwise: Professor Wood at St Josephs Ruango Primary School; Dr Marg Sturdy and Prof David Wood unpacking the first box of vaccines that arrived in Kimbe, West New Britain, all the way from New York; The vaccination team while we were in PNG - from left, Prof Wood, Dr Amos, Jenni Woodhouse, our wonderful nurses, Jess Colliver and Dr Marg Sturdy

A Western Australian orthopaedic surgeon who has provided surgical services to the people of Papua New Guinea for many years has now extended the scope of his involvement by winning the funding needed to help reduce the high rates of cervical cancer in the country.

Professor David Wood has received funding to run a one-year pilot program to provide Gardasil vaccinations to 15,000 girls which prevents the transmission of the most common strains of the Human Papilloma Virus (HPV), a precursor of the cancer.

The project began in March across the West New Britain province and is funded through the Gardasil Access Program, designed to provide at least three million doses of the vaccine to developing countries where more than 85 per cent of the world's cervical cancer cases occur.

"My main involvement in PNG has been as a musculo-skeletal tumour surgeon and often patients with such tumours present very, very late," Professor Wood said.

"But of all these, cervical cancer is the most common fatal cancer in PNG women. In Australia that rate is seven in 100,000 per annum, whereas in PNG it is 40 per 100,000 per annum and yet up to 85 per cent of cases can be prevented.

"Even though I don't treat these cases it is impossible to be unaffected by such unnecessary suffering, so I thought it important to help prevent this if possible."

Professor Wood, who is the Winthrop Professor of Orthopaedic Surgery at the University of Western Australia, works out of the Hollywood Private Hospital which supported his campaign by contributing $20,000 through a charity dinner to help cover the costs of the application and feasibility study necessary to win the funding.

He said West New Britain had been chosen for the pilot project because of the keen support of the Governor, the CEO of the local hospital in Kimbe, Dr Victor Golpek, and the enthusiasm of health and education representatives.

He said the Gardasil Access program would provide 46,000 vaccine doses for girls aged from 9 to 13 years which represented three vaccinations per child.

In Australia the vaccines cost $125 per injection, meaning that the total value of the vaccines donated will be almost $6 million.

"Developing nations can never afford to pay such a cost, yet they have the greatest need," Professor Wood said.

"Most women are offered no screening and have limited access to pathology which invariably leads to late presentation.

"In West New Britain, for example, only about 100 pap smear tests are conducted per year for a population of 300,000."

Professor Wood is now a member of the Cervical Cancer Working Party which will oversee the pilot program and said there was hope that the project could be rolled-out in following years as a national public health program.

He said that an initial education campaign had been run in September and October last year to train health workers in the provision of the vaccine and the need for consent while teachers were then offered training to allow them to explain the project to children.

More than 2000 school children have so far attended such information sessions with plans now underway to make HPV and cervical cancer prevention an on-going subject within the personal health component of the PNG school curriculum along with HIV AIDS.

Professor Wood said that while there was initial hesitation in speaking of sexual health matters, the children had been keen to learn.

"Everyone in PNG knows someone who has been affected by cervical cancer so the most common reaction even from the boys is: How can we protect our sisters and our mothers?" he said.

"Like anywhere there was an initial preconception by both boys and girls that people with HPV were dirty or promiscuous, but we simply explain that it is like the common cold of STD's, that most people are exposed to the virus within the first few years of sexual activity.

"We are trying to reduce that stigma by explaining that if every girl gets the vaccine, the result is community-wide prevention and the children understand that completely."

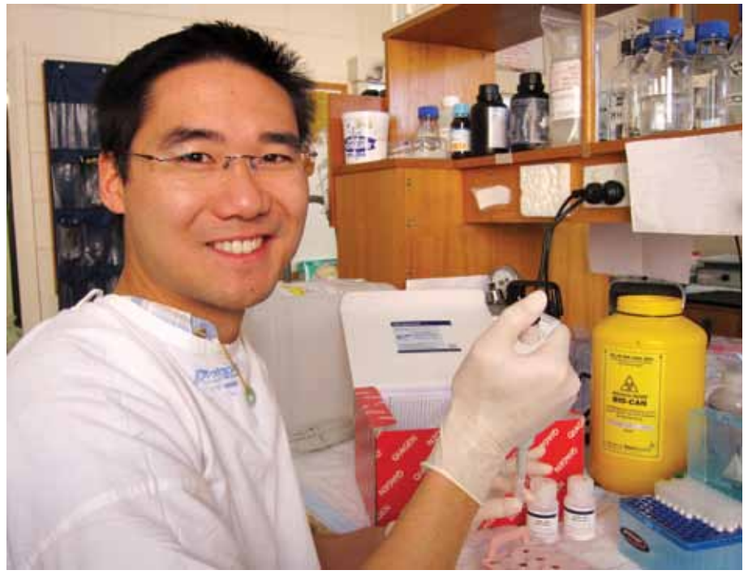
Professor Wood said that the RACS had provided logistical support in the provision of visa and medical registration assistance which allowed him to spend the time needed in PNG to develop the feasibility study.

He said that despite the recent political turmoil in PNG there was very strong interest in the project.

"The National Health Department is taking a keen interest and there are various funding sources it could approach to pay for the vaccines at a discounted rate for a national program in the future," he said.

The Gardasil Access Program is funded by manufacturers Merck & Co, but managed by an independent company, Axios Healthcare Development, a non-profit organisation which administers the program and reviews and approves applications.

With Karen Murphy



Saving precious time

This scholar is looking for a more efficient process

profile

Awards

> 2012 Melville Hughes Scholarship (University of Melbourne)

> 2011 Foundation for Surgery Catherine Marie Enright Kelly Scholarship (Royal Australasian College of Surgeons)

> 2010 Foundation for Surgery ANZ Journal of Surgery Research Scholarship (Royal Australasian College of Surgeons)

> 2010-2011 Postgraduate Medicine Scholarship (National Health and Medicine Research Council, Australia)

Current Projects

> Integrative Genomic Profiling in Prostate Cancer: Defining the Lethal Phenotype

> Origins of Lethal Metastases in Multifocal Prostate Cancer

In an era of fiscal restraint and over-stretched health budgets, Trainee urology surgeon Dr Matthew Hong is working to develop a test that can accurately discriminate between lethal and indolent prostate cancer to allow clinicians to better select those patients needing treatment.

To do this, Dr Hong is not only investigating the biomarkers that differentiate aggressive and indolent tumours, but has also established a world-first program to examine metastatic prostate cancer tissue.

Working out of the Royal Melbourne Hospital and the Australian Prostate Cancer Research Centre at Epworth (APCRC), Dr Hong has set up a program in which men with metastatic prostate cancer undergo a day procedure to donate tissue samples.

In time, this raw data will be made publicly available to scientists around the world so that researchers with different questions can use the information to expand knowledge in the field or test new ideas.

Prostate cancer is the second most common cause of cancer death in Australian men with almost 19,000 new diagnoses and almost 3,000 deaths per year.

Dr Hong said, however, that a significant proportion of such cancers never metastasise resulting in a proportion of patients receiving radical treatment including surgery which is unnecessary.

He said he began his work, part of a PhD through the University of Melbourne, aiming to screen for biomarkers on individual molecules, but had since capitalised on the enormous advances made in genomic technologies which can now allow scientists to screen hundreds of thousands of molecular differences at a time.

"The unique approach we have taken is to look simultaneously at different levels of genetics," Dr Hong said.

"We are looking at the underlying genome, its methylation or regulation and the transcriptome, that is the genes being expressed to produce proteins.

"The laboratory techniques required for this type of multi-dimensional approach have taken the best part of two years to refine and I'm only beginning to see preliminary data now.

"I have found a hint that there are subtle molecular differences in the benign parts of prostate glands between those harbouring high-grade versus low-grade prostate cancer, which could lead to a test that gets around the problem of sampling errors in biopsy."

Dr Hong has won considerable support from the RACS for his work, receiving both the Foundation for Surgery ANZ Journal of Surgery Scholarship for 2010 and the Foundation for Surgery Catherine Marie Enright Kelly Scholarship for 2011.

He has presented his work at conferences in Melbourne, the Gold Coast, Perth, and New Zealand and last year gave a presentation on his research at the European Association of Urology Annual Congress in Austria.

Dr Hong said the establishment of the metastatic tissue bank could have a significant global impact.

"This unique program allows us to not only collect the lethal cancer tissue, but enables us to compare it to a sample of each patient's primary tumour given previously so that we can compare the two to understand why metastases develop in a given individual," Dr Hong said.

"This provides access to very rare tissue types and our study has sparked great interest amongst our international collaborators.

"We have just fully sequenced the whole genomes of matched primary and metastatic prostate cancer from our first patient which could well be a world first."

Dr Hong is undertaking his research under the supervision of Associate Professor Christopher Hovens, the Scientific Director at the APCRC, and Dr Niall Corcoran, Urologist, with the entire program overseen by Professor Tony Costello, Director of Urology at the Royal Melbourne Hospital and Executive Director of APCRC at Epworth.

Dr Hong said he had been honoured to receive such support from the RACS and said that the stipends attached to the scholarships meant that he could become fully involved in the ground-breaking work.

"Because of the support, I could fund my own travel to various conferences to become completely immersed in my fields of interest which I think is important to help generate ideas to overcome scientific problems," he said.

"Instead of having to apportion some of my time to making an income, I could use that time for greater productivity.

"It has been extremely rewarding to have the opportunity to concentrate on pure research and the process I most enjoy is asking clinically important questions, understanding the technology available to researchers and then putting the two together by designing and performing experiments that answer the questions.

"We are now moving towards personalised medicine at a rate of knots and I believe that our recently acquired ability to molecularly characterise individual tumours quickly and at a reasonable cost will soon give us an edge over prostate cancer.

"This project has the potential to identify candidate biomarkers for the early discrimination of the lethal prostate cancer phenotype, which in turn could lead to more effective patient selection for radical treatment by surgeons.

"This will mean that clinicians can make confident decisions regarding the significant number of patients with biologically indolent prostate cancer to spare them exposure to the unnecessary risks of radical treatment which in turn could translate into significant health economic savings."

The Catherine Marie Enright Kelly Memorial Research Scholarship arose from a bequest by the late Dr TD Kelly, FRACS, to support Trainees or Fellows wishing to take time away from clinical practice to undertake research.

With Karen Murphy

Factory Visit Program

Occupation Medicine Bridging Course

Surgeons benefit from the opportunity to see a range of work in different industries. Benefits are anticipated to flow in terms of guidance to workers, factories and insurers and in improved surgical outcomes as measured by satisfactory return to optimal activities. The factory visit program is Continuing Professional Development accredited.

Qantas, Sydney

On Friday, 6 July 2012, we have arranged a whole day visit to Qantas Engineering, Catering and possibly Baggage Handling. This follows a memorable site visit to the Heavy Engineering section of Qantas in Melbourne.

At the start of each half day there will be a brief introduction to the worksite; as on previous factory tours. This will be followed by workers discussing their injuries and return-to-work programs. This is followed by an approximately two hour tour of the site during which we see what the workers do, where injuries have occurred and a selection of suitable duties for return-to-work programs. We conclude with the opportunity to further discuss injuries and return-to-work with workers and management. Finally there are group discussions and you have an opportunity to individually reflect on the visit and evaluate the program.

Godfrey Hirst and Ford Motors Carpets, Geelong

On Friday, 21 September 2012, we are considering another whole day visit by combining two work sites; Godfrey Hirst Carpets in the morning and Ford Motor Company in the afternoon. Depending on demand we may organise a bus from the College. Each of these factory visits will be a similar format to Qantas.

Edward (Ted) Schutz
Convenor

Increasing our voice

Advocacy remains core College business

At the College's recent Annual General Meeting, held in Kuala Lumpur during the Annual Scientific Congress, I officially completed my term as Vice President. May I take this opportunity to say it was an honour to represent you on Council for the last nine years and to have served as Vice President over the last two years.

One of the most important responsibilities of the Vice President is to chair the College's Governance and Advocacy Committee (GAC). At a time when the specialty societies are telling us we must do more advocacy, and we must do it better, the work of GAC is surely core College business.

There have been some very positive achievements over the past two years and several projects which are well advanced and which will be brought to fruition by Professor Michael Grigg who has succeeded me as VP.

