

# Surgical News

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

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# A Matter of Life

Fellow Gert Tolleson lends a hand through ROMAC





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ON THE COVER:  
Fellow Gert Tolleson's operation on Larisha Barikoa saved her life.





## President's Perspective

# Advocating for Surgical Services

The College is busy on several fronts

### Budgets and Surgery

The College Council is becoming increasingly concerned about how 'tighter' health budgets in most hospitals are impacting upon surgical services.

Senior officials of both Health Departments and Treasuries are becoming more worried about the impact of health on budget demands and budget blow-outs. As health is now bankrupting the State of Tasmania, just how many other regions will be faced with similar predicaments?

To explore the issue further, the College is focusing the October Surgical Leader's forum on the sustainability of surgical services. With health now at 10 per cent of GDP (compared to 17.5 per cent in the US), what will the year 2025 be like? How will politicians and our senior health managers cope?

More importantly when directors of surgical services have their budgets effectively decreased for another year, how can they respond? With a significant panel of experts, hopefully we will be in a better and more informed position as to how to respond.

### Regional Advocacy

The College Council also is now pushing for ongoing meetings in major regional and city hospitals to talk about issues on the ground. Some Regional Chairs are organising meetings of Department of Surgery Chairs to address these concerns.

I also hope to encourage the Regional Chair and also a Councillor to visit hospitals, especially large metropolitan and base hospitals, to get a better understanding of how we should be helping surgeons within the hospitals where they work.

Often just talking through concerns from a number of perspectives will identify improvements or gain an understanding of how road-blocks can be removed. If you want to assist with this, please contact the Chair of your Regional Committee or the Regional Manager (on the College website at [www.surgeons.org](http://www.surgeons.org))

### Alcohol induced violence

If the 1960s and 1970s were the era of road trauma, then our current decade must be the era of alcohol induced trauma. One cannot be anything but horrified at the injuries, disfigurement and death that are being presented to the hospitals where we work every weekend, if not other nights during the week.

Glassing injuries, knife injuries, and 'king hits' are increasingly a problem. A number of potential solutions have now been identified that address access to alcohol, pricing, types of drinks like 'shots' and the culture that goes with it.

Although many groups are working in this area, it is important that we also assist. Our next Surgical Leader's Forum in February will be considering how to understand what can be done and make sure we advocate more effectively for it.

The College is preparing a document for the Smart Traveller website. We recognise medical tourism is a big issue and will not simply go away so we are hoping to provide advice about the dangers of medical tourism and some advice about how to investigate potential hospitals/surgeons overseas.

**Mike Hollands**  
President

**Blood Belts Booze and Bikes**  
Alan Gregory

A history of the response of the Royal Australasian College of Surgeons to the epidemic of road trauma

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS  
MEDIA RELEASE

**CEO's resignation a symptom of a health system under severe pressure – SA surgeons**

Tuesday 28 August, 2012

The resignation of Central Adelaide Local Health Network (CALHN) Chief Executive Officer, Brian Rousseau, was further evidence of a health system struggling to cope during a period of significant but poorly planned change, the Royal Australasian College of Surgeons has said.

The College's South Australian Regional Chair, Mr Peter Subramaniam, said that while there is little value in speculation as to the reason for Mr Rousseau's resignation, the College, along with other representative organisations, was aware of the tension between the drive to cost saving within the CALHN and the reality that the new Royal Adelaide Hospital may well fall short of delivering the capacity that would justify the planned and significant downgrade of the Queen Elizabeth Hospital (QEH).

"Central to this is the planned closure or downgrade of the Intensive Care Unit at QEH which will have significant downstream impact on emergency, acute care and elective surgical services at this hospital," Mr Subramaniam said.

"While the plan is for this capacity to be taken up by the new Royal Adelaide and an expanded Lyell McEwin Health Service, the College of Surgeons remains profoundly concerned about the feasibility of achieving this within the current economic climate.

"The College has also explicitly expressed its concern to the Minister and the CEO of SA Health about the impact of the planned reconfiguration of hospital services on the viability of high quality surgical training posts to meet the anticipated demand for specialist surgeons in South Australia. "This includes concerns about the possible reduction in outpatient services within the public system, where there appears to be a clear drive towards treating and billing as many patients as possible under Medicare – a step that the College fears may be the thin edge of the wedge towards privatisation of these essential services," he said.

Mr Subramaniam said that at a time when South Australian hospital services were struggling to cope with change that seemed to be driven more by hope than careful planning, the College of Surgeons remained committed to engaging the SA government on issues relating to the provision of high quality surgical care to the South Australian public.

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

Applications close Friday October 19th, 2012.





## Make use of your Skills Lab

Skills and Education Centre staff are on hand to help you devise your course

Just downstairs from the Hughes Room at College headquarters in Melbourne, in the Skills and Education Centre, is one of the best surgical skills laboratories in the country. The Skills Lab has been set up to provide practical surgical and related training in all disciplines and at all levels. It is part of our commitment to the ongoing training and development of surgeons.

Mr Donald Murphy is the Skills Lab Medical Director. He and his team work closely with course providers, not only to provide the necessary infrastructure for training – including instruments, specimens, audiovisual capability and catering – but also to help develop training models which ensure participants are able to practice their skills in a simulated environment with the appropriate level of fidelity. If you have not yet attended a workshop there, I recommend that you arrange with Donald to take a tour.

Recently a couple of workshops held in the Skills Lab have come to my attention: a Functional Endoscopic Sinus Surgery (FESS) workshop and a temporal bone dissection workshop. This pair of complementary workshops was organised by Fellows Chris Brown and Richard Kennedy respectively for Victorian Otolaryngology Head and Neck Surgery Trainees.

What made these courses particularly significant was the level of cooperation and forward planning by Chris and Richard, their faculties, and the staff of the Skills Lab. This resulted in two quite different workshops on consecutive weekends being able to utilise the same specimens and much of the same equipment – a perfect example of “two birds and one stone”.

This type of forward thinking meant that access to the anatomical specimens was less costly and also that loan equipment, some of which was brought

from overseas, was held over for the second workshop.

The wonderful capabilities of the Skills Lab provided for 10 operating stations, each with suction, irrigation, operating microscopes and surgical motors. The Lab’s impressive array of instruments was supplemented by state of the art equipment generously lent for the occasion by medical device companies including Medtronic, Karl Storz Endoscopy and Cochlear Ltd. The specimens accessed for the workshops provided Trainees with the highest fidelity ‘simulation’ – it was a rare opportunity.

The College has a commitment to collaboration and teamwork, and I was most impressed to hear that Chris managed to achieve a faculty to student instructor ratio of one to one. The faculty of 12 surgeons from the Royal Victorian Eye and Ear Hospital, the Alfred Hospital, Monash Medical Centre and Austin Hospital were joined by four theatre and

outpatient nurses from the Eye and Ear Hospital and Victoria Parade Surgery Centre.

This enabled our Trainees to gain valuable experience and insights under expert tuition on a wide range of procedures in two intensive sessions. The FESS workshop focused on the basic surgical principles of minimally invasive endoscopic sinus procedures including septoplasty, antrostomy, frontal sinus miniretrephine, ethmoidectomy and sphenoidotomy, orbital wall decompression, canthotomy, and the ‘bath-plug’ technique for the management of cerebrospinal fluid leaks.

The temporal bone dissection workshop a week later was designed to guide the Trainees through middle-ear and inner-ear procedures including cortical mastoidectomy, posterior tympanotomy, labyrinthectomy, cochleostomy and insertion of cochlear implant electrode arrays.

### Smooth delivery

The Trainees were delighted with both of the courses and gave excellent feedback, highlighting in particular the set-up and specimens, the high instructor student ratio, and the non-stop, uninterrupted nature of the sessions. Clearly the organisers need to be congratulated and indeed applauded.

Richard Kennedy, previously a Trainee of mine, has reported that he found the whole experience extremely positive and will be recommending that more workshops be held in the Skills Lab. Handing over the organising role to College staff can “streamline” the whole process and make it a lot more manageable.

Richard reports that Skills Lab staff did an exemplary job setting up and supporting the workshop. He was particularly impressed on the day with their seamless lab management, and when he asked late in a session whether the waste fluid collectors needed to be emptied, discovered that this had been happening efficiently behind the scenes without anyone noticing. This was important, as it meant that participants were able to work on without stopping for the usual filling and emptying of the irrigation and suction systems.

While some specialties like Otolaryngology Head & Neck Surgery make excellent use of the College’s Skills Lab, others are yet to make the most of this world-class facility for our Trainees.

I encourage Fellows to call Donald Murphy or Skills & Education Centre Manager David Lawrence on 9276 7455 to organise a visit to the lab or to discuss possibilities for future workshops so that together we can work towards our goal of excellence in surgical training.



**Michael Grigg**  
Vice President



**Health**  
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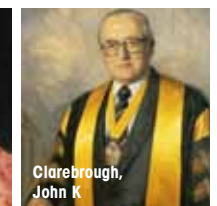
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**Regulating social media**

A leaked consultation paper from the Australian Health Practitioner Regulation Agency could herald a new era of rules for social media use such as Twitter and Facebook. The papers include closer scrutiny of posts about private lives and warned that practitioners who breach rules can face deregistration. It also says health professionals should consider their posts carefully and not accept unknown friend requests. Some are disappointed with the paper, stating that it disregards the benefits of the applications. "That's where our patients are and that's where we need to go," WA GP Edwin Krays said. *West Australian*, September 19.



**Northern road rules**

Northern Territory Fellows have warned the new government about reintroducing open speed limits on territory roads, stating that the Laws of Physics have not changed. Fellows David Read and Phillip Carson pointed out that the Territory already endures a rate of road deaths two and a half times the rest of the nation. "The Northern Territory members of the Royal Australasian College of Surgeons have grave concerns ... based on their experience with the severely injured, the permanently disabled and the grieving relatives that arise as a result of road trauma." *Northern Territory News*, September 17.



**Time won't affect outcome**

New research has revealed that surgical procedures done later in the day are no less safe than those undertaken earlier in the day. Previous research has hinted that surgeries early in the day are more successful and that surgeons get tired over the day. However, this hasn't necessarily pointed to any worse surgical outcomes. Researchers analysed the records from 522 procedures, including kidney stone removals and prostate cancer surgeries. "We really didn't find any significant differences one way or another," said Dr Yair Lotan. "Surgeons are trained to provide the sufficient level of attention so their outcomes are no different (no matter the time of day)." *Reuters Newswires*, September 3.



**Surgical mementoes**

Doctors are being warned of camera usage in the workplace through an article in a recent issue of the *Medical Journal of Australia*. Experts say that some specialists may find themselves in breach of privacy laws and criticise a culture of "click first, care second". "As the distribution of electronic data through the internet, social media and mobile devices becomes easier, appropriate collection, consent and the use of medical imagery is essential," the researchers from Menzies School of Health and Research said. Many of the hospitals surveyed across Australia did not have policies for 'phone' photographs. *Gold Coast Bulletin*, September 5.



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A/Prof Tim Price  
Dr Frank Voyvodic





# Trauma in Indigenous Communities

Prevention of road and traffic injuries among Aboriginal and Torres Strait Islander people; an initiative of the Foundation for Surgery

*This is the final in a series of four articles that derive from the Evidence Based Actions Plans (EBAP's) commissioned by the Foundation for Surgery to help 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 EBAP 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 from around Australia.*

*In this article, Foundation for Surgery Board member, Dr Chantel Thornton, discusses the prevention of road and traffic injuries among Aboriginal and Torres Strait Islander people.*

Transport related accidents are common in Australia. However, Indigenous Australians are disproportionately over represented in fatal transport accidents, at a rate of two to three times that of non-Indigenous Australians.

While road safety interventions have been successful in reducing the road toll, these interventions seem not to have had an effect on the large number of Indigenous fatalities that occur each year. Alarming, in some areas the death rate is 17 times greater within Indigenous communities than within the general Australian population.

Indigenous road fatalities occur more frequently with pedestrians or passengers and occur equally at all ages, compared with the significant peak in the 18 to 25-year-old age group in the non-Indigenous population.

Single vehicle roll-over accidents are also more common in the Indigenous population. Unfortunately, poor data collection and difficulty in evaluating interventions in remote communities make it difficult to understand why Indigenous populations are so over represented in transport-related injury.

There are a variety of risk factors that are unique to the Indigenous population and are directly related to the environment, with 75 per cent of all injuries occurring in regional and remote areas.

Environmental factors unique to remote communities include limited access to public transport and poorly maintained roads. Vehicles are often un-roadworthy due to a combination of reduced maintenance and difficult driving conditions.

A variety of behavioural factors also contribute to the increased rate of transport related accidents in the Indigenous population, including use of alcohol and high speed, driver fatigue, overcrowding, unlicensed drivers, drivers and passengers not wearing seatbelts (50 per cent of Indigenous fatalities were not wearing a seatbelt) and lying on or playing on the road.

Indigenous Australians face significant challenges in obtaining a driver's licence, including financial and educational problems and, as such, many drive without a licence. Unfortunately, transport safety promotion messages have not been effective in raising awareness among Indigenous communities.

Interestingly, education-only based intervention has not proven to be effective in reducing transport-associated injuries among all Australians. Some Indigenous communities have developed culturally sensitive safety programs, but like other educational programs used in the non-Indigenous population, they have not been effective at reducing mortality.

Despite popular belief there is no evidence

that education at school and post-licence reduces mortality. There is, however, strong evidence that speed enforcement detection devices, street lighting, red light cameras, seat belt use, random breath tests and mass media campaigns for safe driving do reduce mortality.

There is limited evidence for the effectiveness of booster seats, pedestrian safety education, pedestrian visibility enhancement, vehicle inspection programs and black-spot programs. Some success has been achieved via a multi-faceted approach in the Northern Territory.

This program, which required roll frames to be fitted to vehicles and changed legislation that deemed it illegal for people to ride in open load spaces, was successful in reducing the road deaths from 10 per cent to 2.1 per cent over a seven year period.

Research is required to address the complex cultural, social and demographic issues that face the Indigenous population in order to determine how to reduce the incidence of transport-related injuries.

Practical initiatives such as improving roads, lighting, signage and pedestrian footpaths and increasing access to public transport in remote areas, combined with raising awareness of the significance of the problem and increasing compassionate enforcement of road laws, may assist in reducing the Indigenous road toll.

Programs that are tailored to the Indigenous communities are urgently required to reduce the rate of transport related injuries. This will require significant collaboration from a variety of diverse groups including health, transport and education authorities, police, local government, the Australian government and Indigenous communities.

**Dr Chantel Thornton**

*Foundation for Surgery Board member*



For those who want to support our work in Indigenous health you can do so by donating to the Foundation for Surgery. A donation form is included in this issue of *Surgical News*.



# Fatal numbers

Single Vehicle Rollover Accidents: Trauma in Central Australia



There are growing concerns about the incidence and consequences of single vehicle rollovers (SVRO) in Central Australia. Between 2000 and 2010, there were a total of 208 deaths due to motor vehicle accidents (MVA's); of these, 116 were due to SVROs. Unfortunately at 58 per cent, Indigenous individuals constitute the majority of the fatalities.

Excessive speed, unsealed and unfenced roads, narrow shoulders, animals crossing roads, vast distances and the high use of alcohol makes the spectrum of SVRO's in the Northern Territory unique.

In the seven-year period (from 2004-2010) the Alice Springs hospital recorded an astounding 1,872 patients involved in MVA's, of which 382 were due to SVRO's. Indigenous casualties contribute significantly to SVRO statistics, 43.7 per cent (n=167).

Interestingly, since the introduction of the speed limit in 2007 by the Northern Territory Government and the instrumental work of the College in this process, there has been a stepwise reduction in the total casualties since 2007 (Figure 1).

This good news is short lived as, even though this reduction is significant, this mainly applies to non-Indigenous casualties while Indigenous casualties remain constant (Figure 2).

Another issue that has arisen is the decreased effectiveness of road transport safety awareness in Indigenous communities, which is manifested in drink driving and unrestrained passengers. Indigenous Australians have been involved in higher rates of SVRO's under the influence of alcohol (Figure 3).

A total of 142 individuals were unbelted in the 382 SVRO's from 2004 to 2010, and of this, 101 persons were of Indigenous descent.

Interestingly, that those who were intoxicated were far more likely to be unrestrained. And those who were belted fared much better than those that were not belted, with those being belted at an average injury severity score (ISS) of nine compared with an ISS of 21 for those who were unbelted.

Single vehicle rollovers and motor vehicle accidents are still a cause for worry in Central Australia and much more targeted primary prevention strategies need to involve remote communities to address alcohol and seatbelt use.

**Mathew Jacob**

University of Notre Dame Australia  
Alice Springs Hospital

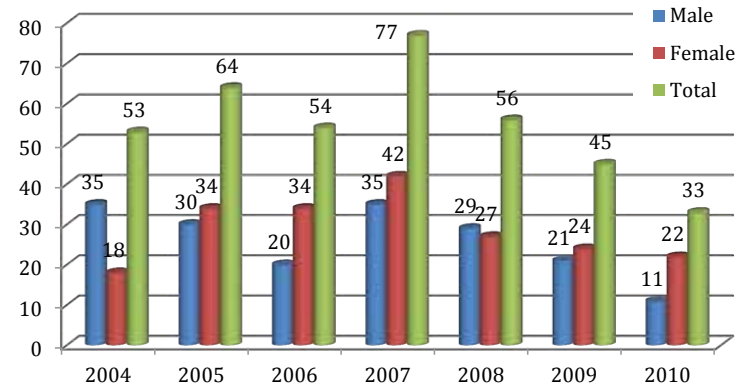


Figure 1. Total number of single vehicle roll over (SVRO) casualties in Central Australia from 2004 to 2010. Since 2007 there has been a step-wise reduction in the incidence of SVRO's, which can be directly attributed to the actions of the College and the Northern Territory Government.

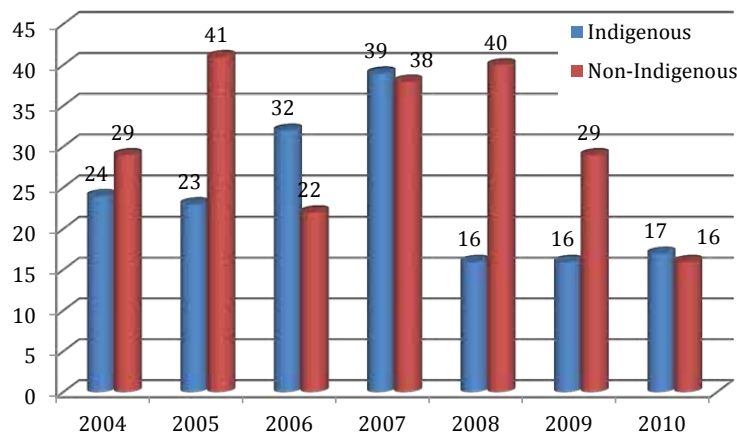


Figure 2. Indigenous as compared to non-Indigenous casualties involved in SVRO's from 2004 to 2010. Indigenous casualties have remained constant since the introduction of the speed limit in 2007..

