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SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:8 September 2009

International Development, page 22:
David Freedman is back from working in Samoa.

THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

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ACCOMMODATION FOR VISITING SCHOLARS

– WE NEED YOUR HELP!

Through the RACS International Scholarships Program, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit one or more Australian and New Zealand hospitals. These visits allow the scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to 12 months.

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

If you would like to help or require further information, please contact the International Scholarships Secretariat on the following details:

International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 – 290 Spring Street
East Melbourne Victoria 3002
Australia

T: + 61 3 9249 1211
F: + 61 3 9276 7431
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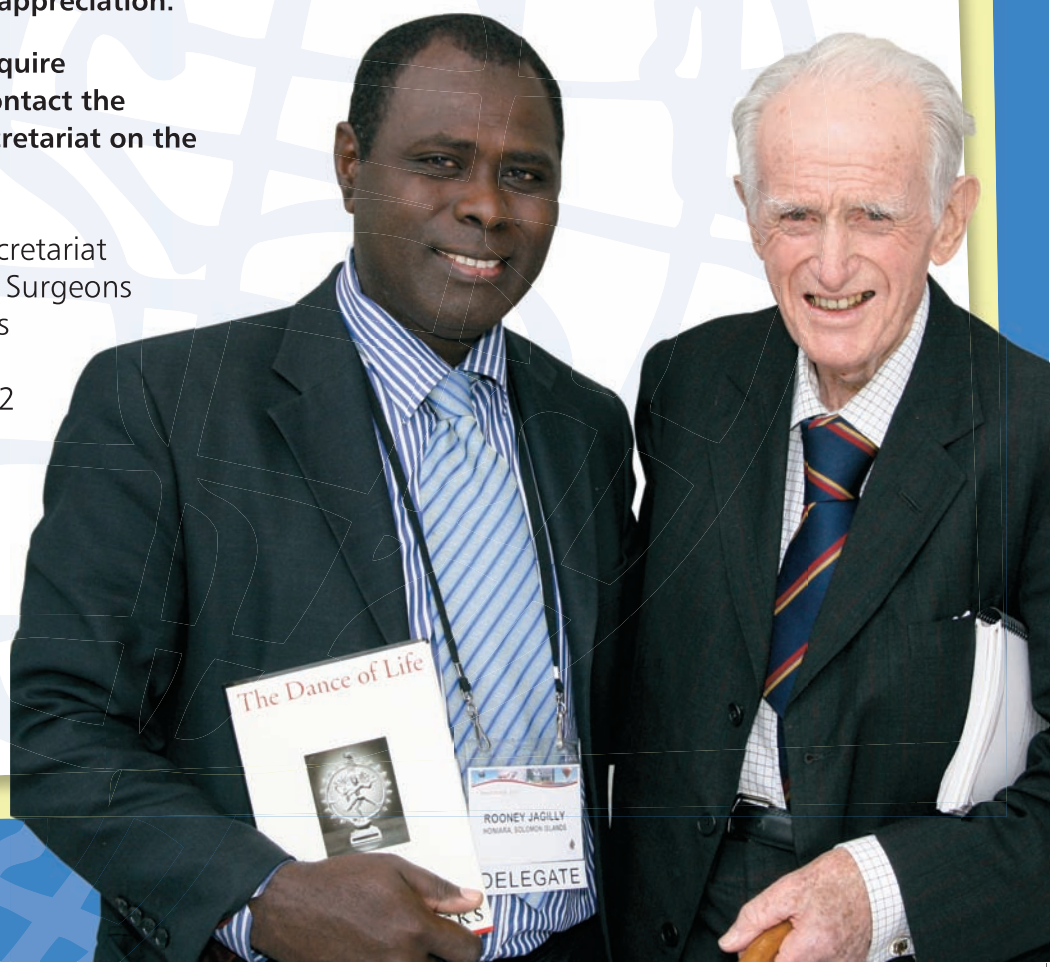
@surgeons.org



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Go Boldly Prime Minister

But the issue is still beds

Ian Gough
President

The Prime Minister released the much awaited National Health and Hospitals Reform Commission (NHHRC) report in late July. The Chair of the Commission exhorted the Prime Minister to go boldly. And so he should, because the system we currently work within may have much of which to be proud, but it is also bursting at its seams, becoming more hostile and uncaring and is manifestly unprepared to cope with the pressures of our rapidly ageing population.