Among the former are the FRACS logo which was formally launched at the Annual Scientific Congress in Adelaide last year and which Fellows can access via the College website. At a time when just about anyone with a medical degree (and a number of podiatrists without one) can call themselves a "surgeon", the FRACS post nominal stands for clinical excellence of the highest order. Fellows can now use this brand on their stationery, websites and the walls and windows of their rooms.

In May last year the College wrote to health ministers, shadow ministers and health department CEOs across Australia and New Zealand, enclosing a report which establishes beyond doubt that the separation of elective and emergency surgical streams in our public hospitals dramatically improves hospital efficiency and patient outcomes. I am pleased to report that this reform is being rolled out at several hospitals; a number of presentations at the ASC in Kuala Lumpur addressed the success of the reform at hospitals ranging from major metropolitan facilities to smaller country hospitals.

GAC is following this up with position papers on medical tourism and bowel cancer screening. The former includes development of a checklist for patients considering travelling abroad for surgery. It raises crucial considerations such as the surgical expertise and the quality of facilities available in a given country, responsibility for post-operative care, and the extent of one's insurance coverage. It is hoped that this brochure will be made available through government channels to prospective medical tourists.

The position paper on bowel cancer screening advocates strongly for two yearly testing of those aged 50 years and over, something governments in both Australia and New Zealand have been very reluctant to fund.

Work on both position papers is nearing completion and has seen GAC consult with relevant specialty societies to ensure their accuracy and persuasiveness.

Another major project involved modelling done by the College's workforce assessment department and which resulted in a report identifying the extent to which Australia's future surgical workforce will be able to meet anticipated demand in 2025.

It found that while the current surgeon per population ratio is adequately and safely servicing the Australian population, this population is expected to increase and its average age to rise, resulting in an increasing workload for surgeons. This will be exacerbated by the fact that a large number of surgeons are themselves approaching the age of retirement. A similar report on the future of the New Zealand surgical workforce through to 2025 is nearing completion.

Several issues that have occupied GAC remain ongoing challenges. The Four Hour Rule is to be rolled out across Australian public hospitals despite its failure in the UK, its controversial results in Western Australia and the obvious objection that you can't responsibly address crowding in the emergency department until you have invested in beds and staff across the entire hospital.

The College remains acutely aware of the uneven distribution of the surgical workforce and the fact that communities in rural and remote areas experience great difficulty in attracting and retaining surgeons. We will continue to remind governments of their responsibilities to all citizens, irrespective of where they live.

I was recently a member of a small team of Fellows who made a site visit to Alice Springs Hospital to try to identify means by which its only resident General Surgeon, Dr Jacob Ollapallil, can be supported on a viable and ongoing basis. The burden of disease and the incidence of trauma there is such that at least two more General Surgeons are urgently required. The team is currently preparing a report that will be provided to the Northern Territory government.

The attempt by cosmetic "surgeons" in Australia to gain recognition as a specialty is another ongoing issue, with the Australian Medical Council still to reach a decision. The College continues to argue that such a specialty would be spurious as Fellows practising as Plastic and Reconstructive specialist surgeons already do all of the work which the cosmetic "surgeons" pretend is theirs alone. The difference of course is that Plastic Surgeons do so much more as well, repairing lives and enhancing the quality of life of those severely burned, disfigured or injured.

I had the very good fortune to attend a host of specialty society meetings over the past two years as well as many regional Annual Scientific Meetings. It was a pleasure to meet hundreds of Fellows and I have done my best to make sure the concerns raised with me at these meetings were subsequently brought to the attention of Council.

I remain firmly convinced that united we stand, divided we fall. The specialty societies are being listened to and heard. Much of what they say makes sense. But in the corridors of power the single voice of Australasian surgeons will always be louder and more authoritative than the disparate voices of nine specialties or thirteen specialty societies.

Keith Mutimer

The Rain

When summer rain brings a feeling that all is clean and fresh

It has been a quiet, sweltering and still afternoon. Humid, hot and overpoweringly oppressive. Sweat beads across my brow and my shirt, soaked, clings to my body. Slick.

The thick grass pours over my feet as I tread through the verdant front paddock. I had mown the lawn just four days ago, but already it has grown long and unkempt. Lush tussocks with long blades of grass envelope my boots. I'll have to buy more fuel for the mower.

Dark sullen clouds have amassed quickly, and tumble over themselves as they march across the sky. They appear rapidly, as if they had been waiting for the right time to ambush.

The raindrops fall

The first few are sparse, but suddenly the heavens open and the water falls from the sky in big fat droplets. They merge and start to form sheets of water, bucketing down. Caught in the downpour, I run. "Skedaddle" is the word that pops into my head. Pistons pumping, arms and legs flailing like a bandy-legged colt, I run to the house.

My clothing is damp. My skin is warm, glowing and wet. I have developed a light golden tan since I have lived here, spending more time outdoors this past few months than I have in years. The water beads over my greasy sunblock, my arms are slippery as eels.

As I get to the back door, the downpour begins in earnest. Now so heavy that everything appears grey with water, I cannot see more than a metre in front of me. Shutting the glass slider behind me, I stand and drip. Steam rises.

The rain thunders down on the tin roof. Rat-ta-tat-tat, like machine gun fire; loud and urgent. I lift my head, eyes to the ceiling, as if I'll be able to see the onslaught.

I am safe. I cannot be hurt. My gaze falls. A soaked lock of hair falls in front of my eyes as I look down at the floor. A puddle has grown around me.

Fresh, crisp, the world is new and clean. The smell of summer rain hangs in the air. I close my eyes and am lost in the roar on the roof and the luscious aroma that wafts around me.

Erector pili contact, I get goose bumps. Wonderful little tingles dance up my arms. It is not cold. It feels more like the soft touch of a lover marvelling at the smooth velvetiness of my skin. A caress. An embrace.

Bliss.

Dr Ina Training

Turning up the volume for Indigenous health

The Foundation for Surgery has funded research into Evidence Based Action Plans to address Indigenous health

The Foundation for Surgery is committed to addressing the health challenges and inequities in Australia's Indigenous communities. As part of this commitment, and through generous donations from Fellows, the Foundation funded research into the development of Indigenous health Evidence Based Action Plans (EBAPs)

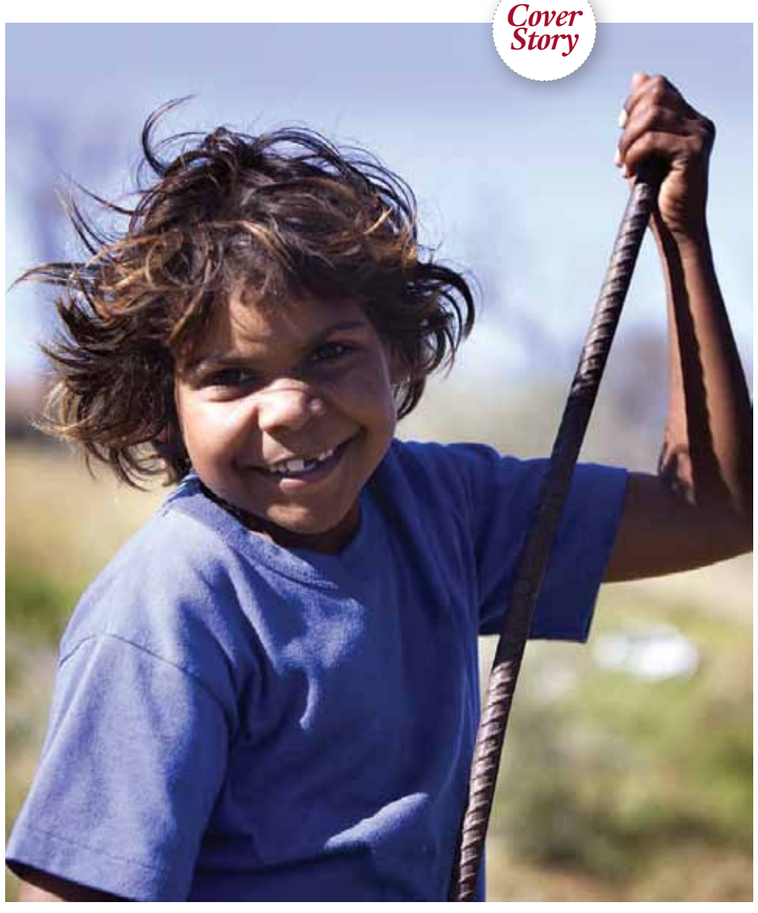
The College's Indigenous Health Position Statement recognises that significant and urgent improvements need to be, and can be, made to Indigenous health and the provision of health care, and that improvements in Indigenous health in Australia and New Zealand will require collaborative, cross-disciplinary efforts.

The EBAPs identify how improvements in the delivery of surgical services to Aboriginal and Torres Strait Islander peoples can contribute to better health outcomes in their communities. The EBAPs are action-orientated overviews developed to help solve identified problems and involve a review of existing research evidence in consultation with stakeholders. The research was led by Professor Russell Gruen at Monash University and Alfred Health and Associate Professor Kelvin Kong, Chair of the College Indigenous Health Committee, in collaboration with relevant research, clinical and policy experts around Australia.

Otitis Media among Aboriginal and Torres Strait Islander peoples is the subject of the first of a series of four articles on the EBAPs to be published in Surgical News. It focuses on the chronic level of ear disease in children, which may, if not treated, lead to loss of hearing, which will have profoundly adverse effects on social development, schooling, speech development and subsequent long-term employment prospects. If not addressed, ear disease is a debilitating burden for the patient, the health care provider and the wider community.

The topics of the three subsequent Evidence Based Action plans to be published in Surgical News are: renal transplantation, eye diseases and trauma.

Cover Story



An initiative of Foundation for Surgery

Otitis Media treatment

Indigenous Health Evidence Based Action Plan – Otitis Media among Aboriginal and Torres Strait Islander Peoples

Otitis Media (OM) is a broad term for infection/inflammation in the middle ear. It is a spectrum of disease with no universal standard definitions. As such it is difficult to determine the incidence, prevalence and costs of OM in both the Indigenous and non-Indigenous population.

It is a major cause of morbidity in Australian children. It has a different disease pathway in Aboriginal and Torres Strait Islander children, in that it is more common, presents earlier and lasts longer. It is more severe, is associated with multiple bacterial strains, is more often recurrent and more often results in tympanic membrane perforation. As such, research findings from the general population cannot be easily applied to this group.

Indigenous children have the highest prevalence of chronic suppurative otitis media in the world, reaching up to 70 per cent of the Australian Indigenous population. It is a major public health issue requiring urgent attention. Inadequately treating OM and its associated diseases causes a devastating cycle that can result in conductive hearing loss. This in turn leads to language delay, learning difficulties and the associated social problems of truancy, early school leaving and unemployment.

To date there is very limited evidence on the effect that surgical intervention (i.e. tympanostomy tubes and adenoidectomy) has on the outcomes of OM in Indigenous Australians, such as hearing loss and incidence of chronic disease.

Different strategies are required for the non-surgical management of OM in Aboriginal and Torres Strait Islander children. New research into recurrent acute OM, immunological responses to infection and the impact of antibacterial vaccines is contributing to a greater understanding of OM.

Measures such as building swimming pools and new housing, that is, addressing the social determinants of health, and new guidelines on antibiotic use have been partially successful in ameliorating the burden of OM in Aboriginal and Torres Strait Islander communities. These programs have not been rigorously evaluated and so their effectiveness is not guaranteed.

Follow-up after intervention is crucial to confirming success. Unfortunately in practice there is often no follow-up, or culturally inappropriate follow-up. Inadequate post-operative care has been linked to poor clinical outcomes.

A coordinated approach involving many services is required to effectively treat the broad spectrum of the OM disease. Services need to be planned to address the current deficiencies in screening, assessment, treatment and local follow up. A multi-faceted approach is required to treat Otitis Media in the Aboriginal and Torres Strait Islander population.

Chantel Thornton,
Foundation for Surgery Board member

The College will soon launch new professional development activities relating to the healthcare of Indigenous patients. An online potal to link to activities will soon be available as well as eLearning modules.