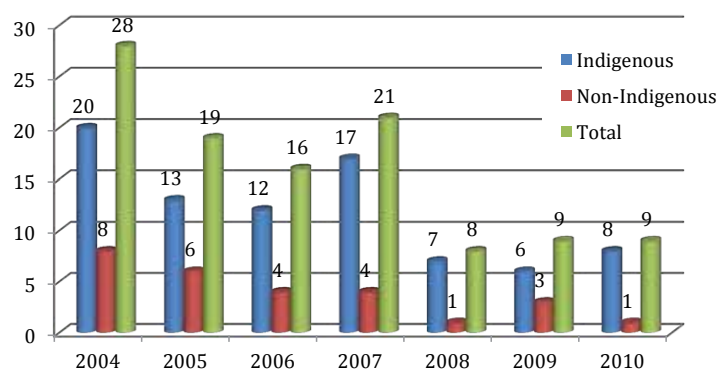


Figure 3. Indigenous Australians are much more likely to be involved in SVRO's under the influence of alcohol compared to non-Indigenous. There has been a slight reduction since 2007 due to much more strict enforcement; however the rate of accidents under the influence remains constant.

# Indigenous Medical Specialists

Medical colleges have come together to encourage Indigenous specialists

In a bid to close the gap in health status between Indigenous and other Australians, the National Aboriginal and Torres Strait Islander Medical Specialist Framework Project (NATSIMSFP) has been implementing the framework recommendations endorsed by the Committee of Presidents of Medical Colleges (CPMC) since July 2012.

The project is housed in and facilitated by the Royal Australasian College of Surgeons.

The main focus of the framework recommendations endorsed by the CPMC in 2010 was to increase the number of Aboriginal and Torres Strait Islander medical specialists in Australia to help improve speciality skills particularly needed to address the poor status of Indigenous health.

The core aim of the project is to encourage pathways for Indigenous doctors wishing to pursue specialist training.

In February 2012, the project surveyed 15 medical specialist Colleges in Australia to identify the scope to implement the framework recommendations. The survey analysis revealed that the majority of Colleges were already engaged in Indigenous health-related learning module development, including cultural competency training. Some Colleges also reported the recognition of Indigenous knowledge and culture in their curriculum development.

The survey also revealed opportunities for improved data collection, and information about training programs for prospective Trainees.

Currently, the project is conducting a second round questionnaire survey to better inform the project implementation process.

As an early achievement, the project has recently developed a standard guideline for Colleges to ask about Indigeneity for data collection purposes. It is anticipated that this guideline will be distributed to all Colleges by early September 2012.

The project aims to launch web pages within the CPMC domain so that the general public and prospective medical Trainees can access project resources.

It is hoped that the web pages will be instrumental in providing information on medical specialist training programs for Aboriginal and Torres Strait Islander doctors hoping to become specialists.

For further information about the project please contact Dr Netra Khadka at [Netra.Khadka@surgeons.org](mailto:Netra.Khadka@surgeons.org).

**Kelvin Kong**  
Chair, Indigenous Health Committee



# Law unto themselves

Lawyers, hmmmph

There is one thing that really annoys me and that is lawyers, well not all lawyers, but some lawyers. I will even admit that I have some friends who are lawyers. They were friends first and then became lawyers and I never quite got round to cutting them off. We curmudgeons are very short with people who waste time by unnecessary questions and chat. Lawyers have no idea of the value of time – my time.

Have you noticed that when you are asked to go to court to give evidence the times available are from 10.30 to noon and 2.30 to 4 pm? Now that is a total of 3 hours per day. What on earth do they do for the rest of the day? In between these hours the legal profession go to their "chambers".

That word in itself is suspicious – it is not their "office", which sounds like a good honest working place. It is not their "consulting rooms", which implies some sort of value for money in exchange for advice. It is not an "operating theatre", which suggests that something really is achieved there.

And then there is the "Judge's Associate". Why is he or she necessary – perhaps someone with whom to play backgammon or whist or whatever the legal fraternity get up to in the hours spent in their "chambers"? And as to giving evidence – they ask your name and address and qualifications. Can't they read the letterhead?

Then the questions go on and on and at one minute to noon they decide to adjourn for lunch. It sounds like a game of cricket. However, the time-sensitive statement to be most feared from a lawyer in court is what I call the great legal lie: "I won't be very long with you, doctor". However, there is a sting in the tail. When we get them in our care we can retaliate with the great surgical lie: "This won't hurt a bit".





## In Memoriam

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

**Franklyn Bell, WA**  
Orthopaedic surgeon

**Sinclair J Smith, SA**  
General surgeon

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

## Informing the College

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

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**NSW:** Allan.Chapman@surgeons.org  
**NZ:** Justine.peterson@surgeons.org  
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## Case Study

"Unconscious patients need intubation for transfer" – if someone had the skill to do it.

A middle aged patient with a headache in the morning, collapsed shortly thereafter. The patient arrived at a rural hospital at around 10am and triaged as a "2". Motor response and pupil dilation was not recorded. Reacting, eye opening 1, speech 1 on GCS, temperature 35.1 and O2 saturation 96 per cent. The secondary hospital emergency department advised transfer unintubated.

During the ambulance transfer, "sats" were 92 per cent to 96 per cent. Airway intervention was resisted despite the patient being unconscious with fixed dilated pupils.

At around midday the patient arrived at the second hospital, breathing spontaneously, with GCS 3. A chest x-ray demonstrated aspiration. Severe hypertension was treated with hydralazine resulting in hypotension. The CT scan demonstrated a massive subarachnoid haemorrhage from a giant basilar aneurysm, with hydrocephalus and evidence of posterior cerebral artery infarction.

By mid-afternoon, mannitol started. The intracranial pressure was greater than 50 with the insertion of an external ventricular drain. Sedation was ceased and the patient remained unresponsive with unreactive pupils. The patient was palliated and brain death certified the next day.

## Comments

In an ideal situation the patient should have been intubated, ventilated and sedated prior to transfer. This would prevent aspiration (if it had not already occurred), help maintain pO2 close to 100 and possibly help control intracranial pressure by preventing the pCO2 from rising. The drugs used for this would need someone experienced in airway management.

Mannitol 20% could have been administered at the rural facility with an initial dose of 100-200 ml IV. This helps intracranial pressure and brain perfusion.

The logistics of communications between rural and major hospitals should be a priority of hospital managements. Advice between hospitals regarding these treatments should occur as most of these treatments can be implemented in the rural setting, if staff have the skills. Training staff with appropriate skills for this type of emergency is also an issue for management.

There was no neurologic assessment chart in the rural hospital record and hence pupil responses were not recorded and motor responses were inadequately noted. These are important components of the GCS. Absence of this chart is a reflection that hospital managements have not planned for these eventualities.

The death certificate was incorrectly completed. Subarachnoid haemorrhage, not brain death was the "cause of death".



**Guy Maddern**  
Chair, ANZASM

## Poison'd Chalice

Though this be madness, yet there is method in't. Hamlet Act 2, Scene

It was a serious discussion. I was talking about succession planning with some of the 'young Turks'. You know the ones; obvious leaders of the future, individuals with something to say, but who couldn't as yet understand why people were not listening to them. To them, the solutions were clear – the ramifications, the province of others. They lacked a sense of how the broader world actually worked, and resisted seeing the bigger picture, intent on only solving the problem at hand, no matter how Draconian. Their desire, to effect change by imposition.

The thoughts of one of my mentors came to mind. He was an earnest Oslerian. I may be able to quote Shakespeare intermittently, but he could ramble on for hours about William Osler. "The Father of Modern Day Medicine," he always said. He often reminded me the biggest weakness of surgeons was working in organisations, hospitals and failing to recognise their role in a larger "Universe". He always quoted Osler and in particular liked the address from 1897: "Physicians as a rule have less appreciation of the value of organisations than members of other professions."

But these young Turks; well, you could appreciate their point of view. Organisations have not always served them well. They are fond of sounding off about the hospital and its management (mainly me, I have discovered); they then start sounding off about our Association and the College. Easy targets, I must admit. Increasing subscriptions and always struggling to justify where they spend the money. All those people off to more meetings. Where is the advantage in that, they ask?

Well, I was ready for that one after my recent discussions with my mentor. Remember Osler I said. In Cushing's biography of him, he states that Osler actively participated in over 110 associations and societies; he saw service in voluntary organisations as an important way to develop leadership and management. So, how about being involved? It is one of those important steps to the future. My concern for them is that

they are completely absorbed in their self-importance, content that they have lots of well paid work, but failing to realise that society is turning away from them.

Maybe they are right, maybe they will be able to complete their careers before the final curtain is lowered – leave it to the next generation to answer for their deficiencies. But something in me says this is not right. Time and again throughout my career I have benefited from battles fought by my predecessors. I feel that they would expect the same of me – to at least try to leave a level playing field for my successors. It might even benefit patients of the future, one of which I will inevitably be.

"Madness", said my younger colleague and mis-quoted Shakespeare back to me. "Where is the method to that madness?" – clearly thinking that he had scored a telling point.

It was getting late in the evening. At least they had come, participated. The discussion had commenced around the significance of credentialing – not the value of it, but the significance of it. For them it was just one more episode of bureaucratic inspired tedious paperwork.

I pushed a bit further – why has credentialing been introduced? Does its mere introduction mean anything to you? After all it is a worldwide phenomenon. "Who mandated it? Will it be successful in improving patient safety? If not, where do you think it will lead?" I probed further, trying to push them to places that they had not previously been. I wanted them to begin to appreciate that there were forces at work beyond their immediate fields of endeavour.

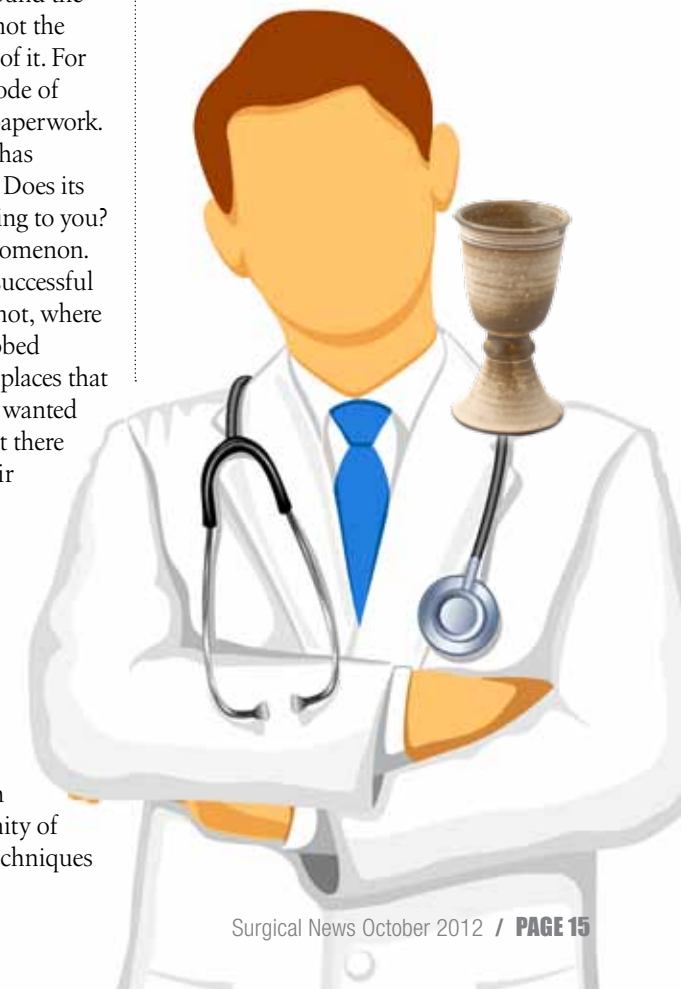
Was I just being an 'ancient' with out-moded views on how surgeons should work together and ensure we not only maintain a profile in hospitals, but also keep our standards high and demonstrable within the health sector overall? It is a paradox. When we are so much more an international community of surgeons with standards and techniques

linked across the world, the challenges of maintaining that local commitment and drive, it seems to me, is more important than ever before.

Osler has provided a warning from the past, 'the dangers and evils which threaten harmony among the units, are internal, not external. And yet, in it more than in any other profession... is complete organic unity possible?' Doubtful would be my immediate response. And yet, it must be said that the most internally unifying event is an identifiable external threat.

Alas there is a real risk that as individuals and professional groups we are so internally focussed that we fail to appreciate the real threat – where our energies and efforts should really be focused. I began to feel tired and quite possibly old, but suddenly I began to see in their expressions, dawning realisation. So where do we go to from here ...

*Professor U.R. Kidding*





# A matter of life

Fellow Gert Tolleson and International Medical Graduate Ashish Jonathan give back life



Cover Story

Two Queensland neurosurgeons have saved the life of a Solomon Islands child who developed a severe brain abscess after a nail penetrated her skull from a falling ladder. Larisha Barikoa was close to death when she was flown to Australia by Rotary Oceania Medical Aid for Children (ROMAC), arriving in Brisbane four months after the accident which happened on the remote Choiseul Island. Despite her grandfather immediately removing the nail, by then the abscess had grown to six centimetres and involved the left frontal lobe of her brain, causing significant weakness in the right upper

and lower limbs and severe language dysfunction with a receptive and expressive dysphasia. The tiny five-year-old was also severely dehydrated and malnourished upon her arrival at Brisbane's Royal Children's Hospital in June, causing the neurosurgery team to delay operating for 24-hours to boost hydration and stabilise her condition sufficient to undergo the first of four surgeries. Lead surgeon and consultant neurosurgeon Mr Gert Tolleson said he had been asked if he could help Larisha weeks before her arrival, but that it had taken time to get her from her remote

island home to Australia for surgery. "The germs on the nail and the skin caused the abscess to form after the direct penetrating injury," Mr Tolleson said. "Her first symptoms were a headache and fever, then difficulty speaking and the loss of movement in her right arm and leg, yet without any scanning facilities local medical staff thought it may have been malaria. "Then even though she was taken to the main hospital in Honiara, neurosurgical procedures are not something they can perform so she was in a very bad state by the time she arrived, virtually dying, with only about one week to live."



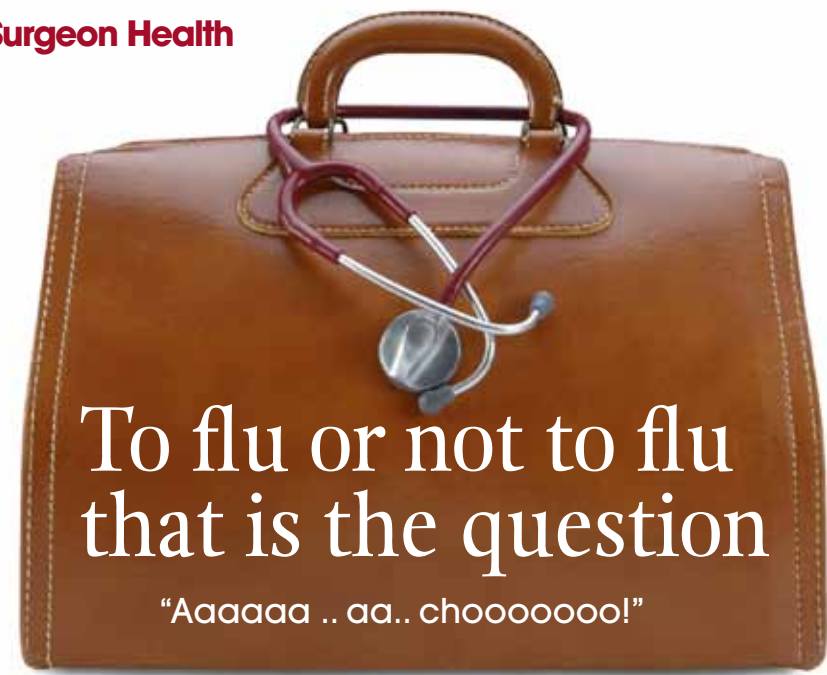
Left: Larisha Barikoa on the mend. Below from left: The abscess when she arrived; Gert Tolleson; The abscess when she left.

Mr Tolleson said Larisha spent that first night in ICU following multiple scans, then the next day underwent a two hour operation in which he and neurosurgical registrar Ashish Jonathan drilled into her skull and with an endoscope inserted a tube to start draining the abscess. Within 24 hours of that initial treatment, she began moving her right arm and was talking and alert. This was followed by further puncture and drainage surgeries on July 4 and July 17 with the last procedure done on July 21 to remove the abscess capsule to make sure no further infection could set in. Now bright, happy and adding every day to her English vocabulary, Mr Tolleson said Larisha had recovered extremely quickly and very well. "She has a slight weakness on her right side and there may be some cognitive deficit because she has lost a lot of brain tissue in the left frontal lobe, but it is hard to know because of brain plasticity and its amazing ability to rewire itself to counteract such deficits," he said. "We are very confident that the abscess won't come back, but as an extra precaution we removed the capsule. In

Australia we could leave it, but in the Solomon Islands with limited tertiary health care and no neurosurgical service she would be in trouble in the remote chance it reformed." Mr Tolleson said that while such brain abscesses were sometimes seen in Australia they were most often caused by a compromised immune system, particular lung infections or sepsis. "This is a very dangerous condition," he said. "We knew what was wrong with Larisha before she arrived and were greatly concerned that she came to Australia in time because the cyst could well have burst which would have caused encephalitis. "She was very close when we finally got to see her, probably in a week she would have been dead, so it is greatly rewarding to help in such cases, particularly when we see such a small person whose whole life is ahead of them and who would otherwise be well if they can get the treatment they need in time." Dr Ashish Jonathan, who assisted Mr Tolleson, is an International Medical Graduate who did his MBBS and Neurosurgical training in India.

Now doing his supervised training, he hopes to be writing his Fellowship exam next year. He said treating Larisha was both medically interesting and personally rewarding and in an interview with Brisbane's Courier Mail newspaper described her as having "the best hairstyle in the world". "She is doing well very well now and we expect her to go home soon," he said. "Now that the abscess has been excised there will be an area of gliosis where the abscess once was which means there is definitely some damage done, but functionally she is doing well. "She does have the best hairstyle in the world. "When she arrived she had her hair in little braids all over her head tied with little pink ribbons. "Unfortunately we had to shave some of it for the surgery, but she is still a picture." Larissa travelled to Australia with her aunt and was cared for in Brisbane by Ms Denise Schellbach who said ROMAC become involved in her case after the Honiara Rotary Club learned of her plight. **With Karen Murphy**





# To flu or not to flu that is the question

“Aaaaaa .. aa.. chooooooo!”

The winter is as usual long, cold and damp, bringing scores of patients to my waiting room sharing their viral-loaded nasopharyngeal droplets. I am well acquainted with their demands and expectations – most hope for a magic bullet, but will leave disappointed that having found no evidence of pulmonary complications I have not offered them antibiotics.

Yesterday I saw one of my favourite patients, Ms Snivels, a surgeon normally in the best of health, but at present suffering from a bout of the flu. She had already spent a day in bed, was still feeling lousy, had commitments to fulfil, and wanted to be full throttle again faster than any normal person.