The breadth and enormity of vision of the report is both its strength and its weakness. With 123 individual recommendations it will be important that we focus on the ones that will maximally improve the quality of surgical services to the communities we serve.

There is no doubt that we are in an epidemic of obesity with a substantial sub-population now at risk of developing chronic diseases such as diabetes, heart disease and cancer and chronic health problems taking up nearly 70 per cent of total health funding. However the key areas that are arguably more focused on our surgical practices include the number of avoidable diagnostic tests, medicines and procedures, the number of avoidable adverse events and preventable hospital admissions if timely and adequate non-hospital health care was available.

Streamlined funding

The College continues to stand by its public statements that funding for health care must be streamlined. To have multiple layers of government doing various components based on historical necessity and political interest is a recipe for the mess that we currently find ourselves in. If one governmental source of funding is not possible then the overlap of responsibilities must be removed and the bureaucracy trimmed. The commission's report seems to partially address this with consolidation under Commonwealth funding of ambulances, primary health care, family and child health, drug and alcohol treatment, dental care and aged care.

It will be interesting to see what changes occur if the Commonwealth does pay for 100 per cent of the efficient cost of outpatient services and 40 per cent of the efficient cost of public hospital acute care (potentially rising to 100 per cent). These changes appear to dramatically improve the funding models that currently produce distortions in our system. It is quite difficult to comment on Medicare Select as the detail will need to be further developed and at the moment it appears unclear how this funding entity would take over administering Medicare functions allowing people to shop between health plans and private funds.

Not enough beds

Returning to the issue that is currently killing our hospital sector – not enough beds. There is growing recognition that our per capita availability of hospital beds is one of the lowest amongst OECD nations. This directly leads to public hospitals persistently being at occupancies of 95 per cent or more, endless queues in emergency departments and elective surgery being delayed or cancelled. It is one of the prime reasons why surgeons now perform 64 per cent of elective surgery in the private sector.

The private sector is more predictable for the patient, their family as well as the hospital, surgeon and other staff. The NHHRC report highlighted that emergency department beds should always be available. This requires an absolute increase in beds of the aged care sector and the acute sector.

Importantly another recommendation that the College had been highlighting is that elective and emergency services in public hospitals should be separated. More beds in facilities dedicated to planned procedures should be a priority.

The College will continue to highlight to all parties that separating elective from emergency services is the most effective way of gaining efficiencies in our bed stock. It provides more certainty for the patient, family and staff. It takes substantial pressure off the other hospital beds and can be adapted not only for high quality clinical care but also outstanding training opportunities.

Other key recommendations of the report included a different approach to waiting list data. The NHHRC has recommended that high priority elective surgery would be focused on cardiac surgery and cancer surgery – these patients would need to be treated within one month and other priority patients within three months.

e-Health

One of the most tantalising recommendations spoke to the issue of electronic records. Many would regard this more as a political holy grail, rather than a workable solution in our own lifetime. The model being proposed by the NHHRC highlighted a record carried by the patient themselves.

Clinicians, having spent decades working with imaging companies to provide images in formats that can be read in all consulting rooms, would view the timelines of introduction by 2012 as ambitious if not foolhardy. However, the NHHRC appears to commit $1.8 billion over five years to try and have this achieved.

So the report is bold and its breadth is all encompassing. I have not dealt with issues of Mental Health, Denticare or Indigenous Health. All incredibly important, all should be addressed. However, while funding and efficiencies are obviously important, the Prime Minister must commit to more hospital beds. A lot more beds.