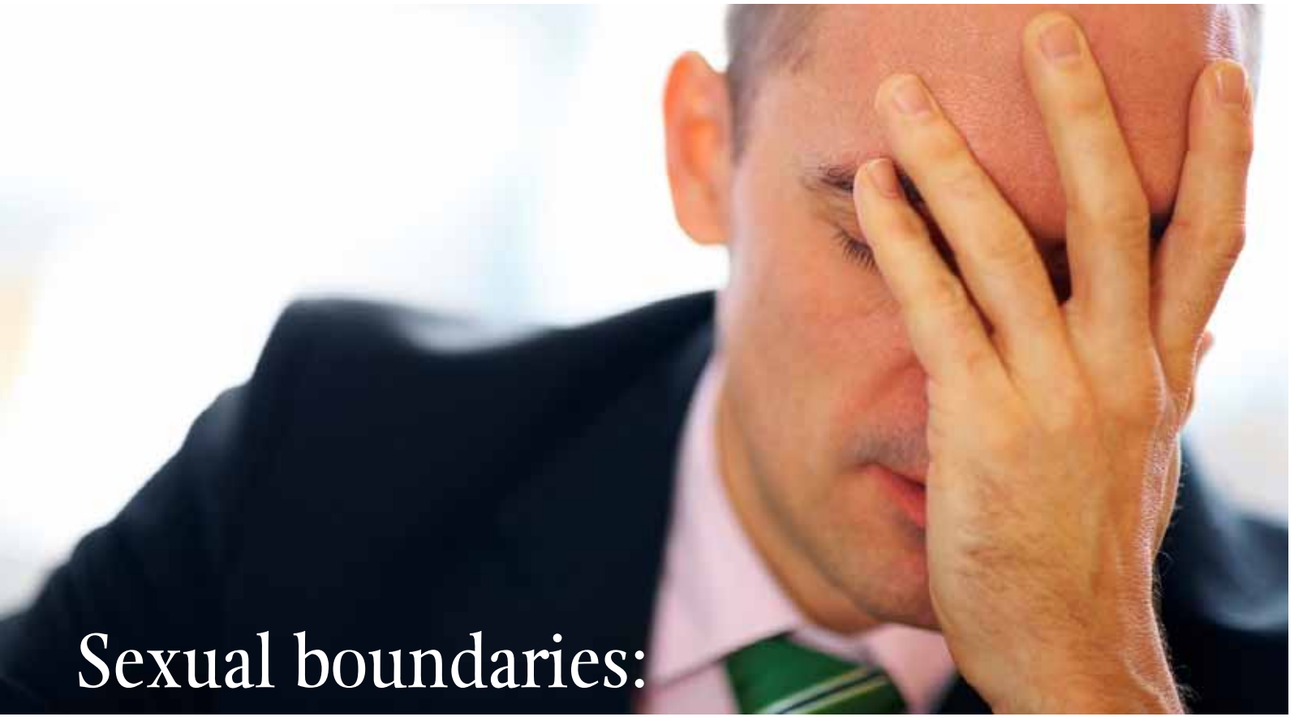
Homestay Accommodation for Visiting Scholars

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

Due to the short term nature of these visits, it is often difficult to find affordable accommodation for visiting scholars. If you have a spare room or suitable accommodation and are interested in helping, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a modest rental and eternal appreciation.

If you would like to be contacted by the College if the need for accommodation in your area arises, please register your details by contacting the International Scholarships Secretariat on the details below. We are currently seeking accommodation in Melbourne (near Royal Melbourne Hospital, The Alfred and St Vincent's Hospital), Brisbane (near Princess Alexandra Hospital), Sydney (near Westmead Hospital) and Adelaide (near Royal Adelaide Hospital) for visits in 2012. We would love to hear from you.

International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 - 290 Spring St
East Melbourne, Victoria 3002
T: + 61 3 9249 1211
F: + 61 3 9276 7431
E: international.scholarships@surgeons.org



Sexual boundaries: Guidelines for Doctors

Be clear on where the line is drawn

In October 2011 the Medical Board of Australia ("the Board") released the Sexual Boundaries: Guidelines for Doctors ("the Guidelines") relating to sexual boundaries between health practitioners and patients. The Guidelines do four main things:

1. Provide guidance as to what constitutes conduct which may be the subject of disciplinary proceedings initiated against a practitioner under the Health Practitioner Regulation National Law (Victoria) Act 2009 ("the National Law");
2. Provide guidance as to what constitutes 'sexual misconduct', which practitioners and employers are obliged to report under the mandatory reporting requirements of the National Law;
3. Explain the harm which can be caused by a breach of sexual boundaries and identifies warning signs as to when sexual boundaries have the potential to be breached;
4. Provide guidance for avoiding misunderstandings and suggest professional standards for conducting physical examinations, including the use of chaperones.

How do the Guidelines affect the legal obligations and liability of practitioners?

The Guidelines affect the liability and obligations of practitioners in two ways. The first is that the National Law provides that any guidelines released by the Board are admissible in disciplinary proceedings as to what constitutes appropriate professional conduct. The Guidelines provide standards for what constitutes "sexual misconduct". These standards would be relevant in disciplinary proceedings where a practitioner is alleged to have engaged in 'unprofessional conduct' or 'professional misconduct' of a sexual nature.

The second relates to practitioners' mandatory reporting obligations. Under the National Law, practitioners and employers of practitioners are under a legal obligation to notify the Board when they become aware that another practitioner has engaged in sexual misconduct in the conduct of their medical practice. The Guidelines now provide a clearer picture of what constitutes sexual misconduct.

What is "sexual misconduct"?

Previously, the only guidance available as to what amounts to sexual misconduct were past decisions of state medical boards and tribunals. The Guidelines now specify behaviour which will amount to sexual misconduct and apply nation-wide. Sexual misconduct under the Guidelines can be divided into three categories:

1. Criminal offences
Sexual assault, including unwanted physical touching or examination without consent, and rape.

2. Sexual activity
This includes sexual activity with a patient currently or formerly under a practitioner's care or a person closely related to a patient. The fact that such activity is consensual or was initiated by the patient is irrelevant. Sexual activity with a former patient may be sexual misconduct depending on the circumstances, including:

- The duration of care provided by the practitioner;
- Whether emotional or psychological treatment was provided;
- The level of vulnerability of the patient and degree of dependence on the practitioner;
- The time elapsed since, and the manner in which, the professional relationship was terminated; and
- The context in which the sexual relationship was established.

3. Sexual harassment or sexualised behaviour
Sexual harassment or "sexualised behaviour" are quite broadly stated in the Guidelines as including the use of "any words or actions that might reasonably be interpreted as being designed to arouse or gratify sexual desire". Examples given of specific behaviour include:

- Making sexual remarks or gestures, touching patients in a sexual way or engaging in sexual behaviour in front of them;
- Ridicule of a patient's sexual preferences or orientation;
- Making comments or requesting details about a patient's sexual history or preferences not relevant to the clinical issue;
- Discussing the sexual problems or fantasies of the doctor;
- Making suggestive comments about a patient's appearance or body;
- Making an unsolicited demand or request for a sexual favour, whether directly or by implication; and
- Inappropriate conduct during examination such as unnecessary disrobing, inadequate draping and intimate examinations without adequate prior explanation.

Why are breaches of sexual boundaries harmful and unethical?

The Guidelines explain that relationships between practitioners and patients inherently involve a power imbalance due to the elements of vulnerability and dependency. A breach of the sexual boundaries is therefore an abuse of this power imbalance and the trust which is the foundation of the practitioner-patient relationship. It may also impair a practitioner's judgment and compromise a patient's care.

What are the warning signs of potential breaches?

The Guidelines list the following warning signs of potential breaches of sexual boundaries:

- Patients requesting or receiving appointments at unusual hours or locations, especially when other staff are not present;
- Practitioners and patients inviting each other out socially;
- Doctors revealing intimate details of their lives, especially personal crises or sexual desires or practices; and
- Patients asking personal questions, using sexually explicit language, being overly affectionate or attempting to give expensive gifts.

How can a practitioner avoiding misunderstandings, particularly in relation to examinations?

The Guidelines note that many issues arise where a patient perceived a practitioner's actions as inappropriate or sexually motivated, only because of poor communication. A common example of this is where a doctor asks questions or conducts an examination which were clinically appropriate, but not adequately explained to the patient. To avoid this, the Guidelines emphasise using clear communication and suggest professional standards for physical examinations. These standards would also be relevant to whether a practitioner has engaged in sexual misconduct in relation to a physical examination and include:

- Explaining what is to occur in the examination and providing an opportunity for the patient to ask questions;
- Obtaining the consent of the patient to conduct the examination, or for anyone else, such as a medical student, to be present;
- Being sensitive to any sign of withdrawal of consent;
- Discontinuing an examination when consent is uncertain, has been refused or withdrawn;
- Allowing a patient to dress and undress in private and not assisting unless necessary;
- Not allowing a patient to remain undressed for longer than is needed;
- Allowing a patient to bring a support person such as a family member or close friend;
- Exploring the value of having a chaperone present;
- Postponing an examination until a chaperone the patient is comfortable with is available; and
- If the practitioner provides the chaperone, ensuring the chaperone is appropriately qualified or trained and of a gender approved of by the patient, parent, carer or guardian.

All doctors should be aware of these obligations, and adopt the suggested practices to prevent misunderstandings and potential claims.

Michael Gorton,
College Solicitor
and Ian Pelekanakis, Law Clerk

NOTSS in Australasia

Collaboration has meant the development of quality courses

The College is very excited to announce the launch of the NOTSS (Non-Operative Technical Skills for Surgeons) course which focuses on some of the non-technical skills underpinning safe surgery.This course has been developed as a collaborative project between the University of Aberdeen, the Royal College of Surgeons of Edinburgh, and the NHS Education for Scotland. It is based on extensive research conducted by a team led by Professor Rhona Flin from the University of Aberdeen, who is presenting at the upcoming ASC in Kuala Lumpur.

NOTSS focuses on four categories of non-technical skills:
Situation awareness
Decision making
Communication and teamwork
Leadership

These categories align with the RACS competencies of Judgement and Decision Making; Communication; Collaboration and Teamwork, and Management and Leadership.

Each category is described by a set of elements or behavioural markers similar to the behavioural marker system which has been developed for pilots, anaesthetists (Anaesthetic Non-Technical Skills – ANTS) and theatre scrub practitioners (Surgical Practitioners List of Intra-operative Non-Technical Skills – SPLINTS). The concept of behavioural markers is also integral to the framework for definition of competence and performance and the associated multi-source feedback assessment tool, articulated in the RACS 'Surgical Competence and Performance Guide'.

You can learn how to identify and rate behavioural skills while watching surgeons perform in theatre in a series of videos. This allows you to reflect on your own performance and provides a tool for giving feedback to colleagues and Trainees.

Traditionally, surgical training primarily focuses on medical knowledge, clinical expertise and technical skills. However, investigations into adverse surgical events show that underlying causes often relate to the non-technical aspects of performance (e.g. communication failures) rather than to a lack of technical expertise. Thus competence in technical and non-technical skills is necessary to ensure patient safety.

Focusing on non-technical skills can increase the likelihood of maintaining high levels of performance over time. Surgeons have always needed to demonstrate skills such as decision-making, leadership and team working, but these have been developed and assessed in an informal and tacit manner rather than being explicitly addressed in training. These cognitive and interpersonal skills underpin the delivery of safe, comprehensive and high quality surgical care to the community.

2011 Pilot Courses

In December, 2010, three College representatives went to Edinburgh to participate in a two-day NOTSS Masterclass. The first Australasian two day Masterclass to train a NOTSS faculty was held in Melbourne at the beginning of April, 2011, with 19 participants. We were very fortunate to have one of the Edinburgh faculty, Prof George Youngson as a presenter. The other faculty members included Bruce Barraclough, David Birks and Brendan Flanagan. Three successful one-day courses were piloted in 2011 in Bendigo, Perth and Melbourne with 39 participants including Fellows, Trainees, IMGs and anaesthetists.

A post-course survey has been undertaken with almost all respondents indicating that they have made changes to their practice as a result of attending the course. Some examples include:

- Discussion about leadership in OR with Trainees;
- Use of graded assertiveness much more often;
- Incorporation of a regular time out and a team debrief.

Overall, the NOTSS course has been successful and achieved positive outcomes both during the course and at a six month follow up. The knowledge and skills gained from the course appear to have been retained several months post-course. Here's what some participants have said:

"Outstanding course which should be mandatory for all the surgeons."