I gave her the best advice I could. Go home, drink plenty of fluids, take another day off, avoid exercise for a few days, don't overtire yourself the first couple of days back, adjust your schedule, confront reality. It's already too late for any benefit from anti-virals. As Ms Snivels was about to depart, feigning thankfulness for my honest if unwelcome advice she asked, “I suppose I should have a flu-shot next year?”

I paused ... I considered... then I decided to be honest, “Personally, I wouldn't bother. There's no evidence to support giving healthy individuals flu vaccination. Now that you've had the flu you'll have earned a good number of years immunity and resistance to another serious bout.”

There's a big push afloat, especially in some health services, to promote influenza vaccination for healthcare professionals. A March 2012 BMJ editorial even carried the subtext that it should be mandatory. The argument proffered

was that nosocomial flu infections have a high fatality rate especially in comorbid patients. They suggested that there is a vaccine effectiveness of 70-90 per cent with a good strain match though admitted this was lowered to 59-83 per cent in its absence. The final paragraph confessed that randomised controlled trials are still needed to prove whether vaccinating health workers actually prevents nosocomial infections. I'm not signing up as guinea pig for such a trial.

The same editorial was somewhat dismissive of healthcare workers concerns about complications, but stated “adverse events are always possible after flu vaccination”. The Australian published an article on August 3 reporting an association between flu vaccine and 10 deaths in the stampede for vaccination following Swine flu, that gentle and kindly strain that many of us brushed off with just a bit of a sniffle, despite a WHO inspired world-wide panic.

You will be interested to know that the Australian taxpayers ended up spending \$131m on CSL's Panvax, without the costs of the 1716 adverse event reports, including seven deaths. Panvax was replaced by Fluvax in 2010 incurring a further 2136 adverse notifications, including 11 cases of Guillain Barre Syndrome (GBS). Yes, there is a small but recognised increase in GBS after influenza vaccination! Imagine how you'd feel being a fit healthcare worker and then suddenly you are on a ventilator for weeks and incapacitated for much of a year after faithfully volunteering for your flu shot. Fluvax was also withdrawn for under-fives in Western Australia when found to induce febrile fits at ten times the normal rate.

So will you benefit from flu vaccination? Not if you are a healthy adult, and there is at least a Cochrane review of some 50 studies and 70,000 adults addressing the subject. Flu vaccines can't stop you dying, don't keep you from being admitted to hospital, don't reduce the risk of pneumonia or time lost from work, nor do they prevent you infecting your patients. The review had a carefully crafted and rather deeply meaningful sentence: “In the relatively unusual situation of the vaccine matching the circulating strain of virus, the development of flu and flu-like symptoms was reduced from 4 per cent to 1 per cent by vaccination.” A flu vaccine manufacturer might promote that as a 75 per cent reduction, but that is nonsense. As most flu vaccines don't match the strain, you can better rephrase it by claiming 96-98 people out of a hundred won't benefit and only one or two healthy adults in 100 would be spared this benign, but prevalent disease (in any one year).

We are witnessing an era where health care resources are being splashed out on vaccines which swell the global balance sheets of CSL, Glaxo and Smith-Kline with billions of dollars for a product of questionable evidence base. The claim that flu vaccinations should be mandatory for healthcare workers is unfounded and should be strongly resisted. There remain strong vested, financial conflicts of interests and massive lobbying of public health bureaucrats by pharmaceutical companies with the collusion of some infectious disease physicians. I don't know what Ms Snivels will decide personally, but at least I pointed to the lack of evidence. There are a lot more dangerous things to be protected against with vaccines that have really been shown to work.

But please excuse me; I think I'm catching something ...  
Aaaaaa... aa... chooooooo!

**Dr BB G-loved**

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# What's new in the Library

New Evidence-based Practice Resources (EBP) via the Library

The College is continually improving the Library to meet the information needs of Fellows and Trainees in their specialty and area of practice. The positive feedback we receive about the Library confirms that this is a valued resource. In response to popular request, the Library has developed a new area providing Evidence-based Practice (EPB) resources for Fellows and Trainees.

Evidence-Based Practice requires the integration of best research evidence with clinical expertise and patient values. The Library plays a useful role in supporting Fellows and Trainees with the process of their evidence based judgement and decision making by providing access to quality sources of information.

Through specialty and topic focused pages, the Library aims to present relevant resources in a way that helps users to avoid 'information overload' but, at the same time, to find and apply the most useful information.

The new Evidence-Based Practice (EBP) area lists useful sources of evidence, and links to tools for each step of the EBP process, including an in-depth tutorial. The new area aims to bring the evidence-base direct to you and, in doing so, enhance patient care, evidence-based practice and clinical governance.

## Cochrane Library

The Cochrane Library is the single best source of reliable evidence about the effects of health care. The Cochrane Trials Registry contains over 30,000 controlled trials – the best single repository.

The Cochrane Database of Systematic Reviews has over 1000 systematic reviews undertaken by The Cochrane Collaboration. The Database of Abstracts of Reviews of Effectiveness (DARE) database lists other systematic reviews.

Other features of the EBP area include:

## PubMed Clinical Queries

PubMed is a free internet MEDLINE

database. The Clinical Queries section is a question-focused interface with filters for identifying the more appropriate studies for questions, prognosis, diagnosis and etiology.

## SUMSearch

SUMSearch is a “super”- PubMed: SUMSearch simultaneously searches multiple internet sites and collates the results. SUMSearch checks for the Merck manual, guidelines, systematic reviews and PubMed Clinical Queries entries.

## BestBETS

BestBETS provides rapid evidence-based answers to real-life clinical questions in emergency medicine, using a systematic approach to reviewing the literature. BestBETS take into account the shortcomings of much current evidence, allowing physicians to make the best of what there is. Developed in the emergency department of Manchester Royal Infirmary, UK.

## Bandolier

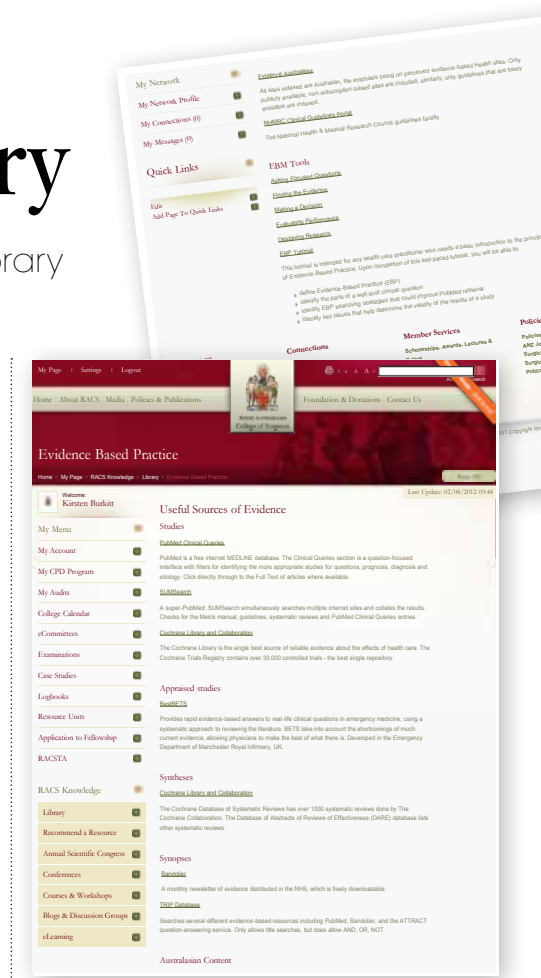
The Bandolier is monthly newsletter of evidence distributed in the NHS, which is freely downloadable.

## TRIP Database

This database searches several different evidence-based resources including PubMed, Bandolier, and the ATTRACT question-answering service. The TRIP database only allow title searches, but does allow word combinations including AND, OR, NOT.

## Evidence Australasia

All sites indexed are Australian, the emphasis being on perceived evidence-based Health sites. Only publicly available, non-subscription-based sites are included; similarly, only guidelines that are freely available are indexed.



## NHMRC Clinical Guidelines Portal

The National Health & Medical Research Council guidelines portal is another useful source.

Ovid MEDLINE® also offers Clinical Queries limit for evidence-based content.

The new EBP Resources can be viewed and accessed at <http://www.surgeons.org/my-page/racs-knowledge/library/evidence-based-practice/> (you will need to be logged in).

If you need assistance searching these resources, or have any other questions about the Library service, please contact the Library by email at [College.Library@surgeons.org](mailto:College.Library@surgeons.org) or use the feedback form on the Library web page.

1. (Sackett et al. 2000. Evidence based medicine. How to practice and teach EBM. Second Images to accompany article edition. Churchill Livingstone. London.)



**Cathy Ferguson**  
Chair, Fellowship Services Committee





Member of the Queensland Trauma Committee Mr Barry Collis is committed to making young drivers see sense

## In their face

After 16 years travelling to schools, Docu Drama Coordinator Mr Barry Collis is not surprised at the positive responses he still receives from students.

The veteran education consultant took it upon himself to teach teenagers about the responsibilities and realities of cars on the road, initially as an employee of Education Queensland and now as a member of the College's Queensland Trauma Committee.

The program is a road accident prevention and education initiative, strongly endorsed by the regional Trauma Committee and with the support of the Paraplegic and Quadriplegic Association of Queensland, the Paraplegic Benefit Fund (Australia), the RACQ and Metropolitan funerals.

Presented to year 11 and 12 students across Queensland, the Docu Drama Program is a simulated car accident showing the causes and consequences of a road accident. It is targeted at those aspiring drivers who fall into the high risk group using our roads.

To create a realistic scenario, Mr Collis features a damaged vehicle and

a number of participants, including student actors (from the visited schools), members of Police, Ambulance and Fire Rescue services, a doctor, a paraplegic, an accident victim, a funeral director, a solicitor, counsellors and even a rescue helicopter when it is available.

Designed to change the attitudes of participants and audiences, the program hopes to inspire drivers with the desire and ability to stay safe on the roads. It confronts young drivers with the realities of a road accident and encourages them to accept a greater responsibility when using the road, as a driver and as a passenger in a vehicle.

In addition to effecting change in audiences, the spectacles generate media attention which promotes road safety in the wider community. Some measure of success has been demonstrated with coverage in local newspapers, such as the South East Advertiser in Brisbane.

Mr Collis believes the program continues to make waves at the school communities he visits.

"Over the years we have endeavoured to make the program as realistic and practical as possible so that our future

road users can readily relate to it."

"This has been done with the hard work and participation of all our stakeholders from emergency services to funeral directors," Mr Collis said.

An effective tactic to engage the student is by using their fellow peers as part of the devastating scenes. This aims to enhance the reality of the situation and dispel the myth that they themselves are invincible – it can happen to anybody.

The students also speak to the victims of car accidents, who tell of the tragic changes in their lives.

### Some comments from participants included:

*"I believe it is definitely worthwhile doing it again, even if it just saves one person's life. It pushes people to think about their responsibility."*

*"From the experience, I now know I do not want to ever be involved in a serious car accident. Having to be stuck in a car for hours as the fire brigade cut me out is something I definitely never want to experience."*

*"I learned that driving recklessly on the roads can create problems not only for*



*me but my family, the victim and the victim's family. The most informative part was where the victims of past car accidents talked to all of us as a group and explained their experiences in life and how they suffered since their accident."*

And  
*"I cried – it made me realise how precious life is. I just don't get the point of drink driving."*

Despite there being no funding to quantify the results of the program, feedback from students has all been positive. One of the regularly participating schools stated that to its knowledge it has not lost a student to a road accident since the program began.

### A Student's Perspective: written by Mackenzie Stuart (Year 12)

**"W**e were asked to quietly walk around a most confronting site – a mock crash scene on our main sports oval, complete with a crumpled car and bodies lying around.

It was a little eerie as we were all asked to look in silence as we circled the bodies slumped over steering wheels and our School Captain lying still on the ground with realistic blood and cuts on his face.

After we were seated on the side of the oval, we were taken through the process of what happens in real life road accidents. Soon there was the

blaring of sirens and flashing lights as a police car and an ambulance came across the oval to arrive at the mock crash scene.

The student who played the driver made a convincing drunk and was handcuffed and taken away by the Police for causing the accident. We saw our School Captain tagged as "deceased" covered with a white sheet and loaded into the back of a funeral hearse.

We also saw the passenger in the vehicle manoeuvred into a neck brace, lifted onto a gurney and placed into the back of the Ambulance.

My first thought on the Docu-Drama was the overwhelming shock at seeing mates injured in what looked like a very real car crash. It opened up a reality that this could really happen, not just to others or on the News, but to people I know. Or even me.

We were shown statistics that more and more people my age die every year in vehicle accidents as a result of drink-driving and distractions. The talks from the real life victims of car crashes – one man in a wheel chair and the other an amputee – made it very fulfilling.

It really hit home for me the consequences of drink-driving and driving stupidly. This simulation of a car crash scene was an inaugural event at Toowoomba Grammar School and hopefully will be held annually, as I think we all learnt a lot."

### A Mother's Perspective: - written by Carmel Stuart

**"I**wanted so much to see the Docu-Drama that I delayed going on my holidays!

Mackenzie had just gone for P plates on the Monday beforehand and I was understandably conscious of his safety being in his own hands for the first time.

In fact, in the Docu-Drama, one of the things pointed out was that very few accidents happened when the aspiring driver was on their L plates, but that the risks significantly increased when they didn't have their parent or instructor in the seat beside them. Hmmm.

Rowdy peer pressure, too many people in the car, alcohol, cavalier attitudes, distractions like phones and music are not things a regular parent would allow whilst notching up that 100 hours for the log book. It is when we allow them out alone in a vehicle you just hope they remember all the boring things you drummed into them.

And that is where this presentation to the Grade 12 boys was so important. Not only was there a "crash scene" on the oval with some of the Toowoomba Grammar School drama students in various states of injury and inebriation, there were representatives from legal and medical fields and real life victims who were willing to share their perspectives.

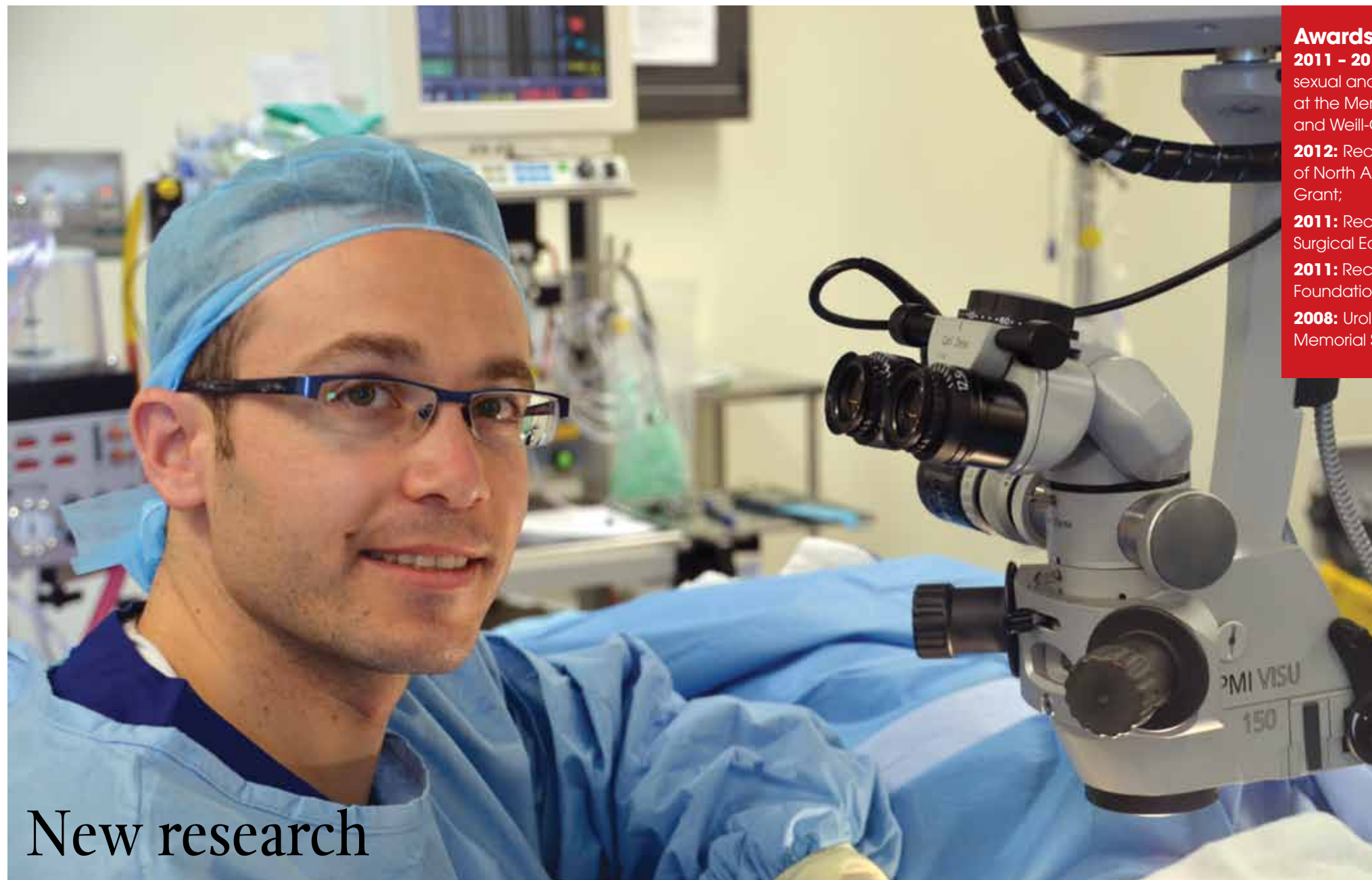
The solicitor said he represented three or four cases of dangerous driving every year. He guaranteed that if there was alcohol involved in the fatal car crash, no court in Australia could get the driver out of up to eight years in prison.

A bit of drawn breath and a mumble went through the crowd of boys listening at this point – they would be as old as 25 after serving this sentence. They would have a permanent conviction on their record and that it may be impossible to get travel visas to some of the countries they might want to visit in their futures.

The emergency room doctor talked about the "golden hour" where if people don't get help they may die or suffer permanent injury. Swelling in the brain would mean the victim would need to be airlifted to Brisbane as they were unable to be treated in Toowoomba.

I think the message definitely hit home to the boys and as a parent I was very glad to be present in order to discuss this later with our son. Having seen what Mackenzie saw and listened to the professionals talk about the scene and the consequences, I had a handy lever. This is knowledge I hope will protect many more of our lovely children as they head into independence."





## New research

Scholar Dr Darren Katz is part of some pioneering surgical research

Victorian Fellow Dr Darren Katz will be one of the first urologists in Australia and New Zealand to have completed a Fellowship in andrology, prosthetics, sexual and reproductive urology and male infertility.

Dr Katz spent from July 2011 to June 2012 working at two of the most prestigious medical centres in the US – the Memorial Sloan-Kettering Cancer Center (MSKCC) and the New York Presbyterian Hospital/Weill Cornell Medical Center (NYP/WCMC).

The Memorial Sloan-Kettering Cancer Centre is the world's oldest and largest private cancer centre and the Cornell Center for Male Reproductive Medicine and Microsurgery is one of the largest male infertility centres in the US.