The Australian Defence Force

A career in the Australian Defence Force (ADF) offers unique opportunities for those Trainees up to a challenge

Jim Iliopoulos
RACSTA, Vascular Representative

Undertaking surgical training is a busy and relatively intense period. However, a career in the Australian Defence Force (ADF) offers unique opportunities for those Trainees up to a challenge. Many a time we have glimpsed familiar faces on the news of our colleagues serving our nation on deployment, working in austere and remote locations such as Rwanda, Somalia, Bougainville, East Timor, Solomon Islands, Iraq and Afghanistan.

In the course of their civilian employment, there is occasion where Trainees may consider they are working outside of their comfort zone. None more so, than serving in the ADF whether conducting comprehensive preventive medical examinations, providing trauma care in the field setting or at sea. Medical Officers undertake Initial Entry Officer Training at the Royal Australian Naval College (Navy); Specialist Service Officer Course at the Royal Military College (Army); and Initial Officer Course at the Officer's Training School (Air Force), where specialist officers learn about service etiquette, history, and service specific requirements e.g. navigation, field craft and survival, and weapon handling for Military Officers.

Further professional development courses are available and include logistic and staff officer courses. There is some overlap with professional courses that the Trainee would expect to undertake at some stage during their training, and opportunity may exist for sponsorship for attendance on courses like the Early Management of Severe Trauma Course and the Definitive Surgical Trauma Care Course, which includes the Military Module. There may be opportunity in the current climate with a high operational tempo to put some of this training into practice on operational deployments. Prior to attainment of the Fellow of the Royal Australasian College of Surgeons (FRACS), Trainees may deploy as General Duties Medical Officers. This may be to a humanitarian, peacemaking, peacekeeping or warlike setting.

The media and society focus a great deal these days on healthy lifestyles. One is often drawn to advertisements and reality television programs of fitness instructors putting participants through their paces in order that they may gain a level of fitness consistent with healthy living. Physical fitness is an important element of service within the ADF. The tri-service Physical Training Instructors take great pride in serving in this capacity. Of course, it provides a wonderful incentive for those Trainees that may desire some added encouragement to balance their studies with physical activity.

Numerous employment opportunities exist within the ADF. So too are the extensive professional mentoring and social networking opportunities. The service is privileged to have amongst its members notable FRACS. This is across most specialties including general, vascular, cardiothoracic, orthopaedic, and neurosurgery. We currently have Trainees posted to a wide variety of units across the ADF. In the Navy this may include working on a naval base or on board a ship, such as the HMAS Kanimbla or HMAS Manoora with the Primary Casualty Reception Facility. For the Army these include, though are not limited to, the Health Support Battalions (our hospitals), Combat Service Support Battalions, Arms Corps units, and within the Special Forces. A posting in the Air Force may include the Combat Support Hospital or with an Aero-Medical Evacuation Team.

The new Surgical Safety Checklist

Fellows will recognise the good sense behind this initiative

Ian Dickinson
Vice President

Left: Ian Dickinson, the Hon Nicola Roxon & Cheryl Winter (President of the Australian College of Operating Room Nurses) Right: Ian Civil, the Hon Tony Ryall, Minister of Health & Alan Merry from Australian & New Zealand College of Anaesthetists

The College was pleased to host the official launch of the new Surgical Safety Checklist at Parliament House, Canberra on the evening of 19 August. The Federal Health Minister, the Hon. Nicola Roxon MP launched the checklist before a gathering of Senators, Members of Parliament and invited guests. The event was well attended by representatives of the specialist medical colleges and health departments involved in the development of the checklist and in next month's edition there will be coverage of the New Zealand launch, 27 August.

Fellows will be aware that the checklist is an important initiative aimed at reducing mortality rates and the incidence of surgical complications in Australian and New Zealand operating theatres.

It is based on a prototype developed by the World Health Organisation (WHO) and trialled at eight hospitals around the world representing a variety of economic circumstances and a diversity of patients. Results of the trial were published earlier this year in The New England Journal of Medicine. Data was collected on 3,733 non-cardiac surgical cases prior to the introduction of the checklist and on 3,955 non-cardiac cases subsequent to its introduction.