"Very good for raising awareness. I am motivated to pass my knowledge on."

"Excellent course, I thoroughly enjoyed it…relevant and will lead to improvements in my clinical practice."

2012 Courses

Ten face-to-face courses are planned in a range of locations during 2012. An eLearning module is also being developed which will provide a blended approach to course delivery. The provision of background and core knowledge, complemented by required pre-course online activities will prepare the participants to undertake NOTSS. The eLearning module content will be enhanced by involving an advisory group in the development of content and activities for the module.

Another train-the-trainer workshop is being organised for 2012. If you are interested in finding out more about NOTSS, please visit www.surgeons.org email pdactivities@surgeons.org or call +61 3 9249 1106.

Francis Lannigan
Chair, NOTSS Working Party

Workshops & Activities

Life long learning through professional development can improve our capabilities and help us to realise our full potential as surgeons as well as individuals.

Supervisors and Trainers for SET (SAT SET)

29 May, Brisbane; 14 June, Perth

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting.

Management of Acute Neurotrauma

2 June, Brisbane, 18 August Townsville, 31 October, Adelaide

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

Keeping Trainees on Track (KToT)

5 June, Adelaide

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

Strategy and Risk for Surgeons *NEW*

8 June, Brisbane

This practical whole day workshop is divided into two parts. Part one gives an overview of basic strategic planning and provides a broad understanding of the link between strategy and financial health or wealth creation. Part two focuses on setting strategy; formulating a strategic plan, the strategic planning process, identifying and achieving strategic goals, monitoring performance and contributing to an analysis of strategic risk.

Non-Technical Skills for Surgeons (NOTSS) *NEW*

16 June, Auckland

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

How Well Do You Know Your Practice? A game plan for success *NEW*

22 June, Perth

This whole day workshop focuses on how gathering data and information, in a systemised manner, through analysis and a willingness to challenge the status quo, can lead to effective decision making and improved customer service. Practice staff as well as Fellows are welcome to attend.

Leadership in a Climate of Change

14-15 September, Sydney

This 2-and-a-half day workshop can help you to understand what it takes to be an effective leader in this century. It uses the DISC model (DISC stands for dominance, influence, steadiness and conscientiousness) to examine the nature and practice of organisational leadership, through the exploration of issues such as organisational communication, influence, power and styles of leadership. You can also learn more about working as a team and gaining team commitment.

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

DATES
MAY - JULY 2012

NSW

4 July, Sydney
AMA Impairment Guidelines, 5th Edition: Difficult Cases

6 July, Sydney
Occupational Medicine: Getting Patients Back to Work

20 July, Sydney
Finance for Surgeons

NZ

16 June, Auckland
Non-Technical Skills for Surgeons

QLD

29 May, Brisbane
SAT SET Course

2 June, Brisbane
Acute Neurotrauma Management (Rural)

8 June, Brisbane
Strategy and Risk Management for Surgeons

24 July, Brisbane
Keeping Trainees on Track

SA

5 June, Adelaide
Keeping Trainees on Track

TAS

5 July, Launceston
Keeping Trainees on Track

VIC

30 April, Melbourne
SAT SET Course

21 September, Melbourne
Occupational Medicine: Getting Patients Back to Work

WA

14 June, Perth
SAT SET Course

22 June, Perth
How Well Do You Know Your Practice

RACS Competency Training Standards: leading the way

How do we communicate what stage a Trainee has reached?

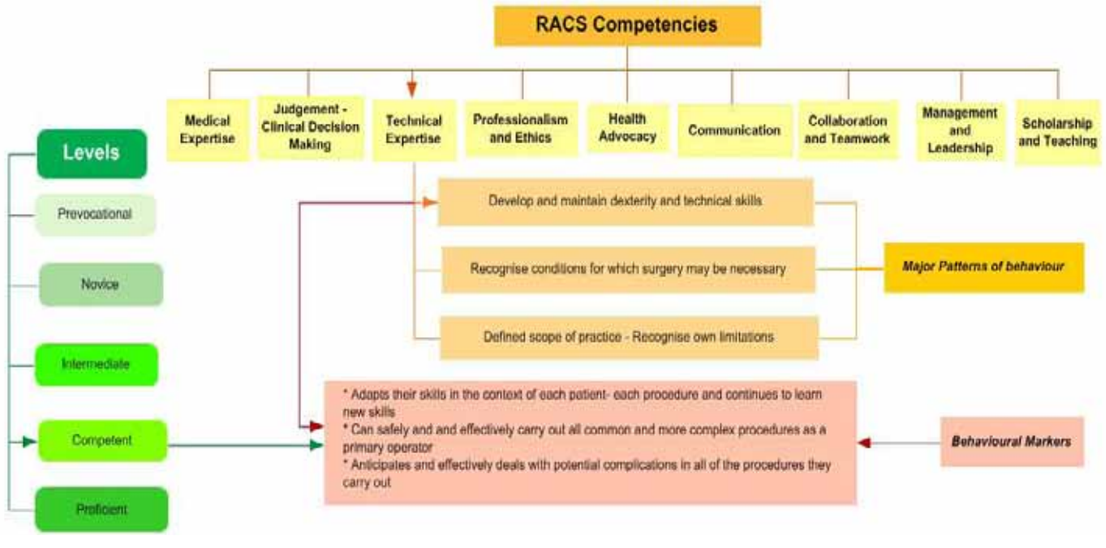
Surgical supervisors discuss the progress and performance of their Trainees on a regular basis. The information shared, and the language used to describe is rarely written down, and certainly no agreed framework exists. Despite this, surgeons do know how to communicate roughly what stage a Trainee has reached. Such conversations are usually lacking in an agreed framework for assessment of progress, or in agreed descriptors that have clear meaning and are highly relevant to where a Trainee is at.

Eighteen months ago, the College recognised the need to provide a framework and a generic description of progress through the stages of becoming a surgeon. The AMC encouraged us to define these standards and stages, but no one had tackled it across all the specialty training programs provided by a College. It was a good thing to attempt, but could we achieve it in a way that would be both educationally sound and still employ the everyday language of the surgeons?

We were tasked with something that for surgery is leading the world – identifying and defining the progressive development of competency standards for specialist surgical training.

It is more than two decades since the first publication of CanMEDS which introduced a framework of competencies for medical specialty training. Yet, up until now, the stages and standards for the development of those competencies have not been described within the clinical context of the workplace, other than for some individual procedures or skills.

In 2011, a working party of senior Fellows and College staff was established to develop a structure and sequence of standards. The standards were based on the agreed nine RACS competencies each with three patterns of behaviour that have been defined in the RACS Guide to Surgical Competence and Performance http://www.surgeons.org/media/348281/pos_2011-06-23_surgical_competence_and_performance_guide__2nd_edition_.pdf. A major aim was for the descriptors of competency acquisition to maintain alignment with how the College recommends the performance of practicing surgeons should be assessed.



The working group also identified progressive development through five stages of increasing complexity (from pre-vocational to novice, to intermediate, to competent, to proficient) for each competency. These are consistent with the concept of competency-based rather than time-based training, and recognise the need to assess each of the competencies and patterns of behaviour separately.

A set of key performance markers were described for each of the three major patterns of behaviour relating to the nine competencies. These describe how knowledge, skills and attitudes are translated into performance. Each performance marker had to be observable and thus assessable by a surgical supervisor.

The image below illustrates the structure and sequence using 'Technical Expertise' as the example competence. The three major patterns of behaviour being:

- Develop and maintain dexterity and technical skills;
- Recognise conditions for which surgery may be necessary;
- Defined scope of practice – Recognise own limitations.

The behaviour markers for one of these (Develop and maintain dexterity and technical skills) at the level of competence, is then delineated.

The full range of performance indicators, from pre-vocational to proficient for that 'pattern of behaviour' is outlined in the Table to the left.

Develop and maintain dexterity and technical skills

Pre-vocational	– Can perform basic clinical skills such as resuscitation, suturing simple superficial wounds, knot tying, maintaining sterile field, Pain management. *Refer to Elementary Surgical Skills Document*
Novice	– Seeks opportunities to learn new skills. – Learns new skills quickly. – Aware of the importance of positioning patient for safe surgical access. – Can safely and effectively carry out parts of some common procedures under close supervision. – Able to perform basic surgical skills and tasks relating to surgical specialty. – Demonstrates basic use of common surgical tools such as diathermy, suction, retractors. – Demonstrates understanding of the importance of gentle handling of soft tissue and of wound care. – Aware of how to use surgical instruments and use of local anaesthetic.
Intermediate	– Assists effectively at major or complex procedures. – Able to position patient, gain surgical access. – Can safely and effectively carry out most common procedures or individual components of major procedures with supervisor in theatre. – Can safely and effectively carry out significant parts of more complex procedures under close supervision. – Can anticipate and effectively deal with potential complications in the most common procedures.
Competent	– Adapts their skills in the context of each patient-each procedure and continues to learn new skills. – Can safely and effectively carry out all common and more complex procedures as primary operator. – Anticipates and effectively deals with potential complications in all the procedures they carry out.
Proficient	– Consistently demonstrates sound surgical skills. – Has a professional development plan for continuing enhancement of skills. – Can effectively teach others to perform surgical skills and carry out procedures. – Has appropriate processes for learning or introducing a new technique, e.g. visiting a surgical expert or mentor.

Technical Expertise

Your Trainee has been on the unit for the past five months. During this time he/she has assisted you for the major procedures and performed minor ones either with your assistance or with you observing and advising unscrubbed. Last week you realised it was time to give him/her some further responsibility and so you allowed him/her to perform the exposure for a major case independently whilst you saw some patients in the ward. When you arrived in theatre you found that the patient was in a good position on the operating table for the procedure to be carried out, but that the exposure was compromised by too short an incision. Having scrubbed and extended the incision, and with yourself being an additional assistant, the exposure was then adequate. Your Trainee then proceeded to mobilise the organ for resection, remain in the correct tissue planes and ligate the key vessels.

The defined behavioural markers are not intended to be a comprehensive analysis of Trainees' performance and behaviour, nor are the identified behaviours expected to be observable in every work-based situation. Rather they have been selected because they represent observable behaviours which are sufficiently important to be considered as key indicators of each Trainee's progression towards being judged as a competent and safe practitioner.

As such supervisors and Trainees can use the behavioural markers to:

- highlight examples of progression towards competent performance;
- provide a shared framework of steps towards the next or future stages of 'becoming competent and proficient';
- enable supervisors to be more confident that their standards and expectations are the same as their colleagues;
- provide a common vocabulary for training, briefing and debriefing, providing feedback, and communication between Trainees, supervisors, and training boards about each Trainee's performance;
- clearly identify when a Trainee is performing at, above, or below, the expected standard for their level of training;
- provide a framework for establishing shared meanings between safety and quality, training, and assessment.

The resultant document, 'Becoming a competent and proficient surgeon: Training Standards for the Nine RACS Competencies' has been approved by Education Board and College Council for use across the specialties. Each specialty and training board now has the opportunity to decide how this resource can be best used to advise and assist supervisors and Trainees. The performance markers could also be used as part of the assessment process during examinations.