Working under the supervision of two pioneers in the subspecialty of male sexual and reproductive urology and male infertility, Professor John Mulhall and Professor Marc Goldstein, Dr Katz gained particular expertise in prosthetic devices, microsurgical treatments for male

infertility, reconstructive techniques for Peyronie's disease and penile ultrasound.

While much of his work was related to the treatment of men who had suffered sexual difficulties or fertility problems as a result of cancer or cancer treatment, he also learnt the skills necessary to treat complex male hormonal, erectile and continence problems.

Dr Katz explained that many of these techniques can also be used to help men who have not been diagnosed with cancer, but may still have erectile or fertility problems.

He said that while many of the patients he treated have had cancer within the pelvic region (most commonly prostate, bladder or rectal cancer), almost any male receiving chemotherapy could have their testosterone levels and fertility affected.

"Part of the package of cancer care offered at MSKCC, is a Survivorship Initiative which is devoted entirely to optimising the quality of life of males of all ages who have had cancer or been affected by their cancer treatment," Dr Katz said.

### profile

#### Awards

**2011 - 2012:** Fellowship in andrology, prosthetics, sexual and reproductive urology and male infertility at the Memorial Sloan-Kettering Cancer Center and Weill-Cornell Medical Centre, New York;

**2012:** Recipient of the Sexual Medicine Society of North America – Scholars in Sexuality Research Grant;

**2011:** Recipient of the Ian and Ruth Gough Surgical Education Scholarship;

**2011:** Recipient of the Australian Urological Foundation Travel Grant;

**2008:** Urologic Oncology Research Fellowship at Memorial Sloan-Kettering Cancer Center, New York.

"Erectile function, continence, fertility and testosterone levels can all be affected by certain cancer treatments. Working within a multidisciplinary team framework, our goal was to optimise these functional outcomes. Many patients would even come to us before surgery or chemotherapy so that we could start preventative measures that often limited the side effects of their cancer treatments.

"I was involved with one of the largest penile rehabilitation programs in the world and recently we instituted a fertility preservation protocol which spanned both paediatric and adult patients. Under this protocol, we were able to extract sperm using specialised techniques such as microsurgery or electroejaculation-under-anaesthetic for those patients who had a zero sperm count or were too sick or too young to be able to provide a sperm sample for banking," added Dr Katz.

"The urological subspecialty fields that I worked in while overseas are comparably quite underdeveloped here in Australia. It is good to see these areas in men's health are progressively getting more air-time than they once did, but unfortunately gaining experience and training in the surgical management of such condition as male infertility, erectile dysfunction, incontinence and complex penile disorders is difficult in Australia and New Zealand. This is because our surgical training system is based in the public health sector and, understandably, with the limited budgets of public hospitals, such quality of life conditions are not high on the priority list.

"However, for the men who suffer incontinence or erectile dysfunction or who may never be able to be a biological father because of cancer treatments or for other reasons, the distress can be considerable and so if we have the opportunity to learn the skills to help these patients, we should."

Dr Katz said he first became interested in the subspecialty of andrology and men's sexual health after completing a research Fellowship in 2008 at the MSKCC as an uro-oncology Fellow.

While in New York, he met Professor Goldstein and Professor Mulhall and after collaborating on various research projects, was offered the year-long Fellowship.

He was then offered the College's Ian and Ruth Gough Surgical Education Scholarship to help cover the costs of moving to New York with his wife and young daughter.

During his Fellowship, Dr Katz also conducted a number of research projects, many of which have been published in peer-reviewed journals and presented at international conferences, and continues to collaborate with his colleagues in the US.

#### These projects include:

- > The development of a new technique for the insertion of an artificial urinary sphincter;
- > A global study of peri-operative practices aimed at preventing penile prosthesis infection with the goal of identifying patterns and creating uniformity in the field;
- > The future of fertility preservation in the male cancer patient;
- > Outcomes of fertility preservation strategies in male teenagers with cancer;
- > Intravesical verapamil for the treatment of Peyronie's disease;
- > The effect of nerve sparing surgery on erectile function following radical prostatectomy; and
- > Laparoscopic externalisation of the retroperitoneal vas deferens and inguinal vasovasostomy for iatrogenic inguinal vasal obstruction, which is a novel surgical technique to treat infertility secondary to inguinal hernia repair.





Dr Katz said he believed the treatment of erectile dysfunction and in particular male infertility is currently quite fragmented in Australia when compared to the US where there is a much more co-ordinated approach to these conditions.

"In the Australian system, male infertility is mostly handled by gynaecologists, low testosterone by endocrinologists and only a small minority of urologists have had formal sub-speciality training in andrology, erectile and male continence problems. But it would be great if we could harness the experience of many of these specialities and develop a multi-disciplinary approach to these conditions where possible."

He said he hoped in the future to establish specialist clinics in both the public and private sector to offer world-best-practice care to all men in need.

These clinics could also help Trainees gain experience in treating these conditions. Dr Katz would also like to introduce survivorship initiatives to some of the major cancer centres in Australia, such as the fertility preservation and penile rehabilitation programs, that he saw work so effectively in the US.

"This is about developing treatments for males of all ages that would facilitate those undergoing cancer surgery or chemotherapy to receive specialised care to help maintain fertility, sexual function and their overall quality of life," Dr Katz said.

"These strategies can make a tangible difference to young men with cancer who could miss out on the chance to become biological fathers, older men with prostate, bladder or rectal cancer who may become impotent or incontinent and young boys who are not psychologically ready to provide a sperm sample?"

The Ian and Ruth Gough Surgical Education Scholarship carrying a stipend of \$10,000, is open to both Fellows and Trainees and was designed to encourage surgeons to become expert surgical educators.

Now working at the Western Hospital in Melbourne and about to travel to Western Australia to take up another Fellowship at the Fremantle Hospital, Dr Katz has already been asked to travel interstate to mentor other urologists in some of the techniques he has learnt. He hopes to develop and lead workshops in urological prosthetics, microsurgery, and penile reconstruction for the treatment of Peyronie's disease.

He thanked the College for its support and recognition of the importance of this area of surgical expertise and said one of the highlights of the Fellowship had been the reaction of his patients.

"Working in this field often means dealing with patients who have suffered, often for many years, because of infertility, impotence or incontinence," Dr Katz said.

"Then, we provide treatment for them and for the first time in a long time they experience a significant improvement in their quality of life.

"We can help them to be fathers, we can improve the intimacy in their relationships and we can get them out of incontinence pads and restore to them a meaningful sense of self.

"Consequently they have been some of the most happy, pleased and grateful patients that I have treated in my career."

With Karen Murphy

Get ready for the 2013 ASC in Auckland, New Zealand.

Take a look at the Call for Abstracts on page 45



# spring *Lifestyle* post op



14 page lifestyle section



# Jet-propelled surgeon

Flying at 400 knots is relaxing for this SA Fellow





# On a high

Fellow James Edwards gets his adrenalin fix in the air

“I feel the need for speed,” said the character Maverick from the hit movie Top Gun, a quote that resonates when talking to South Australian cardiothoracic surgeon Mr James Edwards.

Not only does he love to fly, he loves to fly his own ex-military training jet and not only does he like to take it up for a spin every other week or so, getting up to speeds of 400 knots or Mach.08, he’s now in the process of learning aerobatic manoeuvres to possibly perform at future air shows.

Yet he insists he is a conservative flier, only ever willing to push the envelope just so far and no further.

His wife Elizabeth is yet to be convinced, however, and despite flying alongside Mr

Edwards for years in more sedate aircraft, has yet to climb aboard the jet.

“I can’t deny I get a rush when flying the jet, it is an absolute buzz,” he said.

“Yet I’m described by a mate of mine who flies the same model as a conservative pilot and I like that.

“Still when you take it down the runway and let it go you get a push in the back that keeps on coming and that feels great.

“My wife, however, doesn’t like the little jet and I’m still in the process of talking her into it, but we’ll get there, we’ll get there...”

The little jet that Mr Edwards refers to is a SIAI Marchetti S211, made in Italy and bought by various countries as a trainer jet for Air Force pilots.

Mr Edwards purchased his in 2009 when the Singapore Air Force decided to sell its fleet of 20 then in use at its training facility in WA as part of an aviation up-grade.

Having gained his pilot’s licence in 1991 when working in Newcastle as a General Surgery registrar – to both fulfil a childhood dream and as something to focus on outside the pressures of training – he couldn’t resist the temptation to buy.

“These are really nice little jets and I knew they would be very well maintained because the Singaporeans are such perfectionists,” Mr Edwards said.

“They have a standard Pratt and Whitney engine which is very, very reliable, they are ex-military so all the physics in the design have been thoroughly worked out and they are reasonably quiet for a jet.

“It’s a trainer so it’s fast but not faster than a 737, for instance, but it is way more aerobic.

“They cost between \$200,000 to \$300,000 and I thought that was a terrific bargain; my version of a Porsche and while it is an expensive hobby, particularly in terms of fuel, I don’t think it’s outrageous.

“It is the best aircraft I’ll ever fly, so I enjoy it immensely.”

When he heard news of the sale, Mr Edwards and fellow pilot and owner of an aerospace company Jim Whalley travelled to Geraldton for flight training, assessment and authorisation before being handed the keys to the craft.

“We went there for training from a man named Willy Chew who used to be the chief instructor in the Singapore Air Force,” Mr Edwards said.

“He’s a lovely, gentle man outside an aircraft, but as soon as he sat in the back in his role as instructor his character changed and he became this adrenalin-charged fury, barking instructions at us, and took on the persona of his nickname of “the godfather”.

“He’s retired now and although he must have terrified some of the young pilots in the Singapore Air Force, I bet he kept them safe.”

Mr Edwards keeps his jet at Goolwa Airstrip outside Adelaide under regulations that stipulate where such ex-military planes may be kept and flown.

Yet he has hopes of being able to bring it into the city soon to Parafield Airport.

“The Civil Aviation Safety Authority is in the process of reclassifying the S211 as part of a broad project to up-grade the risk index of all ex-military planes flying out there and they’re doing a good job,” he said.

“At the moment, with the old risk index, they don’t want jets like mine flying over populated areas; they stipulate that if you lost engine power you should be able to glide down over uninhabited terrain, but they also know this is a very safe jet so I’m hopeful the restrictions might ease up soon.

“Still, I can go up at the coast at 500 feet and at 250 knots and most people I take up love that and I throw in a few loops and rolls if they can take it.”

Mr Edwards said that he was so captivated by flying that as a teenager he considered a career as a military pilot before deciding on medicine and surgery instead.

Now he works out of the Royal Adelaide Hospital and at Wakefield and Ashford Hospitals and has particular expertise in minimally-





James Edwards loves the view from up here. Inset: James' favourite passenger.

invasive mitral valve surgery, achieving such exceptional patient outcomes that Adelaide is now becoming recognised as a centre of excellence for minimally-invasive cardiac surgery.

He is a board member of the South Australian State Committee of the College and a board member of the Medical Advisory Committee for the Calvary Wakefield Hospital.

At the same time, his other passion has never waned and he also owns a Pitts Special aerobatic bi-plane, has travelled to Alaska to learn to fly a Float Plane and has flown with Elizabeth around Australia in a De Havilland Chipmunk as part of a fund-raising benefit for the Flying Doctors Service.

He said that not only were there similarities between cardiac surgery and flying a jet fighter, but that doing one, made him better at the other.

"Both involve systems, planning, logic and complex sequences," Mr Edwards said.

"I feel the same satisfaction after conducting complex surgery as I do after completing a successful flight where you get where you're going when you plan to get there.

"I also think it is really important for surgeons to have outside interests and to also have non-medical friends and broader ties with the community because otherwise I think you are at risk of losing perspective.

"I have seen so many colleagues struggle with retirement or even the prospect of retirement because their lives are so utterly wrapped up in work and I have always been determined not to let that happen to me.



"I also think I'm a better surgeon having the jet, because it takes focus and skill to fly which forces me to stop thinking about work and that's refreshing while the flying is a buzz."

Now Mr Edwards is pushing his aerial skills further, going up in the jet alongside those flown by Mr Whalley and fellow pilot Steve Gale to expand his abilities in aerobatic flying.

"Formation flying is fantastic because each move has to be thoroughly worked out before we even get up there, but when you pull it off it feels wonderful," he said.

"We're thinking of becoming more involved in Air Shows and may take more trips together in the future.

"But the key to formation flying or aerobatics is to always keep it safe. Whenever you see something go wrong at an Air Show you can bet that someone could not resist the urge to do something they don't normally do because of the spectators.

"As someone once said, the aim of such flying should be to thrill the uneducated, impress the educated and scare nobody." ●

With Karen Murphy



# The thrill of beating hooves

Dr John Quinn on his love for the world of horse racing

**V**ascular surgeon and the College's Executive Director for

Surgical Affairs Australia Dr John Quinn has had a lifelong passion for horse racing. Not only do he and wife Deborah make splendid sartorial statements each November during the Melbourne Spring Racing Carnival, they are also members of a racing syndicate. Yet, despite the colour, glamour and thrill of the racetrack, he maintains a phlegmatic, amused approach to the search for equine success noting dryly that none of the syndicate's horses have been very good or very fast or very impressive. Still, there's always the next sale, the next horse, the next big thing.

Dr Quinn talks to Surgical News about his love of a day at the races.





**When did you first become interested in horse racing?**

I grew up as a young lad in country Victoria around Echuca and my father was a race judge at a number of country tracks in the area so it was part of my life from an early age. I would go with him upon many occasions and I got to know quite a bit about the industry.

**What do you love about it?**

There are a number of things that make horse racing wonderful. Firstly, the horses themselves are magnificent, majestic creatures, absolutely beautiful to look at and immensely powerful. Then you combine that with the ability of trainers, jockeys, strappers and handlers to not only get them into peak physical condition, but to train them to want to race and want to win. That to me represents an intriguing cooperative relationship between humans and animals. Then there is the spectacle of the event, the competition, the glamour, the crowds, all of which I find greatly enjoyable.

**Does your wife Deborah share the passion?**

Yes she does. My wife loves the races too. She used to ride in her younger days, competing in dressage and equestrian events so she comes to it from a different background. Deborah also has a strong interest in fashion and millinery and likes to support and showcase the work of various milliners whose creations she finds appealing. The fact that we can share this passion adds to the pleasure of it.

**Do you own race horses?**

For some years now I have been a member of a syndicate of 10, with me in Queensland and the rest in Melbourne. We only ever own one horse at a time and while none have been terribly successful we do it for the love and fun of it, not the success. So far we have owned about five horses over the past 10 years or so, but none have been very good or very fast or very impressive. In other words we have not found that elusive Black Caviar yet and while you do sometimes think you're pouring money into a bottomless pit, with so many people in the syndicate you don't lose too much. Then again, you don't win much either.

**Do you get to name them?**

Yes. We buy them as yearlings and then the syndicate members get together for lunch or

dinner and after a glass of a good red or two we collectively put names forward until we find one we can all agree on. Then we check on line to ensure the name is available and send that through to the racing authorities to make sure there is no other horse racing with the same name.

**Who do you have as trainers?**

All our horses have been with Freedman Racing, but you can't blame them for our lack of success.

**Do you have a new hopeful now?**

This season we have a horse called Evastar racing. He is a three-year-old and this will be his first spring racing season. We expect him to race in country meetings such as Pakenham, Cranbourne and Bendigo and we'll see how he goes, see if he makes it to a city track. Unfortunately, we've already heard that he's only mediocre... But then like surgical Trainees some come good in the most unexpected ways.

**Do you always try and make it down to Melbourne for the Spring Racing Carnival?**

We have been coming down to Melbourne in November for a long time now. We particularly like Derby Day which is the best racing day in Australia while the Melbourne Cup is a terrific spectacle. We tend to spend those days in a mixture of being on course, in the Birdcage or a marquee and occasionally we have a carpark on the rails and organise catering with a group of friends.

**How do you dress?**

In a top hat and morning suit, the traditional dress for major meetings; appropriate for the sport of kings.

**Do you have memories of a best or worst day at the track?**

Any day at the races is a good day. I enjoy all of it: the thrill, the spectacle, the camaraderie, doing the research to understand which conditions best suit which horse. As to a bad day, my punting is never big enough to create any anxiety.

**Does it distress you to hear suggestions, as recently reported in Victoria, of corruption within the industry?**

If it's true it's of concern, but I'm not sure it would ever be entirely surprising because



wherever money is involved there is likely to be crookedness. Still, Australia's horse racing industry is pretty clean and suggestions of wrong-doing have always been part of the tapestry of racing, an aspect of the thrill of the punt in a way. There is always talk around racing which is part of the game of picking a winner. You have to figure out what and who to listen to and what to ignore and sometimes it works and sometimes it doesn't, which is part of the fun as long as it stays within the law.

**Do you have any other interests outside horseracing and surgery?**

Yes, Deborah and I are both opera lovers. I am particularly fond of the operas of Mozart and Puccini though I love them all. Whenever we travel overseas we try to arrange tickets to the opera in whatever city we are in. We are also lucky in that Queensland Opera has a season each year. ●

*With Karen Murphy*



# How to enjoy the best of the *West*

Dr Jessica Yin is not just an expert on WA's four-hour emergency rule, she also knows how to enjoy Perth and its surrounding playground



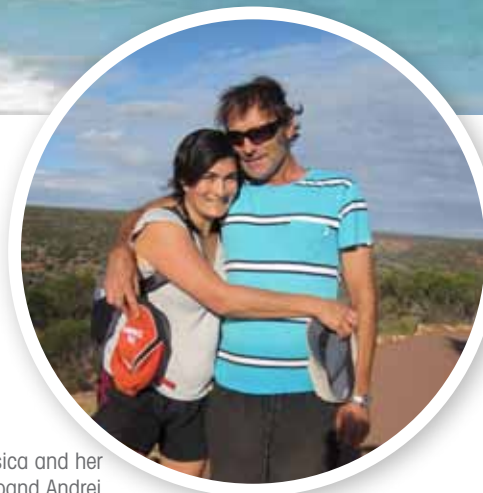
When Western Australia became the first state in the country in 2010 to introduce the four-hour rule that mandated the time patients could remain in the Emergency Department before either discharge or admission, Urologist Dr Jessica Yin found herself in the hot seat.

As Chairwoman of the WA State Committee of the College, Dr Yin was forced to devote all her available free time to negotiating on behalf of hospital surgical staff who believed the policy flawed as opposed to bureaucrats and politicians committed to its implementation.

“This policy was based on one that was introduced into the National Health Service in the UK, but without provision of the same resources,” Dr Yin said.

“The UK Government spent millions on the NHS before the introduction of this policy in terms of separating out elective from emergency cases and changing the operation and make up of their surgical units, whereas none of these things happened in WA.

“Our junior doctors were under enormous pressure without the same workforce numbers and the fact that there was no increase in the mortality rate across



Jessica and her husband Andrej

the hospital network was a testament to how hard they worked and how dedicated they were.

“Our Committee did everything possible to get the Government to undertake an independent review of the policy and consequently the Stokes report validated almost all of our concerns, which in turn meant that before the policy was rolled out across other states many of the problems faced here were understood and rectified.”

Yet no matter how fraught or high-stress the negotiations, there is nothing in Dr Yin's life to suggest that they phased her one iota, for she appears to be fearless.

Having arrived in Perth from Burma as a small child and living all her adult life there, Dr Yin took to the great outdoors with a passion becoming an experienced sky-diver, keen canoeist, paddleboarder, off-road explorer, camper and rock climber.

Her husband, Andrej, was her sky-diving instructor and the two even marked their nuptial union with a demonstration jump.

Dr Yin said that since her tenure as Chairwoman expired last year, she now prioritised family time as much as professionally possible.

“I have found that what has come with age is the wisdom and ability to pull back and say no to things,” she said.

“I enjoyed my time as Chairwoman of the WA State Committee and found it to be a wonderful learning experience, but it did take a toll on my family.

“My husband has always been my saving grace and when we married we made an arrangement that I'd look after the children when they were babies and then he would take over when they were older, so now he is the primary care giver.

“He is sports mad and has always enjoyed having the children involved and now our daughter competes at the national level in synchronised swimming and our son is obsessed with trampolining and soccer.

“However, a few years ago Andrej broke his neck from a sky-dive and although he was neurologically fine and only forced to wear a brace for three months, it was a wake-up call to us both that perhaps at this stage of our lives we might have to live more conservatively for the sake of the children.”

Dr Yin works out of the Hollywood Hospital and King Edward Memorial Hospital for Women and has a special interest in continence and reconstructive surgery.

With such an active family, she easily reeled off a list of the best of the west for Surgical News, but she also provided a warning: be prepared to pay.

“There is barely one aspect of life in WA that has not been touched by the mining boom,” she said.

“Jobs at the mines are so plentiful and the money so good, that businesses in Perth have trouble attracting staff and have to pay more to keep them.

“That means higher overheads, so if you come to Perth don't be surprised to pay \$10 for a cup of coffee. We have all had to get used to it.

With Karen Murphy ▶





**PERTH'S PERFECT BEACHES:**

As the cooling breeze of the Fremantle Doctor sweeps into Perth, there's no better place to chill out than at one of Perth's beautiful beaches, paddling in the Indian Ocean and watching the sun finally set in the west. Yet while Cottesloe Beach – with its towering Norfolk pines and a boulevard buzzing with restaurants and cafes – may be the most famous, the locals have their own favourites. Scarborough Beach is a hit with the young, offering impressive surf breaks while the foreshore is lined with clubs and pubs while Floreat Beach is a favourite for those who like a quiet spot of beach fishing. Families with children appreciate the tranquil waters of Mettams Pool while those who are in search of that perfect wave head to Trigg where shifting sand banks cover rocky ledges to create a powerful surf break. Kite surfers prefer Leighton beach when the "Doctor" is in.



**THE SUBLIME SWAN:** With its shady lawns, little sandy beaches and gentle slow-moving waters, the Swan River is Perth's favourite playground. Known in its upper reaches as the Avon, the Swan River winds its way down 240kms from east of the Darling Scarp, through Perth and down to the sea at Fremantle, in the process offering one of the most peaceful, picturesque ways to explore the city and surrounds. Ferries and cruise boats ply the waters throughout the day and into the evening, but for more high-octane water thrills you can hire a surf cat, jump on a jet ski or climb aboard a power boat.

**NINGALOO REEF:** Dr Yin said she and her family often went up to Ningaloo Reef for camping trips far from the madding crowd, but it says something about the mind-set of people from the West that distance is no barrier to beauty given that it is a 12-hour drive from Perth. Still, she said she believed the reef more glorious and pristine than the Great Barrier Reef, less overcome with tourism and one of the world's most amazing natural environments. Located off Coral Bay, north of Perth towards the town of Exmouth, Ningaloo Reef is one of the largest fringing reefs in the world and unlike most, can be reached just by stepping into the water. It is home to hundreds of varieties of reef fish and hard corals while it also has a year-round population of manta rays, green turtles, bottlenose dolphins, dugong and reef sharks. During the annual coral spawning in March and April, the reef also sees the arrival of whale sharks, the biggest fish in the ocean.



**FLYING AND FLOATING IN NORTHAM/YORK:**

For those keen on aerial pursuits, Dr Yin recommended a visit to Northam in the Avon Valley, given that it has now become one of Australia's most noted centres for aviation activities. With a calm climate, minimal air traffic and gentle countryside, the area boasts some of the best flying, ballooning and soaring conditions in the world and is located, this time, just one hour's drive from Perth. Here you take in the beautiful scenery by hot-air balloon or try your hands at gliding, flying, hang-gliding, paragliding and microlighting.



**WESTERN WINES:** According to Dr Yin, if you want to fish when in Perth you head north, but if you wish to wine and dine you head south – in particular to Margaret River, Dunsborough, Pemberton and Augusta. What was once a laid-back surfer town, Margaret River has now become one of the most famous and prestigious wine and food regions in Australia, offering not only 60-plus vineyards to visit along with restaurants and boutique breweries, but also a spectacular scenic backdrop. The region is just over three hours by car from Perth, but if you wish to taste and tiddle, bus tours leave Perth regularly. Nearby lies the town of Augusta, which Dr Yin said she preferred, for its natural beauty and more hidden charms. Canoeing the Blackwood is not to be missed. Also here is the historic Cape Leeuwin Lighthouse, situated at the tip of the dramatic peninsula where the Southern and Indian Oceans meet, the most south-westerly point of Australia. ●





Clockwise: The entrance hall at the Society of Apothecaries; Henry the VIII; Fellow Peter Burke at St Thomas' Hospital.



# London dissected

A guide for the curious

It seems almost inevitable that, as surgeons, we will at some stage visit London; whether it be to attend a conference, visit family, take up an exchange Fellowship, or even work in the National Health Service.

Depending on the time available, the surgeon has many options available to guarantee a most rewarding visit to this great city: there are all the well known attractions such as St Paul's Cathedral, the National Portrait Gallery, the Tower of London and the Victoria and Albert Museum and so on.

There are even more abstract attractions such as the Harrods' Food Halls, the incredible Silver Vaults off High Holborn, Portobello Road Markets, ad infinitum.

However, the surgeon has many more options available of collegiate and historical interest. An excellent start would be to visit the Wellcome Collection in Euston Road where there is an extraordinary collection relating to medical history from all countries in the world, an excellent library and fascinating current displays: this

Collection is aptly self-described as, "a free destination for the incurably curious".

Sir Henry Wellcome, pharmacist, entrepreneur, philanthropist and collector, with Silas Burroughs formed Burroughs Wellcome & Co in 1880: they were one of the first to introduce medicine in tablet form: prior to that medicines had been sold as powders or liquids.

'Wellcome Images' provides one of the world's richest and most unique image collections, incorporating materials as diverse as, medicine and magic, science or satire [[www.wellcomecollection.org](http://www.wellcomecollection.org)].

The Science Museum now remains the permanent custodian of the vast majority of Henry Wellcome's collection which is estimated to consist of no less than two million objects! [[www.sciencemuseum.org.uk](http://www.sciencemuseum.org.uk)].

The origins and history of the English College of Surgeons include the union of the 'Fellowship of Surgeons' and the 'Company of Barbers' by Henry VIII in 1540 to form the 'Company of Barber-Surgeons'. This event is

commemorated with the magnificent Hans Holbein portrait of the monarch presenting representatives of both bodies with a paper signifying this Act of Parliament. As we shall see, the original portrait remains with The Worshipful Company of Barbers and a copy is in the Edward Lumley Hall at the R.C.S. in Lincoln's Inn Fields.

A summary of the process of evolution relating to these two bodies follows:  
c. 1300-1540, The Company of Barbers (incorporated 1462)  
The Guild of Surgeons (not incorporated);  
1540-1745, The Company of Barber-Surgeons;  
1745-1800, The Company of Surgeons;  
1800-1843, The Royal College of Surgeons of London;  
1843 - The Royal College of Surgeons of England.

Accordingly the next visit could be the Royal

College of Surgeons of England where one can find the recently refurbished Hunterian Museum; also the Archives may be accessed, there is also the Wellcome Museum of Anatomy and Pathology, and the Library.

There are always interesting exhibitions to visit: currently, coinciding with the Olympic Games, 'Olympic Connections: Sporting Surgeons': and earlier this year, 'Anatomy of the Athlete', which explored sports surgery through medical art.

Accommodation is also available at the College [[www.rcseng.ac.uk](http://www.rcseng.ac.uk)].

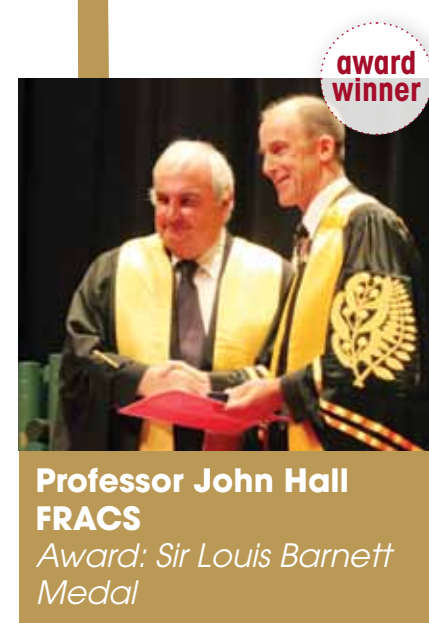
The Worshipful Company of Barbers, which celebrated its 700th anniversary in 2008, has the magnificent Barber-Surgeons' Hall, in the heart of the City of London, adjoining the ancient Roman Wall. ▶



# CONGRATULATIONS on your achievements

Presentations from the College ASC 2012

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



**Professor John Hall  
FRACS**  
*Award: Sir Louis Barnett  
Medal*

John Charles Hall grew up in Melbourne and graduated from the University of Melbourne in 1969. His surgical training at the Austin Hospital was interrupted by a period of National Service in the Australian Army. He received the FRACS in 1976 and undertook further training in the United Kingdom at the Essex County Hospital and St. James's University Hospital in Leeds. He was a Lecturer at the Flinders University of South Australia before his appointment to the University Department of Surgery at Royal Perth Hospital in 1985.

John Hall has been a dedicated 'hands-on' surgical educator and a consistent contributor to surgical education. He has had a major influence on all aspects of surgical education in the University of

Western Australia. He served the Faculty of Medicine and Dentistry as Chair of the Assessment Committee from 1996-1999 and was a Senior Examiner for the Australian Medical Council from 1993-2001. Professor Hall was recruited to participate in the evolution of the RACS from a credentialing into a training institution. He served as Chairman of the Pathology Bank for basic surgical training from 1999-2001 and then became the Interim Dean of Education.

John Hall has a strong research record and was awarded the John Mitchell Crouch Fellowship, the premier research award of the RACS, in 1996. He has a deep interest in biostatistics and has published clinical trials in *The Lancet*, *British Medical Journal* and other leading surgical journals. He has published more than 160 articles in peer-reviewed journals, two of which are citation classics with more than 100 citations each.

He has a deep commitment to the promotion of research interests in surgical Trainees – 20 surgical Trainees have been a first author on peer-reviewed publications. Professor Hall has been an active clinical leader. He was Chairman of the Division of Surgery at Royal Perth Hospital from 1992-1994 and Head of Surgery in the University of Western Australia from 1998-2001. He founded the Drug Audit Program, Nutrition Review Group, Antibiotic Review Group, Theatre Quality Control Group, and the Young Investigators Day at Royal Perth Hospital. John Hall has been a chairman of Institutional Ethics committees for both human and animal research.

He served as Editor-in-Chief of the ANZ Journal of Surgery from 2007-2011. During Professor Hall's five year tenure as Editor-in-Chief, the journal underwent significant change. In 2011, the acceptance rate for original articles was about 20 per cent, compared with an acceptance rate of 67 per cent in 2007.

Dedicated to the promotion of outstanding surgical practice, and research of contemporary and international interest, the journal's readership has become increasingly international, with 22 per cent of readers from Australasia, 22 per cent from the United States, 20 per cent from Europe, 7 per cent from the United Kingdom, 5 per cent from China and 2 per cent from Japan. Fully 60 per cent of articles submitted for consideration come from countries other than Australia and New Zealand. There is now a much more efficient flow of manuscripts, with Professor Hall having led a team of conscientious editors and reviewers. The journal's format has become more attractive and user-friendly.

Professor Hall's tenure will also be remembered for the development of the journal website – ANZJSurg.com. It is a remarkably comprehensive website, with every article that has ever appeared in the 80-year history of the journal now able to be retrieved.

Professor John Hall, a great contributor to surgical education, is a truly worthy recipient of the Sir Louis Barnett Medal.

*Citation kindly provided by  
Mr Keith Mutimer FRACS*

The Barber Surgeons coat of arms.



As we have noted, until 1745, the Barbers had controlled also the craft of surgery: this curious combination of occupations arose from the customary employment of the barber in mediaeval monasteries for the purpose of blood-letting, as well as, for the preservation of the tonsure.

In the 18th century, as surgeons were becoming more skilled and numerous they petitioned the House of Commons to be allowed to separate from the Barbers. Royal Assent was received on May 2, 1745, and with this split the Barbers retained the Hall and many of the treasures, which may be viewed there today.

The Hall has had a difficult history, being severely damaged in the Great Fire of 1666 and the remnants being destroyed in an air raid in December 1940; finally a new hall was opened in Monkwell Square in May 1969.

Barber-Surgeons' Hall is well worth a visit with all its surgical associations, its veritable treasures, paintings, Physic Garden and the Charter Room containing the Company's royal charters from 1462; the signature of Sir Thomas More is on the 1530 ordinances: for any person interested in heraldry, this is the perfect locale [[www.barberscompany.org](http://www.barberscompany.org)].

The Worshipful Society of Apothecaries has a magnificent building within the city of London which is also a most suitable destination: the apothecaries did not become an independent body until December 1617; the sale of drugs was originally under the control of the Grocers Company.

Their charter incorporated them as the 'Master, Wardens and Society of the Art or Mystery of Apothecaries', and the company is one of the few which continue to fulfil the functions for which it was founded.

With the Apothecaries Act of 1815 the Society was given the statutory right to grant, after due examination, a licence to practise medicine throughout England and Wales. John Keats was possibly the most famous person to qualify as an apothecary: he served a four year apprenticeship and "walked the wards" at Guy's Hospital, prior to passing the examination on 25 July, 1816, "with ease; a creditable and talented performance".

When the apothecaries left the Grocers' Company, they

purchased a building which had constituted part of the 250-year-old Dominican Priory: most of the building was destroyed in the Great Fire of 1666 and rebuilding commenced in 1668. Fortunately the hall survived the air raids of WW2, a German 500 pound bomb penetrating the basement and failing to explode on impact!

Visit, just to view the 1671 staircase, the Great Hall panelled in Irish oak from that 17th century rebuilding, the heraldic stained glass panels and the collection of old decorated and glazed apothecaries' pill tiles and jars [[www.apothecaries.org](http://www.apothecaries.org)].

Closely associated with the apothecaries was the Chelsea Physic Garden, a three-and-a-half acre site, provided through the intervention of Sir Hans Sloane, who arranged a lease in perpetuity. A visit to this

fascinating and well-organised institution illustrates the importance of medicinal herbs in the physician's medical therapy of those distant days [[www.chelseaphysicgarden.co.uk](http://www.chelseaphysicgarden.co.uk)].

Other places to visit are the major hospitals of London, including St Bartholomew's the oldest hospital in London, having been founded in 1123, still occupying its original site. There is a museum outlining the history of "Barts" and on the walls of the staircase leading from the official entrance hall to the hospital's Great Hall are two murals painted by William Hogarth, 'The Pool of Bethesda' (1736) and 'The Good Samaritan' (1737) [[www.bartsandthelondon.org.uk](http://www.bartsandthelondon.org.uk)].

The long lost operating theatre of St Thomas' Hospital reached by the ascent of a rather steep and narrow staircase is again worthy of a visit along with the adjoining Herb Garret. One of the most unusual museums in London, the operating theatre is the oldest in Europe [[www.thegarret.org.uk](http://www.thegarret.org.uk)].

In conclusion, the websites provided should provide a lead for many memorable and worthwhile visits and as a guide to many other similar destinations: readers of *Surgical News* will also be aware that the Royal Society of Medicine can provide accommodation [[www.rsm.ac.uk](http://www.rsm.ac.uk)]. ●

**Peter Burke**  
Victorian Fellow



Inaugurated in 1998, the ESR Hughes Award is designed to recognise distinguished contributions to surgery by Fellows of the College and others. It was created in recognition of the outstanding contributions to surgery by Professor Sir Edward Hughes. The sole criterion for the Award is distinguished contributions to surgery.



award winner

**Professor John Harris**  
AM FRACS FRCSEng  
FACS

*Award: ESR Hughes medal*

John graduated MB BS, first in year in surgery, from the University of Sydney in 1972 and undertook surgical training at the Royal Prince Alfred Hospital. He became a Fellow of the Royal Australasian College of Surgeons in 1979 then continued training at the Southend General and Rochford Hospitals in Essex, becoming a Fellow of the Royal College of Surgeons, London in 1979. He then trained in the United States of America at the Northwestern Memorial Hospital, Chicago before returning to Australia in 1981 to be a consultant at the Royal Prince Alfred Hospital and Senior Lecturer at the University of Sydney. He became a Fellow of the American College of Surgeons in 1986 and in 1988, he obtained the Diploma of Diagnostic Ultrasound (Vascular) from the Australian Society of Ultrasound.

John has held many senior positions at the University of Sydney since 1989, including Sub Dean, Deputy Associate Dean and then Head of Department of

Surgery. He has been a member of more than 20 committees at the University of Sydney and more than 12 at the Royal Prince Alfred Hospital since 1983.

John has received numerous awards and honours: The Jobst Fellow, Peripheral Vascular Surgery, Northwestern University, Chicago, 1980; The Travelling Fellow, RACS, Malaysia, 1990; The Toshiba prize, annual scientific meeting, Society for Vascular Technology, Boston 1991; Membership of Society for Vascular Surgery, North America, 1997; The Foundation Visitor, Division of Vascular Surgery, RACS, ASC, Auckland, 1999; the Distinguished Fellow, Society for Vascular Surgery, North America, 2003; the Honorary Membership, Society for Vascular Surgery, Great Britain and Ireland, 2003.

In 2007, John was awarded the Order of Australia for services to medicine and advances in vascular surgery, ultrasound procedures, medical education and public health administration.

John has had a very active role in the Royal Australasian College of Surgeons since 1985, both at the NSW Regional level and on a national level and he is the Vascular representative on the NSW Regional Committee. Professor Harris became a member of the Court of Examiners in General Surgery in 1992 and in Vascular Surgery from 1996 to 2003, being the Senior Examiner from 1999. He was a member of the Executive and has been Chairman of the Section of Academic Surgery since 2002. He was the Vascular Representative on the Council of the College from 1999 to 2003.

Professor Harris has been a member of the Executive of the International Society for Cardiovascular Surgery since 1993, was a Convenor of the Annual Scientific

Meeting in 1995 and was elected President in 1997. In 2000, he became President of the Australian and New Zealand Society for Vascular Surgery.