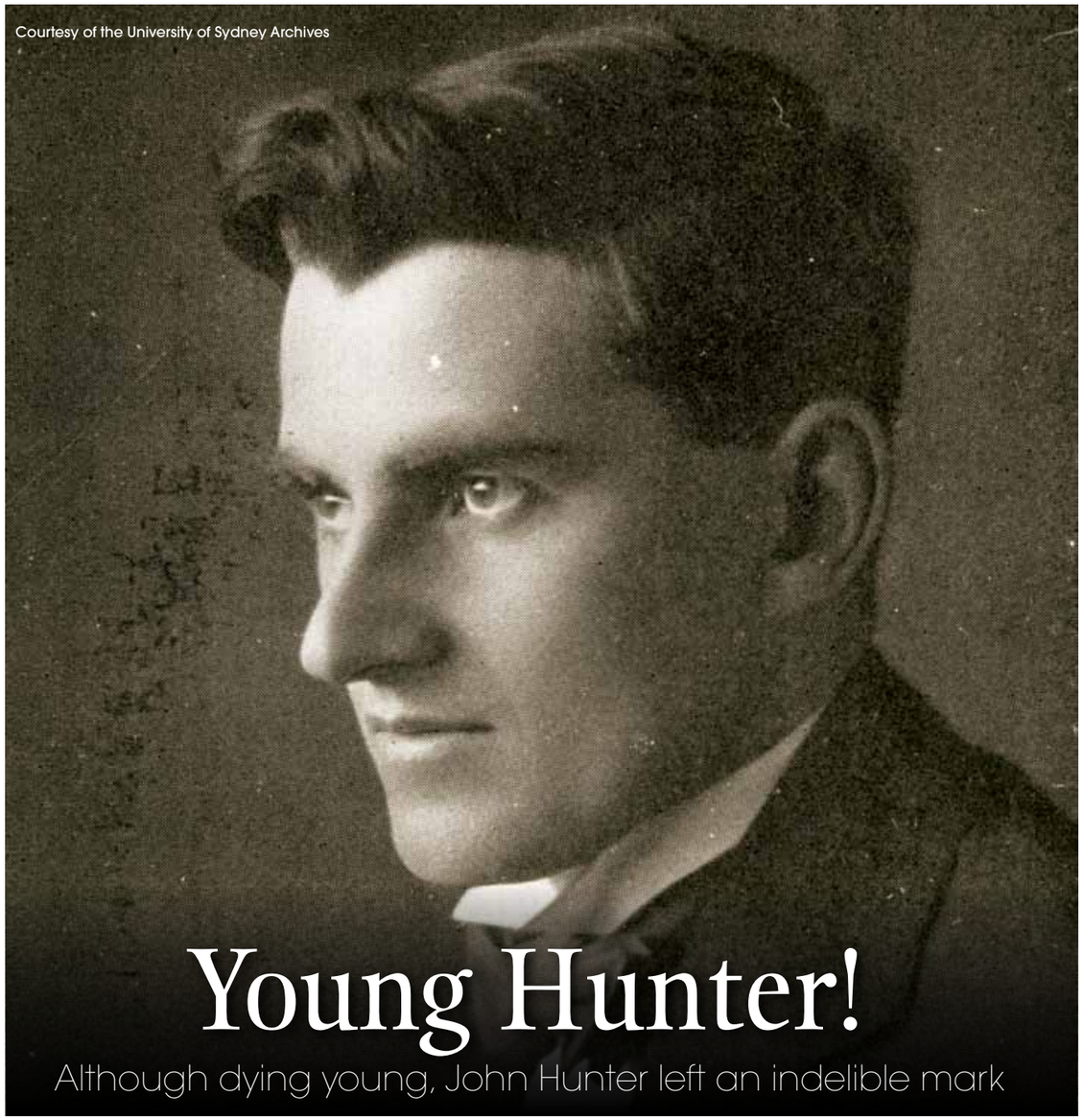
The first edition contains vignettes for each competency, designed to illustrate the sort of performance that might need to be assessed. For example, the following vignette applies to Technical Expertise.

Specialty training boards also have the opportunity to revise the vignettes to make them more specific to their own specialty.

The distribution of this work marks a significant step in meeting the challenge towards defining progressive standards of competence throughout training, not just in surgery, but across all post-graduate medical training. Since the RACS competencies are closely aligned to the original seven of CanMEDs, these competency standards can potentially be adopted and adapted by medical disciplines other than surgery.

The document can be accessed on-line at: http://www.surgeons.org/media/452878/dft_2012-02-24_training_standards_final.pdf

David Watters,
Chair, Performance Assessment Committee



Courtesy of the University of Sydney Archives

Young Hunter!

Although dying young, John Hunter left an indelible mark

'For John Hunter is dead; dead ere his prime, Young Hunter! And hath not left his peer'

In December, 1924, John Irvine Hunter, Challis Professor of Anatomy at the University of Sydney, died in London at the age of 26. Eulogised by AE Mills as the University's 'most gifted son,' Hunter was universally mourned and in an unusual gesture, his passing was lamented in a motion of the NSW Parliament.

For Douglas Miller who entered the University of Sydney's Medical School in 1919, Hunter was a memorable genius 'who shone in all branches of medical learning.' An Associate Professorship in Anatomy had been created for Hunter almost as soon as he graduated in 1920 and Miller found that:

"His lectures were almost electrifying as he poured forth his words with such enthusiasm that he actually used to froth at the mouth. To him anatomy was an exhilarating, exciting exercise of discovery… When Wilson [James Thomas Wilson, first Challis Professor of Anatomy], left for Cambridge Johnnie Hunter was appointed to the chair at the age of 24. Full of energy, ideas and enthusiasm, this life of great promise was to be short."

While a student at Sydney University, Hunter came in contact with Norman Dawson Royle, later a Foundation Fellow ▶

of the College and the pair collaborated in research, which was to seal Hunter's fame and perhaps even his fate. They investigated the regeneration of nerves and muscles, muscle activity, reflex action in the spinal cord and the sympathetic innervation of muscles and muscle tone.

Royle was an unusual character, an orthopaedist who had kept himself afloat as a student by teaching physical education. He became interested in how muscles work and are controlled. Influenced by the Dutch histologist Jan Boeke, this led him to investigate how spastic paraplegia could be alleviated. Initially he performed ramisection on goats, then moved on to cadavers and performed experimental surgery on patients returning from World War I. A creative researcher, he trained himself in the voluntary control of his own muscles and his observations contributed to his paper: 'The Functions of Human Voluntary Muscles', 1938.

Following his graduation in 1920 with First Class Honours and the University Medal, John Hunter went overseas for two years and engaged in research in the fields of embryology, anthropology and physiology. After investigating ovarian pregnancy, he also studied the anatomy of the oculomotor nucleus of a tarsius and with Dr Ariens Kappers in Amsterdam, researched the forebrain of the apteryx (kiwi) – this formed the basis of his MD which was awarded in 1924.

Hunter also analysed the controversial Piltdown skull and other remains at the British Museum and his research, published in a monogram in 1922, concluded that when the 'occipital region is properly constituted and orientated, it presents a much closer analogy to the condition found in the new-born African anthropoids than it does any other human skull'. Although the Piltdown skull was finally revealed as a fake in 1953 when a Fluorine Absorption test showed that the cranium was that of a medieval man and the jaw came from an orang-utan, Hunter's research indicates his active and far reaching intelligence.

Sympathetic fibres

Lecturing and demonstrating at American and Canadian clinical schools before his return to Australia, Hunter showed a particular interest in Henry Head's work on aphrasia and according to Professor Elliot Smith, Hunter 'did a great deal' in making Head's work understood.

The most important collaboration between Royle and Hunter began when Hunter returned to Australia in 1923. While in London, Hunter had seen some of Professor Kulchitsky's histological samples which indicated that 'the sympathetic fibres to striated muscles did not go to the same muscle fibres as the medullated nerves'.

This combined with experimental work helped inform Royle and Hunter's hypothesis of double innervation of muscle – 'the idea that the sympathetic nervous system controls 'plastic' (postural) tone' and that spastic paralysis could be alleviated by sectioning the sympathetic nerves.

The Scottish surgeon Sir William McEwan known for his orthopaedic work on bone grafts and pioneer work in neurosurgery visited Australia in 1923 and he was followed by the American physician William Mayo (a founder of the Mayo Clinic) in 1924. In the narrow surgical circles of the time, it was inevitable that McEwan and Mayo would be aware of Hunter and Royle's work. Future College President, Sir Hugh Devine who sponsored Mayo during his visit had certainly met Hunter and it was Devine who somehow obtained the memorial plaque to Hunter which now resides in the College Archive.

It was not surprising therefore, that in October 1924, Hunter and Royle were asked to deliver the John B Murphy Oration in New York. They were then to travel to England where Hunter was to lecture at Cambridge (the new home of Hunter's mentor, Professor JT Wilson) and London. As Douglas Miller says, the American part of the trip went well:

"…they were warmly welcomed and their work seemed to be acclaimed. Harvey Cushing, the great neurosurgeon was tremendously impressed by Hunter and Cushing was not easily impressed."

However, in England, their work was criticised and later disproved. And while in England, Hunter became sick and died in London's University College Hospital and Royle, who had suffered from mild influenzal encephalitis on the voyage to England, then developed some sort of brain fever which affected his health in later life. Although Hunter purportedly died of typhoid fever, it has been suggested that Hunter and possibly, Royle may have been exposed to the encephalitis lethargica virus rampant in New York in 1924.

The theory of double innervation of muscle was refuted within a few years of Hunter's death, but remained an active area of research. Albert Coates, for example also made a detailed study of the sympathetic innervation of skeletal muscle tissue and his work (with OW Tiegs) was published in the Australian Journal of Experimental Biology and Medical Science in 1928. Douglas Miller effectively sums up their contribution to medical science:

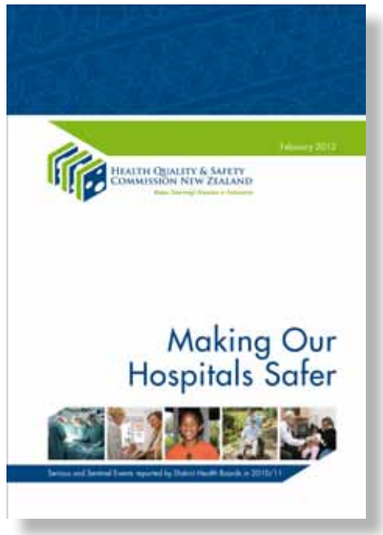
"Though their work was discounted he and Royle had opened up great interest in the previously ignored sympathetic system and much good came of it."

And Elliott Smith who worked closely with Hunter during his first trip to England bewails the loss of such a young and brilliant mind and provides this panegyric.

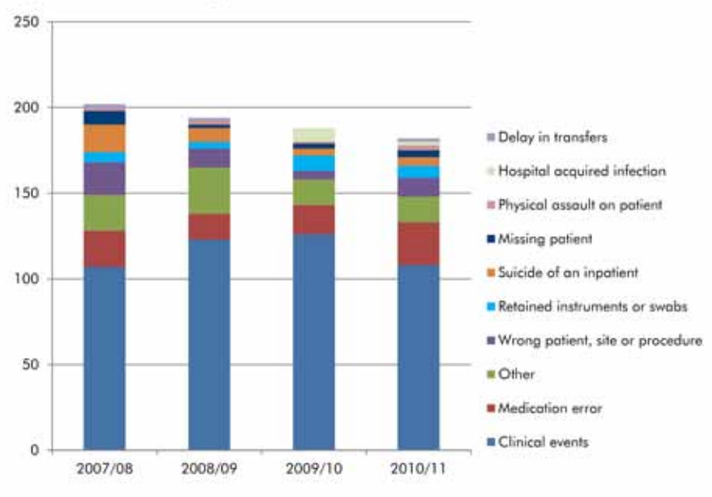
"It is impossible to convey to those who have not come under the spell of his personality any adequate conception of the magnitude of the loss anatomy and in fact medical science in its widest sense have sustained in the death of John Hunter. The great name he bore would have overwhelmed a smaller man; but it is no exaggeration to claim that he has added fresh lustre to it."

Written by Elizabeth Milford, College Archivist

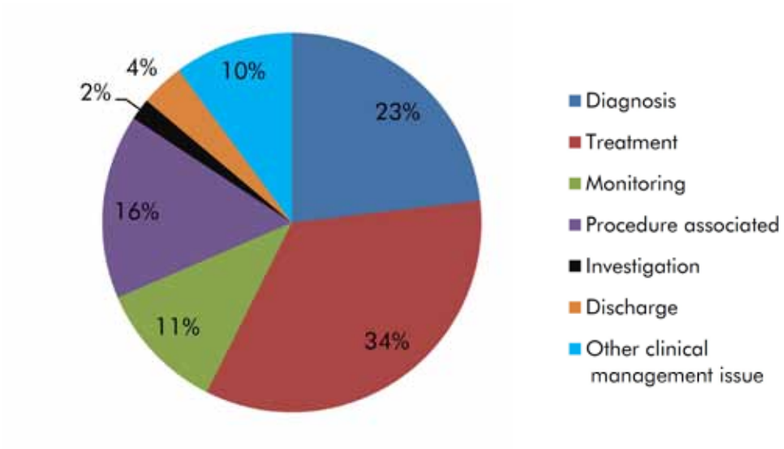

ND Royle c 1920s



Main event categories (minus falls) 2007/08 to 2010/11



Clinical management events 2010/11



Quality and Safety of Health Care

How does NZ fare?

In 2010 the Health Quality & Safety Commission (HQSC) assumed responsibility for collating information about, and reporting on, serious and sentinel events in New Zealand public hospitals. Its Serious and Sentinel Events Report, released in February, outlines 377 events which occurred in 2010/2011. The report, the fifth collating information provided by New Zealand's 20 District Health Boards (DHB), does not capture all adverse events that occurred in public hospitals, only those considered by each DHB as serious or sentinel events. There is no national report on such events in private hospitals.

Professor Merry, the Commission's Chair, observed that New Zealand has an excellent health and disability system, with more than 2.7 million people treated in public hospitals or as outpatients each year and very few occasions of serious harm. However, he also said: "The people involved in these 377 events were let down by the system that exists to protect them... We should view these events through the eyes of patients and their families, and acknowledge that many of them should never have happened... It's not acceptable to keep making preventable errors and all of us who work in health need to redouble our efforts to ensure patients receive the best and safest care... It's not about apportioning blame – it's about improving the quality and safety of our health and disability services."

It is of considerable concern to find the report includes 18 episodes specific to surgery – 11 wrong patient, site or procedure and seven retained instruments or swabs. Each of these reflects a failure of operating theatre process and is of direct concern to surgeons. With the introduction of the Surgical Safety Checklist, it had been envisaged that errors of this nature should be avoidable. As approximately 50 per cent of elective surgery is completed outside the DHBs (and private hospitals have not universally accepted the Surgical Safety Checklist), it is likely that the total number of these events in New Zealand in 2010/2011 was significantly greater than addressed in the report.

Although the detail is sparse, the reported 108 instances of serious and sentinel clinical management events are likely to include examples of significant failure on the part of individuals and systems. This larger grouping contains six sub-groups – errors of diagnosis, treatment, monitoring, procedure associated, investigation, and discharge. Surgeons may have contributed to any or all of these sub-groups, and closer examination of errors of treatment and procedure associated categories may yield valuable lessons for us.

Of the 377 events, 195 arose as a consequence of patients falling, resulting in significant adverse consequences. While many of these patients were probably elderly, exhibiting poor balance, co-ordination or confusion (and therefore at greater risk of falling), a detailed analysis of each incident may identify common additional predisposing factors in the clinical environment and the provision of their care. With this knowledge, it may be possible to introduce measures that are better targeted to protect vulnerable patients.

The New Zealand National Board is strongly supportive of the work of the HQSC and has already established a close link with the Chair (Professor Merry) in an endeavour to obtain more detailed information. (Professor Merry and Dr Janice Wilson, CEO of HQSC, attended the March NZ National Board meeting.) It is anticipated that a careful appraisal of each incident involving surgeons will provide greater understanding of the circumstances around these adverse outcomes and, through improved education and practice, reduce the risk to surgical patients in the future. Recognising that approximately 50 per cent of elective surgery in New Zealand occurs in private hospitals, the National Board strongly encouraged the Commission to seek serious and sentinel event information from private providers also.

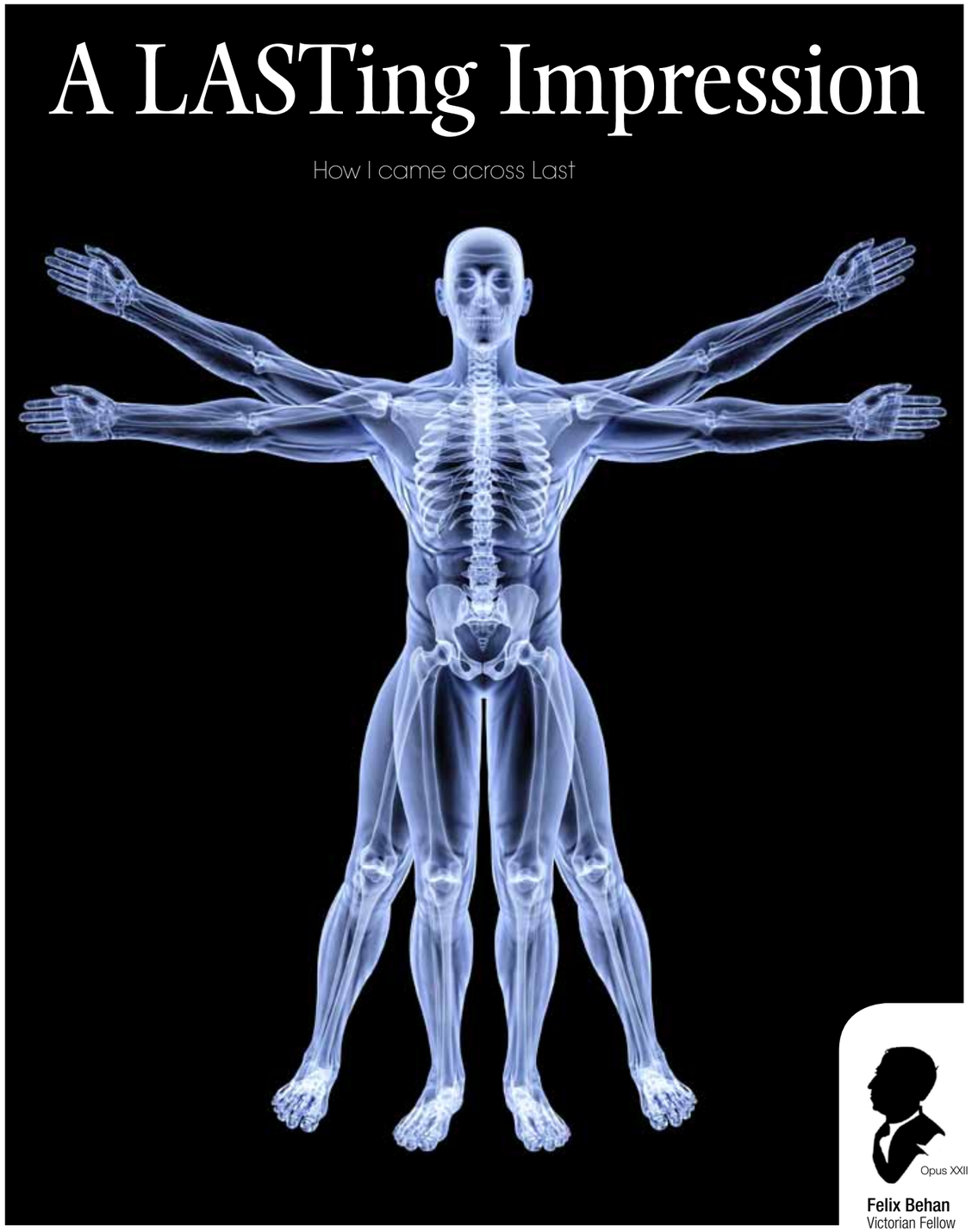
The first report from the Perioperative Mortality Review Committee (POMRC), which was set up in 2010 under NZ's Public Health & Disability Act, was also released in February. This gathered perioperative mortality data from existing data sources and then examined more closely four surgical procedures (hip and knee arthroplasty, colorectal surgery and cataract surgery), as well as deaths occurring within 48 hours of a general anaesthetic. This provided national epidemiological information in respect to those procedures and anaesthesia in the public hospitals, but again, did not capture information on these in all private hospitals.

There was no detailed assessment of any individual case. The NZ National Board regards the establishment of this Committee as a very positive initiative and recognises that broad epidemiological data has its uses. POMRC has asked for comment on its future directions and the National Board will continue to urge POMRC to institute systems to review individual perioperative mortality cases (in common with ANZASM) in order to identify areas for clinical improvement.

Scott Stevenson,
Chair NZ National Board
With Allan Panting,
Executive Director for
Surgical Affairs (NZ)

A LASTing Impression

How I came across Last



Felix Behan
Victorian Fellow

In the January 2012 issue of *Surgical News* I enjoyed the story about Raymond J. Last and his Abyssinian (Ethiopian) adventures. He then became Professor of Anatomy at the Royal College of Surgeons in London. I found in this article no references to his witticisms (a term used by Dryden for witty remarks since 1670s).

We have all enjoyed reading this textbook for anatomical and functional interests through our student and Fellowship years. As students of anatomy and surgery, we have a firm bonding with this readable text and as Bob Marshall would most likely have observed – it reduces this important subject of living anatomy into what has been described as dynamic realism.

Professor McMinn succeeded Ray Last as Professor of Applied Anatomy at the College of Surgeons in London. Last also held the Wardenship of Nuffield College of Surgical Sciences at the Royal College of Surgeons where I lived for three years. How did it all begin?

During my time at the VPSU at PANCH in 1970 I was finishing my General Fellowship while training in plastic surgery under Benny Rank. I can still remember doing essays on abdomino-perineal resections on Benny's suggestion, which he would get Alan Cuthbertson at Royal Melbourne to correct (thank you, Alan, after all these years).

I passed my Fellowship exam in October 1970, a trainee in plastic surgery. My first major case as a "qualified registrar" was that same evening at PANCH when I had to do a sigmoid volvulus with Ken Brearley on call.

He said: "Son, you have a Fellowship, you should be able to handle that." It was not to be and Ken graciously came in from Brighton and got me out of a tight corner (or should I say "a twisted loop").

During my PANCH days, food was freely available to Consultants and I dined regularly with David Conroy and Gordon Trinker who incidentally would regularly come in to every motor vehicle accident at all hours to document the details. And that acknowledgment regarding the safety belts and the College was repeated in *The Age* again recently.

In London

One day David Conroy said to me: "Felix, why don't you go to London? Now that you have your Australian Fellowship they will give you the English one." It was exactly as David said; my viva examiner, I think, was Felix Eastcott who spent the whole viva discussing Maurice Ewing's transition to the antipodes.

David had suggested that I also book accommodation at Nuffield College to do the six week English Fellowship course beforehand which enabled me to visit every major teaching hospital in London to meet the experienced surgical minds of the day – as Bruce Mann is currently organising for the FRACS locally.

On that first morning we were waiting for the bus outside Lincoln Inn's field; I remember wearing a standard English club tie – angled burgundy and blue – when someone came up to me, extended his hand, shook mine quite positively and said to me, "King's College, Cambridge, I presume". I hesitated, caught my wits and thoughtfully responded: "No, this tie comes from Fosseys of Footscray (a clothing store) in Melbourne".

Thanks to Alan MacLeod, I ended up working for three years in the Head and Neck Service at the Marsden with Henry Shaw, at the Westminster with Charlie Westbury in melanoma and with Ian Wilson at St George's, Hunter's old stomping ground. I slowly matured in the art of reconstruction, focusing on the vascularity of flaps during a concurrent research year at the College of Surgeons as a Bernard Sunley Research Fellow.

Professor McMinn describes Last's warm personality and the embracing style of his textbook writing. My three year stay at Nuffield College meant I had privileges few could have dreamed of – food, accommodation and access to the Hunterian collection, even meeting Jessie Dobson, the curator of the Hunterian museum.

She introduced me to my first Dodo – the flightless bird with vestigial wings presumably brought back on the Beagle by Darwin after trans-navigating the world. She even invited me to the Darwin's residence.

At the College, I worked with David Thomsett on the methyacrylate injection studies on stillborn babies during that Bernard Sunley Fellowship year. This helped me to develop the concept of the angiotome or vascularised segment and it was the basis of these fascial lined flaps with dynamic in vivo development which led me to the principle of the Keystone Island Reconstructive flap which is really a con-jointed or double VY.

Free parking

The then Warden, Doctor Livingstone, did not own a car which gave me the privilege of parking next to the Presidential Rolls, I think owned by Sir Thomas Holmes-Sellars at the time. And my Ford Zodiac (of Z-cars fame) did not match the prestigious vehicles of the College council members who also used the same car park. It was the luck of the draw to get free parking at Lincoln's Inn Fields in the centre of London.

The Department of Anatomy after Last and now under Professor McMinn where this work was completed was a reflection of English academic excellence. I had access to the college's photographic department run by Ralph Hutchings – the author of numerous anatomical illustrations with Professor McMinn – which was of the highest standard and from him I learnt the importance of photographic reproductions to encompass lighting, tone and composition. This experience has been invaluable in my recent publication.