John has been a member of the Executive of the Australian Society of Ultrasound in Medicine since 1989 and Honorary Secretary from 1993 to 1995. He has been an Examiner for the Diploma in Diagnostic Ultrasound and Convenor of Australian Workshops in Vascular Ultrasound.

John has held positions as Councillor of the NSW State Branch of the Australian Medical Association (1987-1990) and was Chairman of the AMA Health Fund from 1990 to 1998. John has had a very active role in surgical research and teaching and has received 16 research grants since 1980.

As President of the ANZ Society for Vascular Surgery, John participated in the negotiations that culminated in Vascular Surgery emerging as a separate division of RACS.

John has initiated the RACS Inter-Collegiate Working Party on Recognition of Training in Peripheral Endovascular Therapy (2000), the Section of Academic Surgery RACS (2002) and the Master of Surgery programme at the University of Sydney (2003).

John is currently Editor-in-Chief of ANZJ Surgery. John has published 41 chapters in vascular surgical text books and 117 articles and 58 abstracts in referred journals. He has written five editorials, four book reviews and three full-length published and referred conference papers as well as eight unpublished conference papers. He has written numerous articles for non-referred journals, research and departmental report.

*Citation kindly provided by  
Mr Joseph Lizzio FRACS*

## Workshops & Activities

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



### NSW

**13 November, Sydney**  
Keeping Trainees on Track (KToT)

### NZ

**23 October, Wellington**  
Non-Technical Skills for Surgeons

**3 November, Wellington**  
Keeping Trainees on Track (KToT)

### QLD

**30 November, Gold Coast, QLD**  
Non-Technical Skills for Surgeons

### SA

**17 November, Adelaide**  
Building Towards Retirement

### VIC

**26 October, Melbourne**  
Strategy and Risk Management for Surgeons

**26 October, Melbourne**  
SAT SET

**30 October, Melbourne**  
Keeping Trainees on Track (KToT)

**2 - 4 November, Melbourne**  
Process Communication Model

**23 November, Melbourne**  
Occupational Medicine

**7 December, Melbourne**  
Non-Technical Skills for Surgeons (NOTSS)

### Non-Technical Skills for Surgeons (NOTSS)

**23 October, Wellington, NZ;**  
**30 November, Gold Coast, QLD;**  
**7 December, Melbourne**

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.

### Strategy and Risk Management for Surgeons

**26 October, Melbourne**

This whole day workshop is divided into two parts. **Part one** includes formulating a strategic plan; the strategic planning process; identifying and achieving strategic goals; monitoring performance; and contributing to an analysis of strategic risk. **Part two** focuses on the directors' knowledge of risk for the organisation and their monitoring of management's ongoing assessment and treatment of risk.

### Supervisors and Trainers for SET (SAT SET)

**26 Oct, Melbourne (AVSM - incl dinner)**

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. This workshop is also available as an eLearning activity by logging into the RACS website.

### Keeping Trainees on Track (KToT)

**30 October, 2012 - Melbourne;**  
**3 November, 2012 - Wellington;**  
**13 November, 2012 - Sydney**

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.

### The Process Communication Model (PCM)

**2 to 4 November 2012 - Melbourne**  
(Introductory)

PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful.

### Building Towards Retirement

**17 November, 2012 - Adelaide**

Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. Fellows from a variety of disciplines and their partners join with colleagues and corporate speakers in an interactive discussion format that focuses on three sessions on preparing for retirement, options after retirement and resources to realise options.

### Occupational Medicine: Getting Patients Back to Work

**23 Nov, 2012 - Melbourne** (Morning session, part of AOA/RACS/MEDLAW meeting)

A unique opportunity to see CBD building construction from the ground up. Starting with holes in the ground and all stages through to the completion of the buildings. You will see all trades at work. The aim is to provide surgeons with knowledge useful in proactively advising workers recovering from injury or illness.

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.





## Paddling together

The College supporting Pacific Islands surgeons

The ninth Pacific Islands Surgeon's Conference was held in Tonga in August. The New Zealand National Board and the New Zealand Office have supported this meeting since its inception in Rarotonga in 1994.

The Conference was officially opened by HRH the Hon Princess Frederica Fatafehi o Lapaha Tuita with the Queen Salote School of Nursing Choir providing wonderful music prior to and during the opening ceremony.

In his blessing during this ceremony the Reverend Savinata Moala spoke of the importance of Pacific Island nations "paddling together" to improve the health of their citizens, recognising that a canoe moves cleanly through the water when the paddlers work together.

### The themes of this 2012 Conference were:

- > surgical response to non-communicable diseases;
- > disaster preparedness; and
- > developing a sustainable Pacific surgical workforce.

Diabetes is a major cause of the burden of non-communicable diseases in the Pacific. In many Pacific Island nations at least 50 per cent of their non-acute surgical admissions are related to diabetes. This absorbs a large proportion of the Pacific's scarce health resources.

The keynote address on this topic by Lord Tangi o Vaonukonuka FRACS (Chief Surgeon, Vaiola Hospital, Tonga) stressed a surgeon's role as a health advocate. Surgeons must play their part in managing non-communicable diseases at all levels. This could range from counselling individual patients and their families about canned drinks, to actively supporting public health initiatives.

Pacific Island nations have experienced many natural disasters in recent years – earthquakes, tsunamis and cyclones

– and will continue to do so in the future. Dr Ian Norton, Director of Disaster Response and Preparedness, National Critical Care and Trauma Response Centre (in Darwin) gave a keynote presentation on disaster preparedness.

A number of Pacific surgeons have attended an AusMAT training program; all acknowledged the importance of preparing for disasters, as well as regularly reviewing and updating disaster protocols.

The Pacific Islands Surgeon's meetings have come a long way since the conference was previously held in Tonga. In 2000, seven Pacific Island nations were represented by nine surgeons, and there were no surgical Trainees. Fast forward 12 years and we find 10 Pacific Island nations represented by 17 surgeons and 15 surgical Trainees.

While everyone involved can be proud of the increase in training numbers and improved retention of surgical graduates within the Pacific (and the considerable increase in the number of Pacific Island surgeons), these are still small numbers for the population of the region. So workforce development and retention of surgeons continue to be key concerns for these countries.

The "generalist versus specialist" debate is important in the Pacific, just as it is for Australia and New Zealand. While we debate maintaining general skills to deliver care in provincial hospitals and meet on-call commitments in metropolitan units, the Pacific is debating where and when they should move away from a "surgery in general" model of care.

Variations in population numbers and population distribution challenge the ability of these nations to provide surgical care. In the larger nations, such as PNG and Fiji, a degree of 'sub-specialisation' into general surgery, urology, orthopaedic surgery and paediatric surgery occurs.

But the small Pacific nations (such as Nauru, Cook Islands, Kiribati and Tuvalu) require general surgeons with the right skill set to respond to acute presentations across the surgical spectrum and some elective surgery in general surgery, orthopaedics, urology and paediatric surgery.

As on previous occasions, a number of surgeons from New Zealand and Australia attended and supported the program. This included, for the first time, the President of our College. The Tongan medical community hosted him superbly.

Michael Hollands may have been prepared to contribute to the teaching sessions and conference program, but I doubt he had anticipated his attendance would include active participation in the dancing and singing that is always such a large part of the social programme at these Pacific surgical meetings! However, he responded admirably, displaying great dancing agility and singing ability, with willing participation in the cultural events.

PISA meetings rely on financial assistance from New Zealand or Australia; without this the opportunities for information sharing and networking across these nations would be very limited. Funding from NZAID and from SSCSiP (Strengthening Specialised Clinical Services in the Pacific, an AusAID funded initiative) made attendance at this conference possible for 12 of the Pacific Islands' surgeons and the 15 Pacific Islands' Trainees.

The goal is to promote surgical self-sufficiency in the Pacific to the degree possible with the resources available, identifying and meeting the needs of these dedicated surgeons. The meeting's organisation was supported by the NZ Office of the College and the Pasifika Medical Association (PMA), with in-country support from the Tongan Medical Association.

Kiki Maoate (President of PMA and a member of the College's International Committee and Rowan Nicks Scholarships Committee) once again played a major role in assisting with the structure and content of the Conference program.

PISA has decided that the next conference will be held in Fiji in 2014. This gives plenty of time for interested New Zealand and Australian surgeons to prepare to support the meeting – and this may possibly include honing up on your dancing and singing skills!

*Scott Stevenson*  
Chair, NZ National Board

Surgeons  
leading  
cultural  
change in  
patient care

Annual  
Victorian  
Scientific &  
Fellowship  
Meeting

FRIDAY  
26 OCTOBER &  
SATURDAY 27  
OCTOBER 2012  
Venue: Rydges  
Exhibition St,  
Melbourne

**Dinner Venue:**  
**MCG**

(pre-drinks in the National Sports Museum with guest speaker Prof David Fletcher)

**Prizes for the following categories:**

**2012 DR Leslie Prize** – For the best clinical registrar paper

**2012 RC Bennett Prize** – For the best laboratory based research paper presented

**Royal Australasian  
College of Surgeons**

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## Farewell: Professor Bruce Barraclough, Dean of Education

College staff gathered in the Hughes Room on the cool afternoon of Tuesday, August 29, to hear David Hillis farewell Professor Bruce Barraclough; this is a copy of the speech

**B**ruce has contributed enormously and in a most distinguished manner to many senior roles in his career. As we farewell him from the role of Dean of Education at the College I would like you to consider three key words over the next few minutes. The first is Hughes-Room, the second is shoulders and the third is different.

We are deliberately farewelling Professor Barraclough in this room, the Hughes-Room because it speaks so much to what the College is, what it does and how it contributes not only to surgery, but also to society as a whole.

The portraits around these walls are some of the outstanding surgeons who have contributed enormously as individuals to their patients and their communities. They are then involved with their profession to ensure its development, the maintenance of its standards and educational programs. All the surgeons in these portraits have been recognised as outstanding leaders, as people respected and honoured by their peers of the day.

However, this is the Sir Edward Hughes Room. Let me speak about Sir Edward just briefly. He was a leader

in a world of leaders. A renowned colo-rectal surgeon, he worked at the Royal Melbourne Hospital along with others like Sir Albert Coates and Sir Weary Dunlop. He was then appointed the Professor of Surgery at the Alfred Hospital. He was Censor in Chief of the College, at the time when the Surgical Training Boards were established, and the first days of international comparability and recertification were being addressed.

However, Sir Edward went beyond this. When initially appointed to Council, he agitated the College to be actively involved in public health. The public health issue of the day – and this was 1969 – were motor car accidents. In those years, over 1,000 deaths occurred on roads in New South Wales and also in Victoria. Hospital beds were ‘clogged’ with the young and the maimed.

Through a combination of highly publicised seminars, establishment of committees and development of policies in which Sir Edward was highly involved, changes were introduced that we now know have dramatically reduced the road toll. Compulsory wearing of seat belts legislation was introduced. Cars were actually scrutinised for safety. His efforts generated the



ABOVE: 2012 ASC KL Post Convocation  
Bruce Barraclough  
Leigh Delbridge  
Gerard Doherty

decades of enthusiasm in people like Gordon Trinca. It is a matter of record that he was knighted for his services to medicine and surgery; he was awarded the Sir Hugh Devine Medal of the College.

But he was also the rarest of College Fellows. He was a three year President. There is something about a three year President. Their peers acknowledge they understand the strategic imperatives for surgeons and the strategic imperatives for surgery in the community. To understand how the College needs to change, must change and will change. Sir Edward was a three year President. He was a giant among surgeons.

So, why the focus on Sir Edward Hughes and three year Presidents? The College in its history has only had four, three year Presidents. A Councillor recognised by his peers who stands as a giant among surgeons. One was Sir Edward Hughes. Professor Bruce Barraclough is also a three year President.

Professor Barraclough is described in the Mantle of Surgery<sup>1</sup> as being “gifted with the ability to enunciate the deep truths of surgical philosophy in a way that leaves little room for misunderstanding or dispute”. It goes much further than this.

An outstanding breast and endocrine surgeon with a substantial profile in cancer related services, as President he revolutionised the way the College functioned. He clearly identified the requirement to be a modern educational organisation, to advocate on issues to government and to be regularly involved at the highest level of health policy and debate.

While Sir Edward focused on road trauma, the challenge at the turn of this century was to be actively involved in ways to improve the quality of health service delivery, the assessment of technology and the standards of the training programs.

The College during his three year Presidency changed forever, embracing quality initiatives, the necessity of

dialogue and discussion with the governments of the day. Again, like Sir Edward, Professor Barraclough is a giant among surgeons.

After being President, he continued in senior roles in many organisations taking the issues of quality, surgery and engagement quite literally to the front line internationally. In progressing issues to make our health system safer, he has been Chairman of the New South Wales Clinical Excellence Commission, Chairman of the Australian Council for Safety and Quality in Health Care and President of the International Society for Quality in Health Care.

He has written the World Health Organisation Curriculum for Safety and Quality. He has been honoured by many Fellowships of many Colleges, Academies and Associations. He has been awarded Honorary Doctorates. He is an Emeritus Professor in recognition of his substantial academic contributions. Australia has honoured him with the Order of Australia. Inside this College, he stands as a giant. He is a three year President.

Why did I make my first point to remember the Hughes-Room? Because, I wish you to understand the stature of three year Presidents. They are giants. And on that point I wish to move to the second word I asked you to think about, which is shoulders.

It is highlighted in the words of John of Salisbury in 1159 when he stated, “We are like dwarfs sitting on the shoulders of giants. We see more, and things are more distant, because they raise us up, and by their great stature add to ours.”

People sometimes ask me, why work at the College of Surgeons? College structures and professional organisations can be unusual and demanding. However, again as highlighted in the Mantle of Surgery, the College inspires and challenges men and women of goodwill to give freely of their time and their wisdom. ▶



## SURGICAL RESEARCH SOCIETY ANNUAL MEETING 2012

The Surgical Research Society; 49th Annual Scientific Meeting will be held in Adelaide on Friday 9th November

This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers, scientists and medical students.

### JEPSON LECTURER:

Professor John A Windsor FRACS  
Professor of Surgery, Director of Surgical Research, The University of Auckland, New Zealand  
Chair, Section of Academic Surgery  
Lecture title: "Streams in the Desert"

### ASSOCIATION FOR ACADEMIC SURGERY GUEST SPEAKER:

Associate Professor Heitham T Hassoun MD, FACS  
Medical Director – Global Services, Johns Hopkins Medicine International in Baltimore, Maryland, USA  
Lecture title: "Kidney-Lung Crosstalk during Surgical AKI"

### CALL FOR ABSTRACTS:

The call for abstracts will be open on Monday 30 July 2012 and must be submitted no later Monday 24 September 2012. Abstract forms will be available from the email below.

### AWARDS AND GRANTS

The following will be awarded to the best presentations:  
Young Investigator Award  
Developing a Career in Academic Surgery Award  
Three Travel Grants  
Best Poster Award

**CONVENOR:** Professor Guy Maddern

**PRESIDENT:** Professor John McCall



Alan Merry and Bruce Barraclough at the Surgical Safety Checklist launch, 2009.

We all reflect on the commitment and the enthusiasm of College Fellows with which we work. They are truly involved for noble reasons. So you work with organisations where you can honestly feel a difference will be made.

Secondly you wish to work with people who can inspire you. Giants like Professor Barraclough enable us to see further and look at things differently. We can stand on their shoulders. We are in awe of their skills.

And I would highlight at this point, in thinking about Professor Barraclough, the descriptor that most frequently comes to mind is masterful. Understanding the deep truths of surgical philosophy in technical, political and diplomatic skills and delivering on these at international levels for decades is masterful.

Aligning Australia and New Zealand with the health imperatives of the United Kingdom, United States and Canada is a substantial act. And to that, he brings my second descriptor, which is wisdom. Across many domains. Many of us, on staff have been blessed to be able to stand on his shoulders and admire his skills.

I now wish to move to my third word which is different. Giants see things differently. The world is a different place. The horizon includes so many other things. Is it any wonder that Professor Barraclough also chairs the Australian ehealth research centre? Whilst we struggle to find the on-off

button for our computers, Professor Barraclough is chairing one of the peak groups for IT innovation in the country.

The strategic imperatives of surgery, include quality, include standards, but will always include innovation, research and new ways of doing things. In the time that Professor Barraclough has been here as Dean of Education, we have made enormous strides in so many things. Quality, standards, IT support, e-health, audit. All of this has been pushed and encouraged by Professor Barraclough in ways that are both obvious and subtle. The work of a master, sharing his wisdom.

So, in farewelling Professor Bruce Barraclough, I have really given you five key words, not three to consider carefully. They all have a purpose and a reflection on the enormous contribution he has made.

The first was Hughes-Room so you have an understanding of a three year President; the second was the shoulders of a giant on which we can stand, and the third is different for things are truly that. However, to that I purposefully add both Masterful and Wisdom, descriptors that are Professor Barraclough.

Bruce, we will all miss you. I will miss you. As our mentor, our coach, and our three year President.

I. Beasley, A.W., *The Mantle Of Surgery*. 2002, Melbourne: Royal Australasian College of Surgeons.

**David Hillis,**  
CEO

# QASM connects Queensland health professionals

A successful seminar for all healthcare professionals

In August 2012, the Queensland Audit of Surgical Mortality (QASM) held its first one-day seminar for nurses, midwives, and paramedics. This seminar followed from the success of QASM's annual November seminars for surgeons, with a similar theme of *Distance, Delays, and Deteriorating Patients*.

QASM has always acknowledged and promoted the importance of the interface between surgeons and other health professionals. Effective communication is the cornerstone of this interface, and when managed well, it can greatly contribute to better patient outcomes.

The Brisbane-based August seminar provided an opportunity for QASM to connect clinical health professionals and for surgical challenges to be reviewed and discussed.

Most seminar attendees were from metropolitan hospitals. Importantly, however, four regional Queensland towns were also represented. These towns (regions) included: Bundaberg (Wide Bay-Burnett); Kilcoy (Somerset); Mt Morgan (Central); Toowoomba (Darling Downs). Attracting more attendees from regional Queensland is part of QASM's planning strategy for future seminars.

Fifteen surgeons and three health professionals presented to more than 90 attendees. A full day's program resulted in the following issues being addressed by experts in their fields:

- the complex patient – role of first-on-the-scene; the local hospital; the regional hospital; and the tertiary hospital
- the deteriorating patient – organising and managing related issues when distance is involved
- the communication networks for retrieval
- the differences in surgical management of children
- the obstetrics and gynaecology issues at a distance

- the Queensland Health models for safety and quality improvements

The seminar ended with case studies being explored and discussed by a panel of the presenters. This session proved popular with attendees who were able to ask questions and exchange their experiences with the panel.

QASM also sought feedback from attendees to better understand the professional challenges they face and to evaluate the usefulness of this seminar for nurses, midwives, and paramedics.