As the publishers Elsevier told me last week, the 9th edition of Last's Anatomy – Regional and Applied is the one distributed on the Australian scene full of anatomical pearls so characteristic, whereas the 11th Edition (European) authored by Chummy S Sinnatamby have these all but deleted. To recapture a few – the last of Last, we hope not (as said by Ed Morrison):

1. Hilton's Law – the motor branches of muscle nearby also supply the joint. ▶

2. Flexor skin is more sensitive than extensor skin.
3. Flexor muscles are quicker acting and more precise with finer fibres which in animals are more tender to eat.
4. The mandible at birth is in two parts – so Galen was right after all.
5. The size of the breast goes from the second to the sixth rib and with age and pendulous descent, the circulation of the nipple from the intercostal perforators must go from medial to lateral and therefore any breast reconstruction should be so designed.
6. Flexor hallucis longus is defined as beef to the heel with gastrocnemius used in walking and the long flexors for overdrive.
7. And not forgetting, superficial lymphatics follow veins, deep ones follow arteries. Even Trevor Jones reminded me recently that the appendix is a tonsil and the ribs are for breathing.

Now it is time for a cup of coffee as the other part of Last's story embraces that place Ethiopia, where coffee originated. The story goes that a goat-herder was hunting sometime in the 10th century in the hilltops of Ethiopia. He went to round up his herd and found them nibbling a red berry tree under the midday sun – some were more excited than others and I will let you speculate what that means to a goat herd!

Start of coffee

He took some of the tasteless berries home and threw them in the fire. The aroma was elevating. He retrieved the roasted beans from the fire, crushed them, made a drink and that was the start of his Seventh Heaven experience.

Now we recall this Ethiopian story every time we fly over Mocha in Arabia (part of Yemen), incidentally called Arabia Felix. Eventually coffee reached the European scene in the 17th century even needing religious approval for its consumption. It was banned at one stage and needed a Papal Bull from Pope Clement to reverse this restriction.

Even Bach wrote a cantata in praise of coffee: "Ah how good the coffee tastes" for his regular Friday evening recitals in Leipzig. Voltaire was even reputed to have consumed up to 50 cups of coffee a day for its stimulating effect. And across the channel to the United Kingdom where one of the coffee houses in the East End was run by Mrs Jones and was a meeting place for the insurance brokers to negotiate the coffee cargos from Africa, such was its value. What was established nearby in Lime Street? Lloyds of London.

I haven't time to take this dissertation across the Trinidad and the story of Blue Mountain coffee from the Caribbean – to my mind the best in the world (like Petrus wine from Pomerol in Bordeaux). You will have to await my next instalment on coffee drinking, which has become the philosophical basis of communication in a Socratic manner where the didactic questions and answers lead to the advancement of knowledge – as the great minds say, answer the questions, but more importantly question the answers.

Strangely at this 11th hour when refining this article on coffee something percolated through to my awareness. My former surgical registrar at the Western Hospital, Stephanie Tan, gave me a packet of Luwak coffee from Indonesia (which costs $30 a cup in the US). And why is it so expensive? The feline sized mammal the native civet eats the red berries in the jungle, the berries are indigestible and they come out as droppings to produce the finest coffee taste in the world thanks to the intestinal juices.

A Personal Perspective

Moving on to the next stage…

I write this as one of my final duties as chair of the Younger Fellows Committee. Traditionally, such an article would cover my experiences and accomplishments on the committee; however, while considering what to write, it occurred to me that despite an extra year as chairman beyond the usual 10 years, I am no longer a Younger Fellow! I have nothing left to associate with being young! I am the other side of 40 and heading steadfastly into middle age. I thought I'd reflect on this instead.

I started researching the definitions of key words and immediately started feeling better. For example, "young" is defined as "being in the first or early stage of life or growth" which doesn't actually mean much, but definitions go on to add "not old", and even better, "having the appearance, freshness, vigour or other qualities of youth."

This can be translated into the old phrase, "you are as young as you feel". With regards to the definition of Younger Fellow, younger is simply a comparative term, so in some way we are all almost always younger, even if not by College classification.

The end of College youth is in fact a great time in surgical practice. We have 10 years of experience, and would now feel competent and confident in our chosen field of surgery, but not so arrogant that we don't feel we still have many things to learn, both as surgeons and as people.

I find now the thrill of talking to my patients not only about their illness, but about their lives. So many of them have fascinating stories to tell and it really is possible to learn something new from almost every consult. For most of us, health permitting, we have another 20-25 years in practice, enough time to reap the rewards from the profession we love, or still enough to recognise a desire for a change in direction and work towards it.

In College terminology, we have a name for younger surgeons and one for those with far more years under their belts, but no term for the group in the middle, the majority of the Fellowship. Perhaps we should be called the "comfortable fellows?"

At the same time, we all see patients occasionally with terrible prognoses, more and more (as we grow older) younger than ourselves. These patients remind me how precious life is, and put our own problems in perspective. They remind me to make the most of every day we have because the truth really is that we don't know what tomorrow will bring.

Let us also not underestimate the value and productivity of the Younger Fellows, both as individuals and as a College committee. Some of the brightest minds and most skilled hands belong to young surgeons, destined for greatness in a country where innovation has always excelled beyond the expectations of our small population.

Over the next few years, one of the main focuses of the Younger Fellow's Committee will be leadership and mentoring, the very thing to nurture and develop these talented young surgeons, and to lift others who may not be performing so well to a level where they too can enjoy the success of hard work and dedicated training.

Remember that the Younger Fellows are 1500 in number and have a seat at the College council and the ear of many College committees. New ideas, whether generated at the Younger Fellows Forum, Younger Fellows Committee meetings, or a chat over coffee or over the phone to your State representative can develop into recommendations and projects high on the priority list of our Council.

I think it is healthy and important to stay young at heart. Different people help us achieve this; medical students and residents, junior colleagues, our friends, and our families. Many like me have young families and delight in coming home to them every day and being a kid again for a while.

To those like me, no longer Younger Fellows in name only, welcome to the age of the "comfortable surgeon". May your careers flourish. To the new Younger Fellows, good luck in your endeavours and consider becoming part of the Younger Fellows Committee to help mould the College into the Future. To the College, thank you for the privilege and opportunity I have had. I am certain that you will still see me around.

Steve Leibman
Chair, Younger Fellows Committee

Hearing a community

Surgical ENT outreach clinics at Awabakal Aboriginal Medical Service – a model of outpatient care for Aboriginal and Torres Strait patients

Outpatient care is recognised as a safe and effective way of treating patients without the requirement for hospital admission. Many reviews have been performed on what constitutes the ideal structure in which an outpatient setting can benefit the community in a safe and appropriate manner. While general logistics and micro-management issues are of on-going concern in both the establishment and operation stages, the growing need to increase patient turnover rates and yet maintain a structured program of care, is progressively adding pressure to our hospital systems to deliver the standard of health services expected by the community.

One way to alleviate this burden is to provide alternatives to traditional hospital based outpatient clinics. Moving an outpatient service to the community can be one such viable option. Community based outreach clinics offer the additional benefit that they make health care accessible to groups marginalised from the mainstream health care system. Aboriginal and Torres Strait Islander (ATSI) people, living not only in rural and remote Australia, but also in and on the fringes of our urban centres are marginalised as a result of distance, low socio-economic status or because of the inappropriateness of health care delivery.

Increasingly, Aboriginal Community Controlled Health Organisations are being recognised as places best suited to host outreach clinics for the delivery of health care services required by ATSI people. Community control has been widely accepted as a key requirement in the strategy to overcome Aboriginal health disadvantage.

The Awabakal Aboriginal Medical Service in NSW, for example, provides medical services (and other health, education and social support programs) to Aboriginal communities living in the Newcastle, Lake Macquarie and Hunter Valley regions. Close to 85 per cent of Awabakal staff is Indigenous.

Recently Awabakal AMS, supported by several Fellows working at the Royal Newcastle Centre and John Hunter Hospital, established a specialist urban outreach clinic for Ear Nose and Throat (ENT) services, as an extension to the surgical ENT services provided by hospitals in the Hunter New England Local Health Network (HNELHN). Dr Rob Eisenberg, Associate Professor Kelvin Kong, Dr Toby Corlette and Dr Monique Parkin, participate in community based clinics across the Hunter New England region, under the guidance and clinical lead of Abawakal's Aboriginal Ear Health Worker, Markeeta Douglas (pictured).

It is well documented that Aboriginal and Torres Strait Islander people report higher rates of hearing loss than their non-Indigenous counterparts, and that Aboriginal children suffer from re-occurring middle ear infection (Otitis Media) more frequently than non-Aboriginal children.

Otitis Media, if not treated adequately, can cause significant hearing loss. In children this can lead to linguistic, social and learning difficulties and behavioural problems in school, which reduce educational achievement with lifelong consequences for employment, income and social success.

Awabakal's ENT clinics encapsulate a model of outpatient care, where patient needs, treatment and journey through the healthcare system is managed within a comprehensive multidisciplinary framework. By "walking in the footsteps of a patient" those involved and responsible, at every step, for a patient's care, including the surgical specialist, is identified, noted and used to guide patient and case management.

In this way the outpatient service is an extension of the mainstream hospital system. Care is provided in a culturally appropriate setting to maximise patient contact, to 'close the gap' on the prolific ear disease rates and other ENT ailments in both adult and paediatric care.

Best outcomes

Imperative to the success of this model is the role of the Aboriginal Ear Health Worker and their liaison with the patient and health care providers to ensure the best outcomes for patients. In Abawakal's case, Aboriginal Ear Health Worker Markeeta Douglas is a critical part of the solution and is extremely committed to the ENT needs of the local community.

In 12 months of operation, the clinic has seen more than 130 patients, followed through on operative candidates (including two cochlear implants), and incorporated an audiology service to enable early detection of ear disease and hearing loss. Sustainability of the service has been achieved without burdening existing staff, resources and services. Central to the clinic's operation is regular assessment, review and feedback to the community, and the inclusion of the community in formulating strategies for improvement.

In medicine, a chronic disease remains a burden of illness to both patient and health care provider. Adequate management of chronic illness reduces the need for acute hospital admissions, complications of disease, fewer burdens on outpatient services and ultimately better patient outcomes.

Otolaryngology (ENT) is not free from long-term illnesses. Aboriginal and Torres Strait Islander people face many barriers to health care access. The need to overcome these barriers is essential in the provision of health care from an otolaryngology, head and neck surgery view. The need for a separate and specialised focus on Aboriginal and Torres Strait Islander health is not universally acknowledged within mainstream health care services.

The Royal Newcastle Centre is undergoing transformation by capital investment in equipment and revision of the delivery of ENT services. This climate supports a positive re-think, re-design and review of ENT outpatient services, including provision of community based specialised outreach services as an integral part of a renewed and responsive health care system.

The experience of Awabakal AMS has demonstrated new approaches are not only possible, but highly desirable if sustainable new benchmarks in service delivery and health outcomes are to be attained. An outpatient service, created to complement the services being provided by hospitals in the Greater Hunter New England Local Health District, will assist the delivery of appropriate health care to the communities it serves.

Active participation

"The benefits of Aboriginal community control and participation can already have been seen where Aboriginal health service and other Aboriginal community controlled organisations exist. The mere fact that community control shuns dependence on non-Aboriginal systems is a benefit. It promotes responsibility, understanding and allows communities to be active participants. As a result communities are able to identify health problems and possible solutions, contribute to needs based planning and be involved in ongoing evaluation. Communities become active participants rather than passive recipients, and the development processes that emerge allows from the design of structure to meet the specific health needs of Aboriginal people rather than attempting to 'fit' Aboriginal people to exiting systems".

(Source: A National Aboriginal Health Strategy, DoHA, 1989 page xvi)

Kelvin Kong
Chair, RACS Indigenous Health Committee

CONGRATULATIONS on your achievements

These NSW Merit Awards were presented at the NSW Regional Office End of Year Dinner, held on 16 December 2011

award winner

Reginald Lord
Presented by Anthony Graham

Professor Reginald Lord AM, MD, FRCS, FRACS, has shown all the qualities of leadership in the academic and clinical aspects of surgery throughout his career to be a worthy recipient of the NSW Merit Award of the RACS.

Professor Lord graduated in Medicine from the University of Sydney in 1960. He trained at St Vincent's Hospital, Sydney 1960-1965, St Thomas' Hospital, London with vascular leaders Drs Kinmonth, Cockett, and Browse 1966-1967. He trained at UCSF 1967-1969 with Dr Jack Wylie the pioneer of the operation of endarterectomy and completed his training in vascular and renal transplantation surgery in San Francisco.

He returned to Australia and St Vincent's Hospital to join the Professorial Unit with Professor Doug Tracy. Subsequently he became Associate Professor 1972-1985 and Professor of Surgery and Chairman of the Department 1985-2004.

He established the Rural School of Medicine in 2004 at Wagga. In 2004 the UNSW conferred Emeritus Professor Status.

The same year he became the first Professor of Surgery at the University of Western Sydney and helped establish the Medical School. He was Director of Surgery at Campbelltown and Camden Hospitals.

His skills in establishing and maintaining standards in surgery have been used in metropolitan and rural areas throughout Australia by health authorities where codes of practice and outcomes had been a concern. Professor Lord has always been a problem solver for the community and an advocate for our profession.

Professor Lord is author of over 250 publications, mostly related to vascular disease including the text book Surgery of Occlusive Cerebrovascular Disease of which he is the sole author.

He is a pioneer of extracranial arterial and thoracoabdominal aortic reconstructions.

He has been a member of the editorial advisory boards of the Journal of Cardiovascular Surgery, Annals of Vascular Surgery, Phlebology and ANZ Journal of Phlebology.

He has been an invited speaker and visiting Professor in every Australian State, New Zealand, USA, Canada, Portugal, Spain, Brazil, Italy, Monte Carlo, Greece, the Netherlands, England, Scotland, Israel, Singapore, Fiji, China, Japan, Vietnam, Indonesia and India.

He has trained one to three Fellows per year from Asia and Australia in vascular and transplant surgery. Many hold chairs in surgery in Australia and overseas including Professors Effeney, Lusby, Jones, Lynch, Gotley and the late Alex Chao from Singapore.

He has been president of the Australian Chapter and Vice President of the International Society of Cardiovascular Surgery, Chairman of the Section of Vascular Surgery and Military Surgery RACS.

In 1985 he was invited to serve as Colonel of the Royal Australian Army Corps. He led a St Vincent's team to Vietnam 1971-1972.

Prizes and Honours are numerous and include Member of the Order of Australia 2004.

His scientific contributions include dynamic studies of flow in the thoracic duct, haemodynamics of the vascular steal phenomenon in the cerebral circulation, the mechanism of TIAs via alternate pathways and defining the syndrome of carotid paraganglioma.

Together with Dr Yuri Bobryshev, Professor Lord postulated and then identified dendritic cells in the artery wall and defined their role in inflammatory components of atherogenesis.

Professor Lord has encouraged students and graduates to be actively involved in the learning process. He is recognised as a leading academic researcher, teacher and outstanding vascular surgeon with the equanimity that encourages calmness, care, skill and an endless thirst for knowledge. He is the complete Professor of Surgery and deserves recognition by our College.

"It must be remembered that this young upstart had arrived in a town where there was one part-time surgeon plying his trade and stories"

award winner

Alan Kline
Presented by Martin Jones

Alan has been a friend, colleague and mentor for over 20 years. He is, even in retirement, the Senior Surgeon of the Shoalhaven Hospital District in Nowra, on the beautiful south coast of NSW

Alan and his wife Pat have been for many years the ambassadors of Rural Surgery both at home and across the many lands they have travelled. They enjoyed the travel to distant shores initially as a young couple and, despite the arrival of Chris then Tom and finally Amy, their times of camping, walking, biking and sailing all over the world have not slowed.

Alan had his surgical training-wheels on in many of the hospitals of the British Isles, where he worked with many fine surgeons of the time. He was very proud of the academic achievements in his studies into vascular disease. He also worked with the legendary Mr Les Ernest Hughes. This excellent grounding in establishment of logic to investigation has held him in good stead.

Alan and I both are grateful to the pioneering spirit of Dr Irwin Hanan, who established the first General Surgical practice in Nowra. He worked as a General practitioner to establish himself, and then used his skills learned in New Zealand and the United Kingdom to further the practice of surgery. Alan also wishes to recognise the role played by Doctors Pat and Bill Ryan in helping him establish a specialist surgical practice in Nowra in 1978.

Alan had an interest in almost all aspects of surgery. He was truly a General Surgeon. A dab hand at Breast disease, Biliary disease, and hernia repair, Alan would not be daunted by the occasional fracture and hand injury. Children were very much part of his operative repertoire, and I still remember the intensity of concentration over the tiny sick babies with pyloric stenosis.

It must be remembered that this young upstart had arrived in a town where there was one part-time surgeon plying his trade and stories; of GP surgeons removing gallbladders with the hospital gardener attending to the ether mask. Alan was involved in an almost imperceptible change to specialisation amongst the regions' doctors and hospitals. Alan's best man at his wedding had been Col Shepherd, and the Shepherds have spread their influence throughout the practice of surgery in many ways throughout NSW and Australia. Col was Alan's anaesthetist, a lovable larrikin of a GP and part-time anaesthetist. Together they performed the little miracles that defined surgery in country NSW in those times.

Slowly but surely Alan instigated the protocols to his practice and then the hospital that would be used to establish Breast Cancer treatment, Bowel Cancer surgery and Trauma treatment. These practices have been refined over the years but the basis to current practice is easily seen in Alan's work.

Alan was one of the doctors who watched over the establishment of a private sector in the area, and was heavily involved in the establishing audit. There was the arrival of other specialists and the largest change of all, the arrival of specialist anaesthetists. This transition was not the simplest in this GP driven town, however with Alan's involvement many of the difficult moments were smoothed over and possible combatants became tennis partners or sailing buddies.

Alan has one major failure; he likes adventure, but he sometimes gets lost or injured. To have Alan as the doctor for the canoeing trip for his son's school class was in theory an excellent choice, but that is theory for you. Alan, being involved as always, set out in the canoe only to see the paddle stick in an underwater rock and his shoulder continue on its merry way to dislocation. There at the head waters of the Shoalhaven, thankfully he had an epirb alert device and was eventually airlifted out of the canyon, following his self administration of IVI pethidine – the other responsible adult had fainted at the sight of the needle.

Alan has retired from active surgical practice and we are hoping that he will continue in a teaching role in the Shoalhaven. His retirement dinner from the hospital was in Kigali in South Africa and the only people there were his family. Alan is an intensely private man and proud of his Queensland heritage (especially at time of the State of Origin). The people of country New South Wales, especially the Shoalhaven, have benefited from his love of surgery, simplicity and his genuine respect of patients, most of whom now count themselves as his friend.

award winner

Graham R Nunn
Presented by Robert Costa

Graham Nunn has had a great influence not only on my own career, but that of many other currently practising cardiothoracic surgeons, both adult and especially paediatric surgeons. Not one to seek the limelight, outside of the cardiothoracic community, Graham's achievements are perhaps little known.

I first met Graham in the latter stages of my advanced training. I was one of the few fortunate Trainees who were allocated a rotation to the cardiac unit at the RAHC at Camperdown prior to its relocation to the Westmead site. The most striking feature was the absolute attention to detail in all aspects of an operation from the prepping and draping to the application of the dressing at the end of the procedure. This applied no matter whether the procedure was a relatively simple ASD closure or a complex intracardiac structural repair. To this day I strive to achieve an atrial closure suture line that even attempts to resemble a Graham Nunn closure!

Graham is not native to NSW. He grew up in the wilds of Kangaroo Island in South Australia prior to attending the University of Adelaide. His university transcript would make the majority of students blush with shame. His lowest grade appears to have been a credit on a single occasion. Throughout his undergraduate years Graham was awarded no less than seven prizes.

On graduation he went on to the Royal Adelaide Hospital and trained in cardiothoracic surgery under the tutelage of Ian Ross and Darcy Sutherland. On gaining his FRACS in 1979 he undertook further training in both adult and paediatric surgery in London and Boston as well as research work. He worked with Professor Magdi Yacoub, Marcus Deleval, and Aldo Castaneda.

Returning to Australia, Graham was appointed to Westmead Hospital and the Royal Alexandra Hospital for Children as a cardiothoracic surgeon. He subsequently went on to become Head of Department at both these institutions. In 1992 he was also appointed to the Prince of Wales Hospital as a cardiothoracic surgeon. In 1997 he retired from Westmead Hospital to concentrate on paediatric cardiac surgery and subsequently was appointed Consultant Emeritus.

Graham remained at the Children's Hospital at Westmead and the Prince of Wales hospital until 2008 when Queensland Health restructured its paediatric cardiac surgical services and he was approached to lead this service. Graham was appointed Director of Paediatric and Congenital Cardiac Surgery Queensland. He retired from this position in March of this year.

Graham has both a national and international reputation in the paediatric cardiac surgical community having developed a single patch closure technique for the repair of atrioventricular canal defects. He is visiting professor at the Mafraq Hospital in Abu Dhabi in the United Arab Emirates.

Graham was an examiner for the RACS from 1994 until 2002. In 2006 his contribution to cardiothoracic surgery was recognised by the RACS with the Award and Medal for Excellence in Surgery.

His contributions were recognised by the Commonwealth with the award of the Member of the Order of Australia in 2004.

Graham has been an avid supporter of the Operation Open Heart Project of the Sydney Adventist Hospital. This project brings cardiac surgical services to developing nations where no such services exist. He has been on at least 20 such trips. This has led to the development of a fledgling cardiac surgical unit in Port Moresby. The PNG Government has recognised this contribution by awarding him the Order of Logohu.

Graham Nunn's personal attributes are too numerous to even attempt to describe.

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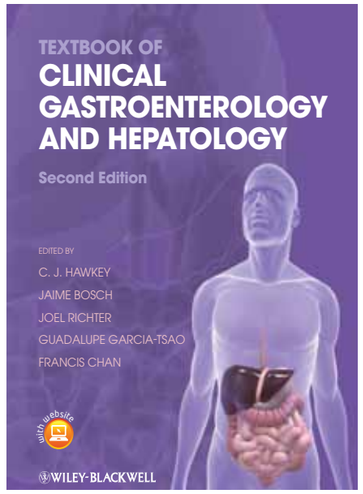

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C. J. Hawkey, Jaime Bosch, Joel E. Richter, Guadalupe Garcia-Tsao, Francis K. L. Chan
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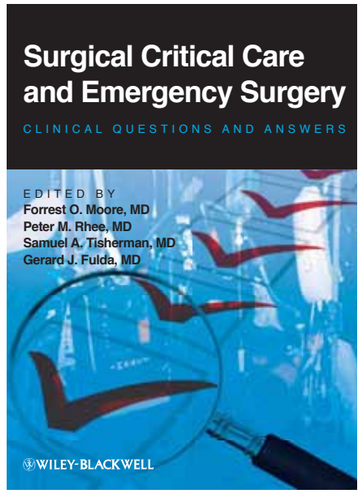

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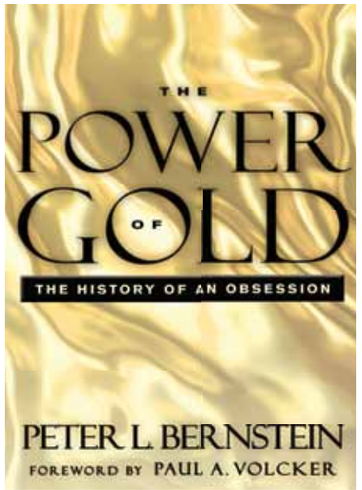

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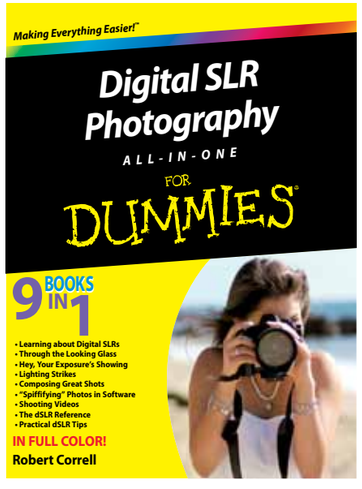

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GAMMEX® Non-Latex range minimises the risks of type IV allergies and skin irritations, but some chemicals contained in GAMMEX® Non-Latex gloves may cause allergic reactions or irritations in some users.

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