### QASM asked: What professional challenges do you encounter when managing deteriorating patients?

*"As I work in a tertiary obstetric facility, we constantly are faced with deteriorating patients, but in a controlled environment. One area of concern is the rapid decline our patients can face and the acceptance of patients in an already deteriorated state. My biggest concern would be when a registrar does not want to 'bother' the consultant to ask for assistance."*

*"Communication with numerous teams (and staff) involved with the care of deteriorating patient and ensuring continuity of information and care."*

*"Having senior staff not agreeing that someone is actually deteriorating; normalising abnormal observations."*

*"Staff not acting as soon as possible when there are clear signs (that is, change in trends) that the patient is deteriorating; and lack of communication between treating teams (between doctors and nurses)."*

*"Senior staff being unapproachable – trying to get medical staff to listen to concerns. A 'them and us' attitude between specialities. Emergency department staff trying to manage sick patients without getting early intervention from specialities."*

### QASM asked: Which aspects of the seminar did you find most useful?

*"Understanding the difficulties that remote areas can face was very useful in understanding the way patients present to us. And the importance of communication in these cases."*

*CEWT: seeing the problem early and diagnosing the deteriorating patient (Children's Early Warning Tool – www.health.qld.gov.au)*

*"Examining scenarios with the high standard of professional presenter was excellent."*

*"Aspects of each presentation had some very useful points."*

*"Presenters from multiple specialties and multiple facilities."*

### QASM asked: Do you think this seminar will help you in your future assessments of patients?

- 90 per cent of respondents said yes.

Thank you to all presenters and attendees for their contribution to QASM's first seminar for nurses, midwives, and paramedics.



**John North**  
QASM Clinical Director

QASM's next surgeons' seminar will be on Friday, 9 November, 2012. *Complex Decision Making in Modern Surgical Practice* will focus on a range of related issues for surgeons. If you would like to attend this seminar please email QASM at [qasmseminar@surgeons.org](mailto:qasmseminar@surgeons.org).



Continuing Professional Development Program – end of triennium update



# Update your CPD Diary

## Finalising your 2012 CPD data

Fellows can complete their 2012 CPD Online Diary at any time, with statements being released in December 2012 to Fellows who meet their CPD requirements.

**Please note that the closing date for submission of 2012 RDFs is 31 January, 2013.** All Fellows are urged to submit their 2012 data promptly to be eligible to receive both their 2012 Statement of Compliance and their 2010-2012 Triennium Certificate.

## How CPD Online works

### ACCESS

- > To access CPD Online, you must be logged in to the College website.
- > Go to My Page.
- > On the right side, in the My CPD Progress area, click on the link to CPD Online Diary.
- > The main view on the page is a summary of your completed CPD activities.

NOTE: If you are currently under Verification, there will be a notice at the top of the page advising the status. This notification will be displayed until the Verification has been either completed or exempted.

### VIEW ACTIVITIES

You can view your CPD activities. Click **View Activities** to take you to the Activities page.

The View Activities page displays a summary of each activity type and how many points you have accrued for each of the three included years. It also shows where you have been exempt.

- A means you have met the requirement.
- A means you have not yet met the requirement.
- An E means you have been exempt.
- A number shows the number of CPD points you have earned.
- If you want to see specific details, click on the link to the activity type.

### ADD ACTIVITIES

- > You can add new activities as you complete them.
- > Click **Add Activity**.

NOTE: you can only add activities for the current CPD year.

From the Category drop down list, select the type of activity you have completed. Once you do, the page will display further fields for you to complete.

NOTE: each activity type will display a different form to complete.

Complete the required information. Any field with a red asterisk \* is mandatory. All forms have the option to attach supporting documents.

### UPLOADED SUPPORTING DOCUMENTS

This is particularly useful if you have been selected for verification and are required to verify the activities and points that you are claiming in your Online Diary.

- > Browse to where you have the file saved on your computer. Select it and click
- > Once you have completed the information, click

### SUBMIT BUTTON

- > The submit button should only be clicked once you have finished your Online Diary. If you want to add an activity and return at a later date to add more activities just click once you have added the activity.
- > At the end of the year, once you have entered all of your CPD activities, you must submit them.
- > To submit your CPD activities, click **Welcome to CPD Online** to go to the Progress Summary page.
- > If you have met all your annual requirements, click

NOTE: this button will only be available to select once you have completed all of the CPD requirements for the year. If you have not yet completed all the requirements, the button will be inactive.

You have not entered sufficient data for compliance.

Please review your entries and resubmit.

If the Submit button is unavailable, please review your records.

- > If the Submit button is available and you have entered all of your activities, you can submit your data. Please note that once you have clicked Submit your data will be locked and you will not be able to enter any further data for that year. Locking of your data will enable your statement to be released.
- > If you accidentally click Submit when your diary is incomplete, contact the CPD Officer to have it unlocked.
- > Once the administrator has printed your statement, you will also be given the functionality to print off your own statements.

### CPD in 2013

As you will be aware, the College is in the process of implementing a new CPD Online Diary in 2013 which will coincide with changes to the CPD program. Further details about these changes will be included in the next edition of Surgical News.

Fellows who wish to discuss any aspect of the CPD Program may contact the Department of Professional Standards on +61 3 9249 1282 or via e-mail at [cpd.college@surgeons.org](mailto:cpd.college@surgeons.org)

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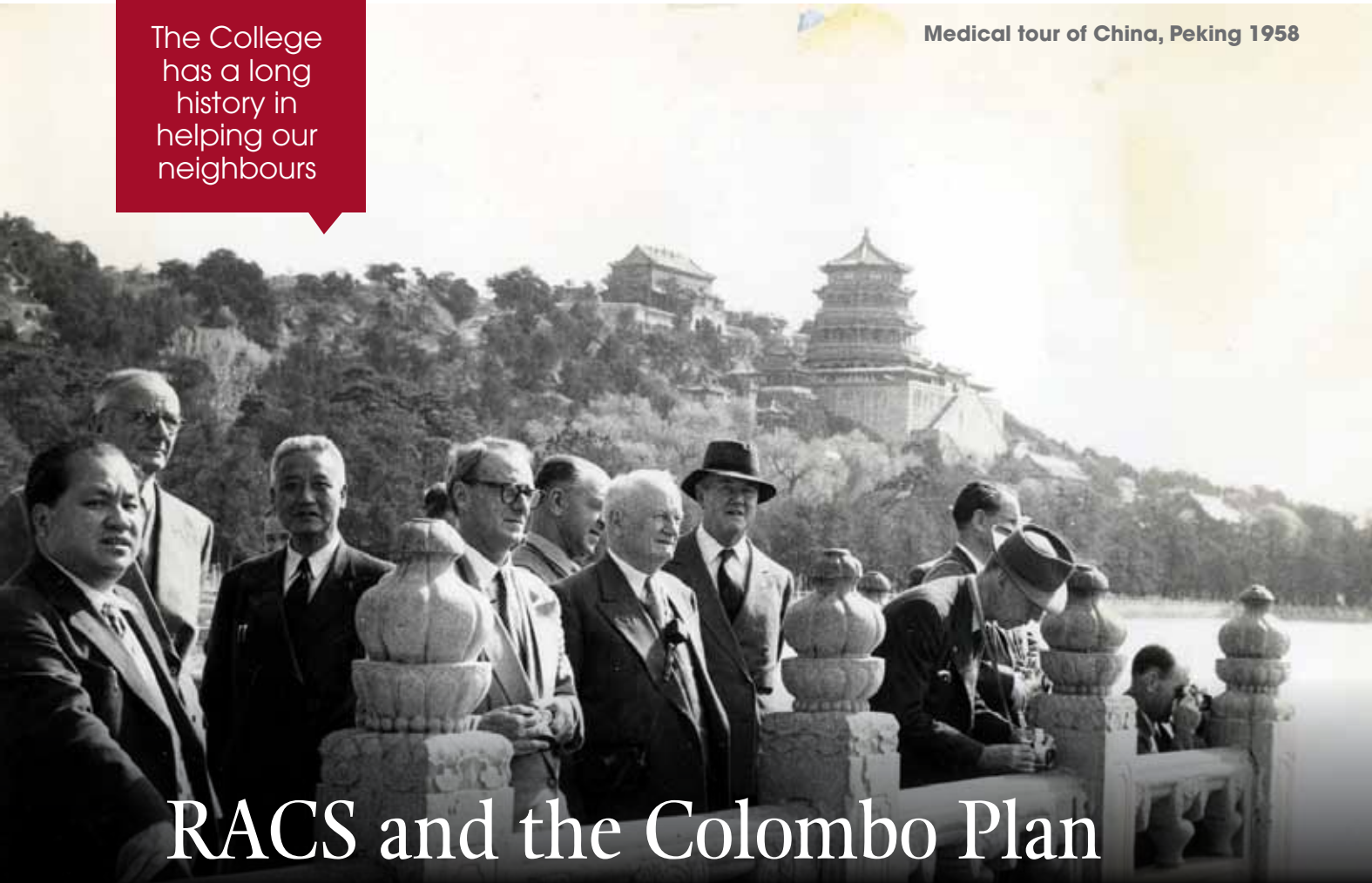
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**From the archives**

The College has a long history in helping our neighbours



Medical tour of China, Peking 1958



Benjamin Rank in India 1954



Douglas Miller at dinner with Dr Yeoh, Singapore 1955



Aris bin Kolop, c1953



Douglas Miller in Thailand 1959

# RACS and the Colombo Plan

In the late 1940s, post-war Australia, shielded by the 'White Australia Policy' had little knowledge of our near neighbours in the countries of South and South East Asia. This was to change primarily due to the efforts of two External Affairs ministers; Percy Spender and his successor, Richard Casey.

In a post-war world rocked by incidents relating to the 'Cold War', a term created by George Orwell in his essay, 'You and the Atomic Bomb', it is interesting that Spender and Casey were far sighted enough to see the value of what was to become the Colombo Plan.

By 1950, Spender, who led the Australian delegation to the British Commonwealth Foreign Ministers meeting in Colombo, Ceylon (modern Sri Lanka), had formulated a plan for an international aid program in South and South East Asia.

A key aspect of the plan was the provision for Asian students to study in Australian tertiary institutions. But, ultimately, its effect was more far reaching and it was to have profound implications for Australia from a cultural, economic and foreign policy perspective.

Developing from the 'Spender' plan,

the Colombo Plan's original membership of seven countries had spiralled to 17 by 1954. R.G. Casey who succeeded Spender as Minister for External Affairs in 1951 was an enthusiastic advocate for the Colombo Plan and through his surgical contacts, involved the College in this new initiative.

By the 1950s, Casey who was later to become an Honorary Fellow of the College, had several indirect associations with surgery. He was married to Maie Ryan, the daughter of Sir Charles Snodgrass 'Plevna' Ryan, known for his surgical exploits in the Russo-Turkish war of 1877/78.

The Caseys were intimates of Daryl and Joan Lindsay. Lindsay had been at the Queen's Hospital, Sidcup with Sir Henry Newland and later, donated Newland's photograph album to the College. When Casey was Treasurer in the Lyons cabinet, he had met Douglas Miller and they appear to have been good friends. In his autobiography *A Surgeon's Story*, Miller mentions his purchase of the Casey's Triumph car and how he was given a 'beautiful cocker spaniel' bred by Maie Casey.

Approached by Richard Casey on behalf of the Commonwealth government in 1954, Benjamin Rank was the first surgeon to participate in the Colombo Plan. Rank was an obvious choice. An advocate for the training of Asian students in Australian Medical schools and post-graduate facilities, he had also operated on Aris bin Kolop, a six-year-old Malay boy with facial disfigurement. In 1953, Aris was flown to Australia by the RAAF and received free treatment at the Royal Melbourne Hospital.

Following Rank's appointment, The Age of November 11, 1954 carried this caption:

*There is a touch of imagination in the decision that Australia should send a distinguished plastic surgeon to Asian Countries to help them in correcting disfigurement and deformity resulting from the diseases with which they are cursed.*

There is a touch of paternalism in this statement, but it also flagged a positive beginning to surgical involvement in Asia. After visiting Indonesia, Malaya, Singapore and India, Rank was able to report to Casey that he had 'performed 39

operations, carried out 75 consultations and given five lectures, all of them on reconstructive rather than destructive surgery'.

Not surprisingly Douglas Miller, who was asked to demonstrate neurosurgery in Singapore, was the next participant in the Colombo Plan. Miller was inspired by the experience. He even found that 'flying was somewhat of an adventure' – and that there was a great deal of interest in brain surgery.

*After the rather difficult removal of a tumour from the spinal cord, Yeoh told me that every surgeon from Singapore and Johore had been in the theatre.*

When he returned to Australia, Miller who was soon to become President, suggested that the College become involved in the training of overseas surgeons for Fellowship. Consequently, in 1956 with approval from Richard Casey, the College sent a team to Singapore to train surgeons for the Primary Fellowship exam.

Douglas Miller went to Asia on several occasions during the 1950s, returning to Singapore, visiting China with a group of

medical specialists, journeying to India, Thailand, Hong Kong and Japan. China was a new experience for him:

*The first sight of China from the windows of the train was like pictures from a book; then there were strange contrasts such as the masked white-clad individuals who dispensed food on the railway stations. It was another world.*

*...I asked my neurosurgical colleague in Peking about head injuries. He gave the astonishing reply, 'We don't have head injuries – our Chairman says we must not.'*

India with its pockets of alcohol prohibition was a more predictable experience. While commenting on the efficiency of hospitals like the Christian Medical Centre in Lahore, Miller laments the lack of 'any alcoholic reviver from the heat and fatigue'. However, he recounts that when he was in Bombay:

*When we got to the party our hostess, Mrs Bharucha asked whether I would like lemon or lime juice. I think I rather despairingly elected lemon and found it strongly fortified with gin. I exclaimed 'what lovely lemons you have' and she whispered, 'Say nothing, there are always spies about.'*

On a more serious note, the Colombo Plan and the College's involvement with it established important links with Asia. With a twist on Commodore Perry's bombastic attempt to open up Japan in the 1860s, Japan's stigmatised for its role in World War II, was slowly reinstated as an acceptable forum for the sharing of ideas.

The Association of Asian and Australian Neurosurgeons with Douglas Miller as its first president and societies such as the Asian Surgical Association routinely involved College representatives in their meetings. Asian patients continued to be sent to Australia for specialised surgery; and training for young Asian surgeons and the opportunity to attain FRACS continued to expand.

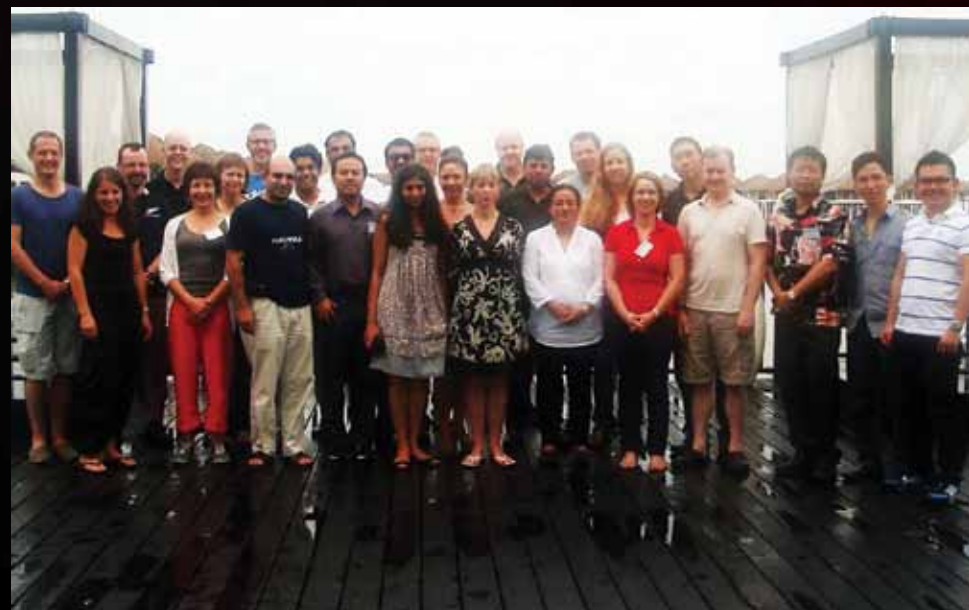
In 2001 a Virtual Colombo Plan, the culmination of Alexander Downer's efforts to revive the 'Casey tradition in Australian Foreign Policy', was launched in Sydney. Its aim was to provide developing countries with access to new technologies – this was another branch for the sapling that had been planted more than 50 years earlier.

**With Elizabeth Milford**



# 2012 Younger Fellows Forum

Experience from Councillors contributed to an interesting and enjoyable 2012 Younger Fellows Forum



The Younger Fellows Forum this year was held at the Golden Palm Tree Resort, just outside of Kuala Lumpur. Thirty five participants, including Younger Fellows and not-so-young Fellows, attended.

Everyone worked hard. We started early, ran late into tea breaks and often into meal times. We had limited pool time but, despite this, the meeting was enjoyed and all Fellows participated actively. The resourceful surgeons made up for the lack of pool time by taking bar time – also by the pool – after dinner.

The value of the meeting was entirely in its contributors. Our guests included: the President-elect, Michael Hollands; the Vice President-elect, Michael Grigg and the Executive Director of Surgical Affairs, John Quinn.

Other guests were Sam Prince, who gave an inspirational talk on how he began with an investment of \$12,000 at the age of 21 and now heads a plate-for-

plate organisation that feeds more than a million people in developing nations worldwide. His other interests include an alternative energy company, as well as an ambitious (but already partly-fulfilled) aim of eradicating scabies in Australia.

John Quinn generated much discussion. Like our Younger Fellows, he was asked to come back for overtime the next morning. Denis King and Michael Grigg brought a wealth of experience and valuable insights in managing administrators and clinicians with different perspectives, but the same goal. Many also came back the next morning, on overtime, to provide a contribution valued by all participants.

The President-elect Michael Hollands, Michael Talbot, Association for Academic Surgery (AAS) visitor Allan Tsung and Steve Leibman (outgoing chair, Younger Fellows Committee) contributed to the Forum further with their angle on balancing surgery,

academia and college commitments.

Our two councillors, Cathy Ferguson and the vice Treasurer-elect, Marianne Vonau, spoke to the topic of what is expected of a surgeon by the public system, as well as what a surgeon needs from the system. Both councillors were key to our successful forum, guiding our recommendations and, above all, being part of the fun.

I stressed out about speakers not turning up – silly, given the responsible guest list I've just mentioned. I then stressed out about whether the people would get into the spirit of the forum and contribute – even sillier, given that most surgeons have opinions we are more than happy to share.

Most of all, I am happy to report that the May 2012 forum was a mixture of fun, positive spirit and a sense of achievement in that we've come up with recommendations: some new, and expected from the topics covered in

the forum; some unexpected, but resulting from the lateral thinking of the younger Fellows within the forum – yet another acknowledgement by the younger Fellows of the resources available within the College and a wish to know more about and engage with the College.

Some of the social highlights included a Master Chef team-building exercise, which appealed to the creative and competitive spirit of the surgeons. Interestingly, different team dynamics were used to come up with a three course meal.

We also enjoyed a beautiful barbecue on the beach, as well as a dance show – an eclectic mix of music that had everyone up on the improvised beach dance floor. On the last night, before we were to write the recommendations, the resort even put on an amazing lightning and sound show typical of the tropics.

I particularly enjoyed having John Morrow and Andrew McCormack at our forum. Their sense of fun guarantees an even better forum in 2013. Good luck guys for 2013!

*Secma Bagia  
Younger Fellows Forum Convener 2012*

From Left: Younger Fellow attendees at the Forum outside of Kuala Lumpur. President Mike Hollands taking part in the team building cooking class; and Cathy Ferguson practising her skills.



## Younger Fellows FORUM

3 – 5 May 2013,  
Auckland,  
New Zealand

All Younger Fellows are invited to nominate for the 2013 Younger Fellows Forum. The Forum focuses on future challenges for surgical practice and the changing face of health care delivery. The core objective is to provide an environment that encourages Younger Fellows to address challenging issues relevant to personal, professional and collegiate life through discussion and debate. It is a great opportunity to share ideas and experiences. In 2013 discussion will focus on supporting underprivileged patients through leadership and health advocacy.

Attendance at the Forum and airport transfers to the venue are covered by the College.

*Applications are open from  
1 September to  
8 December 2012.*

**Contact the Professional  
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# 2012 Australasian Students' Surgical Conference

The enthusiasm of students was demonstrated in the successful inaugural Australasian Students' Surgical Conference

On June 30, 2012, College President, Professor Michael Hollands, and the Associate Dean of the UNSW Faculty of Medicine, Professor Philip Jones, welcomed over 500 delegates from all the 22 medical school across Australia and New Zealand, JMOs, and RMOs, to the inaugural Australasian Students' Surgical Conference (ASSC), Sydney.

The ASSC was presented by the UNSW Surgical Society at the Sir John Clancy Auditorium and Matthews Pavilions, was fully endorsed and supported by the UNSW Faculty of Medicine, and was developed with the active involvement of the College; the ASSC Staff Convenor was Mr Phil Truskett, Chair, Board of Surgical Education and Training.

The theme was "Australasian Students' Surgical Horizons" and it aimed to provide a unique insight into the world of surgery so the delegates would learn, enjoy, and be inspired.

## Keynote Addresses

College President, Professor Michael Hollands highlighted the future expectations and pathways for the upcoming generation of surgical candidates, the historical and ensuing role of the College in the surgical and the wider community, and the developments that lay ahead for all the stakeholders in the surgical arena.

Feedback from the delegates showed that they were excited to hear about the College's humanitarian International Development Program, and were heartened to learn of the efforts the College is making to provide them with training positions and the community with excellent future surgeons.

UNSW Professor of Surgery, Professor Phil Crowe, discussed "why every surgeon



should be an academic surgeon" and conveyed that, "the best doctors treat patients, do research and train tomorrow's health care providers"; being an academic surgeon facilitates the marriage of these competing duties.

Moreover the majority of surgeons, are in some way 'academic surgeons', and belong to the collective of surgeons who are always learning, and discovering, to improve the healthcare of their patients.

## Surgical Specialty Speeches

With the support of the ASSC Staff Convenor, Mr Phil Truskett (General Surgery), and the College President, the ASSC was fortunate to have leading and inspirational surgeons from all of the nine surgical specialties: Mr Michael McGlynn (Plastic Surgery), Dr Yishay Orr (Cardiothoracic Surgery), Professor John Harris (Vascular Surgery), Professor Andrew Brooks (Urological Surgery), Mr Guy Henry (Paediatric Surgery), Professor Ian Harris (Orthopaedic Surgery), Professor Kelvin Kong (Otolaryngology, Head and Neck Surgery) and Professor

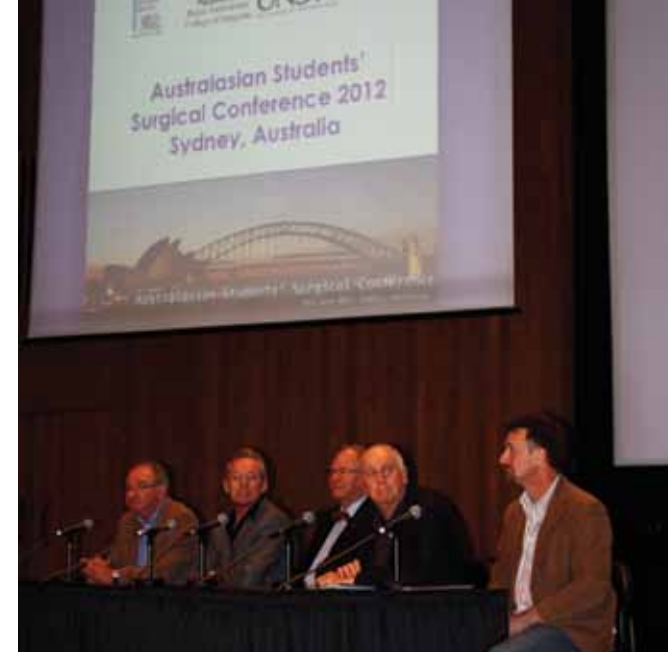
Charlie Teo (Neurosurgery).

The delegates found it educational to learn of the enormous variety and breadth of work available in the discipline of surgery, the nine competencies required of a College Surgical Trainee, and the upcoming restructuring of the entrance requirements for SET.

## Student Surgical Research Presentations

From a competitive field, the Consultant Panel, which partly consisted of Mr Phil Truskett, Professor Michael Hollands, Professor Phil Crowe, and Mr Shing Wong, chose nine abstracts for podium presentation and 14 for poster presentation (see photos and program), and the overall winner of the best presentation at the ASSC was Kiryu Yap (UMELB).

He was awarded a certificate and \$300 prize that was endorsed by the President of the Surgical Research Society of Australasia, Professor John McCall. All presented abstracts were also considered for publication in a special supplement publication in the Australian Medical Student Journal.



## Surgical Workshops – Academia, Anatomy and Skills

In many respects the delegates found the highlight of the day to be the variety of surgical workshops which they were exposed to. From Mr Richard Hanney's overview of the College/AAS Developing a Career as an Academic Surgeon course, Dr Dzung Vu's and Dr Joga Choganti's perspectives on what comprised essential surgical anatomy, Mr Sri Darshn's surgical suturing skills workshop where students practiced on pork bellies and synthetic skin models, Mr Anthony Chambers' chest drains workshop where students practiced insertion on pork rib cages, a bone school workshop where students practised using lag screws and compression plates, and Mr Paul Bannon's aortic valve replacement workshop where students practised on bovine hearts.

Indeed the attendees of Mr Paul Bannon's cardiothoracic workshop scored it a flawless a 10/10 with respect to how much they learnt, enjoyed and were inspired by it.

In future incarnations of the ASSC, we look forward to providing more skills workshops to cover all the nine surgical specialties, and with the support from the College Section of Academic Surgery, Professor John Windsor, a more interactive academic surgery workshop too.

## Outreach, Feedback, and Future

The ASSC proudly supported UNSW ASPIRE (Student Equity and Disabilities Unit organisation), UNSW Nura Gili, and the LIME (Leaders in Indigenous Medical Education) Network by offering seats to 32 high school students from these programs. It was also an opportunity to receive students' perspectives on a variety of surgical issues, and this data is being collated and analysed and will be submitted for review, publication and presentation.

Furthermore with the support of the College and the New Zealand student body, developments are underway for the 2013 ASSC to be held in conjunction with the 2013 College Annual Scientific Congress, in Auckland, and the 2014 ASSC will be presented by the Victorian medical student body.

*Geoffrey Lee, ASSC Founder & Convenor with Phil Truskett*

All proceeds from the non-profit 2012 ASSC have been donated to the College Foundation in support of the International Development Program. [www.assc2012.com](http://www.assc2012.com) [www.youtube.com/assc2012](http://www.youtube.com/assc2012)



## Grant applications open

Applications for the Royal Australasian College of Surgeons \$10,000 Convention Travel Grants for 2013 are now open. As an initiative of Perth Convention Bureau (PCB) under its Aspire Program, the grants are awarded to two RACS Fellows and Trainees to assist in their professional development through attendance at a relevant international conference.

The 2012 Western Australian recipients were Professor Christobel Saunders, a professor in Surgical Oncology at the University of Western Australia, and Dr Peter D'Alessandro, a specialist orthopaedic registrar at Royal Perth Hospital.

For more information and to obtain the application guidelines, email Dr John Quinn FRACS, FACS, Executive Director for Surgical Affairs at [John.Quinn@surgeons.org](mailto:John.Quinn@surgeons.org)

## Erratum

A single one-liner apologising for my mis-identification of the First President of the RACS, Sir George Adlington Syme, is not sufficient.

To summarise, Sir George Adlington Syme was the founder and first President of the college with honorary appointments at the Melbourne Hospital, St Vincent's and Queen Victoria Hospital for Women. He was on the surgical staff of the first AGH and was present at Gallipoli, and with Hamilton Russell and Hugh Devine signed the foundation letter of 19 November, 1925. It should be stated also that in 1926 he was given authority to proceed with setting up constitutional machinery for the organisation, and at the Australasian Medical Congress in Dunedin in February 1927, he was unanimously elected President of the RACS, dying in office in April, 1929. His widow left a donation for the subsequent Syme Oration, the first being delivered in Melbourne at Wilson Hall, University of Melbourne in February 1932, with the presentation of the Great Mace. This oration is now delivered in conjunction with the convocation at the Annual Scientific Congress. I must admit not having attended many such orations, my knowledge was wanting, but as a bonus look what we have all found out.

Reference: Royal Australasian College of Surgeons - Past Office Bearers.

*Felix C Behan  
Victorian Fellow*

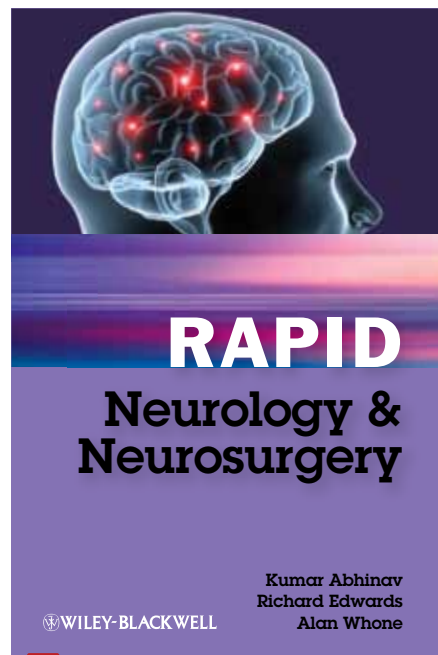


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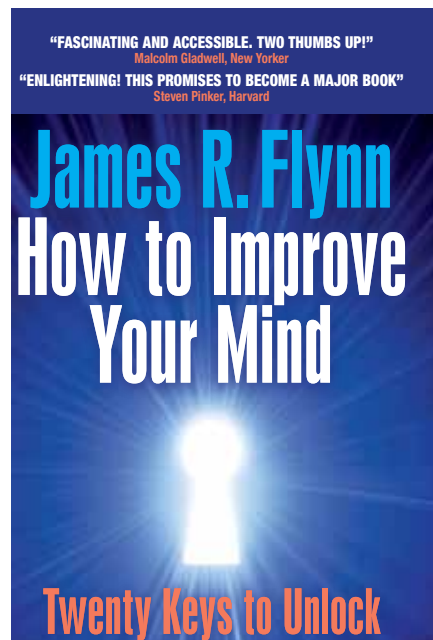
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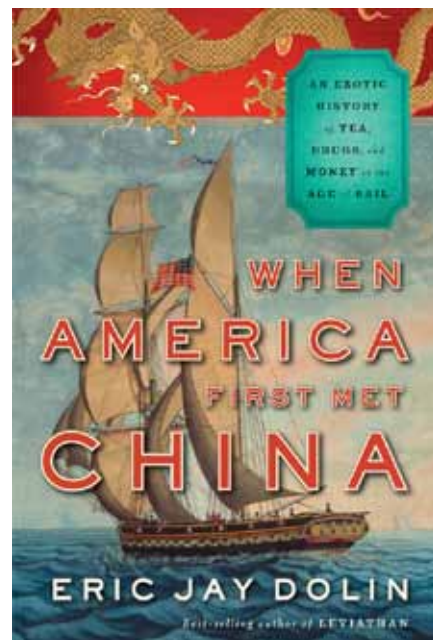
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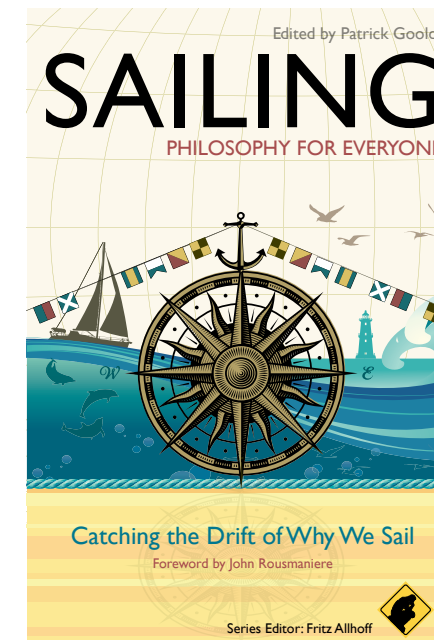
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Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the Call for Abstracts, the Provisional Program and on the Abstract submission site. **ABSTRACTS SUBMITTED AFTER THE CLOSING DATE WILL NOT BE CONSIDERED.**
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Methodology, Results, Conclusion.
4. Non-scientific papers, eg. Education, History, Military, Medico-Legal, may understandably depart from the above.
5. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1750 characters and spaces (approximately 250 words). In MS Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT appear in the abstract book.
6. Abbreviations should be used only for common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
7. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be available in the Congress Provisional Program and in correspondence sent to all successful authors.
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The submitting author of an abstract will ALWAYS receive email confirmation of receipt of the abstract into the submission site. If you do not receive a confirmation email within 24 hours it may mean the abstract has not been received. In this circumstance, please email Binh Nguyen at the Royal Australasian College of Surgeons to determine why a confirmation email has not been received. (binh.nguyen@surgeons.org).

### IMPORTANT INFORMATION

TO SUBMIT AN ABSTRACT GO TO 'asc.surgeons.org' AND CLICK ON 'ABSTRACT SUBMISSION'.

THE CLOSING DATE FOR ALL SCIENTIFIC PAPER ABSTRACT SUBMISSION IS FRIDAY 25 JANUARY 2013.

PLEASE NOTE THAT PAPER OR FACSIMILE COPIES WILL NOT BE ACCEPTED. NOR WILL ABSTRACTS BE SUBMITTED BY COLLEGE STAFF ON BEHALF OF AUTHORS.

If there are any difficulties regarding this process please contact Binh Nguyen, for assistance on +61 3 9249 1279 or email (binh.nguyen@surgeons.org).

### SCIENTIFIC POSTERS

All posters will be presented electronically during the Congress and will be available for viewing on computer screens in the industry exhibition. Posters will be placed on the Virtual Congress in addition to the abstract.

### IMPORTANT DATES

Abstract Submission opens	October 2012
Closure of Abstracts	25 January 2013
Closure of Early Registration	12 March 2013

## RACS ASC 2013 PROGRAM OVERVIEW (INDICATIVE ONLY)

	Monday 6 May	Tuesday 7 May	Wednesday 8 May	Thursday 9 May	Friday 10 May	
<b>Breakfast session</b> 7.00am – 8.20am		Masterclasses	Masterclasses	Masterclasses	Masterclasses	
<b>Session 1</b> 8.30am – 10.00am	Pre-Congress Workshop Program	Plenary	Scientific Sessions	Scientific Sessions	Scientific Sessions	
10.00am – 10.30am		Morning Tea	Morning Tea	Morning Tea	Morning Tea	
<b>Session 2</b> 10.30am – 12 noon		Scientific Sessions	Plenary	Plenary	Plenary	
12 noon – 12.30pm		Keynote Lectures	Keynote Lectures	President's Lecture	Keynote Lectures	
12.30pm – 1.30pm		Lunch	Lunch	Lunch	Lunch	
1.30pm – 2.00pm		Keynote Lectures and Named Lectures	Keynote Lectures and Named Lectures	Keynote Lectures and Named Lectures	Keynote Lectures and Named Lectures	
<b>Session 3</b> 2.00pm – 3.30pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions	
3.30pm – 4.00pm		Afternoon Tea	Afternoon Tea	Afternoon Tea	Afternoon Tea	
<b>Session 4</b> 4.00pm – 5.30pm			Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
4.30pm – 6.00pm		Convocation Ceremony				
6.00pm – 7.00pm	Welcome Cocktail Reception					
7.00pm – 11.00pm	Sectional Dinners	Sectional Dinners and Younger Fellows & Trainees Dinner	Sectional Dinners	Congress Dinner		

### RESEARCH PAPER SPECIALTIES

Authors of research papers and posters are invited to submit abstracts for consideration and inclusion in the Scientific Program in the following areas:

Bariatric Surgery	Pain Medicine
Breast Surgery	Quality Assurance & Audit in Surgical Practice
Cardiothoracic Surgery	Rural Surgery
Colorectal Surgery	Senior Surgeons Group
Endocrine Surgery	Surgical Education
General Surgery	Surgical History
Head & Neck Surgery	Surgical Oncology
HPB & Upper GI Surgery	Trainees Association
Indigenous Health	Transplantation Surgery
International Forum	Trauma Surgery
Medico-Legal	Vascular Surgery
Military Surgery	Women in Surgery
Paediatric Surgery	

### ASC EXECUTIVE

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Scientific Convener	Prof Andrew G Hill
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For further information contact:  
[asc.registration@surgeons.org](mailto:asc.registration@surgeons.org)





### SCIENTIFIC CONVENERS

Bariatric Surgery	Mr Grant Beban
Breast Surgery	Mr David Moss
Cardiothoracic Surgery	Mr Indran Ramanathan
Colorectal Surgery	Dr Mattias Soop
Endocrine Surgery	Mr Win Meyer-Rochow
General Surgery	Mr Patrick Alley
Head & Neck Surgery	Mr Rajan Patel
HPB & Upper GI surgery	Mr Jonathan Koea
Indigenous Health	Mr Patrick Alley Mr Jonathan Koea
International Forum	Dr Kiki Maoate
Medico-Legal	Mr Haemish Crawford
Military Surgery	Mr Ross Blair
Paediatric Surgery	Dr Neil Price
Pain Medicine	Mr James Bartley
Quality Assurance & Audit in Surgical Practice	Dr Catherine Ferguson
Rural Surgery	Mr John Kyngdon
Senior Surgeons	Mr Patrick Alley
Surgical Education	Mr Richard Perry
Surgical History	Prof John Collins
Surgical Oncology	Mr Jonathan Koea
Trainees Association	Dr Deborah Wright
Transplantation Surgery	Mr Adam Bartlett
Trauma Surgery	Dr James Hamill
Vascular Surgery	Mr Andrew A Hill
Women in Surgery	Dr Eva Juhasz

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Convener & Visitor list correct as at time of printing (Aug 2012)

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Keep abreast of program developments on the conference website: [asc.surgeons.org](http://asc.surgeons.org)



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