As one of the hospitals involved in the trial was the Auckland City Hospital, Fellows of our College participated in the study.

The study found that the rate of death was 1.5 per cent before the checklist was introduced and fell to 0.8 per cent after its introduction. Inpatient complications occurred in 11 per cent of cases prior to using the checklist, and in seven per cent of cases after its introduction.

The checklist launched by the Minister was a refinement of the WHO prototype, designed to meet Australian and New Zealand clinical conditions. It was developed by our College, working closely with other specialist medical colleges, the Australian College of Operating Room Nurses, the Australian Commission on Safety and Quality in Health Care, and experts in hospital care from the federal and state health departments.

It is used at three crucial points of a surgical procedure: immediately before the administration of anaesthesia, before the first incision, and before the patient is taken from the operating theatre. Much like a pilot and the team in the cockpit of an aircraft, the surgeons and theatre staff work through the checklist together, ensuring identifiable preventable errors are not made.

It is to be hoped that Fellows will recognise the great good sense behind this initiative and respond accordingly. I'm sure we would all look askance at an aircraft flight crew that decided they were too experienced or too busy to bother with their pre-flight checklist.

As was noted at the launch, use of the checklist involves just a few minutes and no extra cost to patients or hospitals. In fact, by potentially reducing complications, this initiative may well save money. More importantly, of course, it will save lives.

That is why the College will now undertake a sustained campaign to encourage its use in every hospital. A comprehensive and timely roll-out of the list will require the cooperation of state and territory health departments. Therefore the College will lobby for this matter to be considered as part of the next meeting of the nation's Health Ministers, scheduled for 13 November. If we are successful, we would anticipate implementation being underway by February next year. We aim to have the checklist fully implemented by 1 July 2010. Of course, hospitals able to introduce the checklist sooner are strongly encouraged to do so.

While the primary focus of the evening of 19 August was the checklist, Councillors took the opportunity to discuss other issues of importance with parliamentarians. These included the recently released report of the National Health and Hospitals Reform Commission, elective surgery waiting lists, the National Registration and Accreditation Scheme, and the cessation of federal funding to the College's Rural Surgical Training Program.

It was an important part of the College's ongoing effort to raise its profile and to play a more proactive role in what might be termed the politics of health.

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Auditing the Audit

The Victorian Audit of Surgical Mortality has established guidelines that are provided to assesors

Colin Russell
Clinical Director

At the outset, the Victorian Audit of Surgical Mortality (VASM) established a set of "Guidelines for First and Second line Assessors". These are provided to all assessors to guide the review process. The document acknowledges that "There is a degree of subjectivity in the assessment process. To enhance the objectivity of the outcome, VASM and the Australian and New Zealand Audit of Surgical Mortality (ANZASM) has specified a range of outcomes". The range of outcomes specified are the standard definitions used by ANZASM. These 'end points', listed in an increasing scale of criticism, are 'no issues of care perceived', 'area of consideration', 'area of concern' and 'adverse event'. Another important 'end point' is the perceived need for a second line assessment.

An important test of validity of such an audit system is the reproducibility of 'end points' among observers. For this reason we decided to conduct a small audit of reproducibility of the outcomes obtained from a random selection of first line assessments. The objective was to examine the agreement among two independent assessors (initial assessor vs validation assessor) performing first line assessments on the same case. Sixteen cases, representing 10 per cent of cases that had completed first line assessment, were randomly selected. These cases spanned the subspecialty range (Orthopaedics, Vascular, etc).

Right is a summary of the results, the full results can be viewed at
http://www.surgeons.org/Content/NavigationMenu/Research/Audit/VictorianAuditofSurgicalMortality/default.htm

Identification of areas of consideration, concern or adverse event

Most significantly there was unanimous agreement between initial and validation assessors as to the perception of adverse events having occurred. There were differences in opinion in regard to the application of the end points of 'area of consideration' and 'area of concern'. In all of these instances the relevant issues had been identified by the initial assessor but the choice of end point representing the degree of criticism provided to the treating surgeon differed.

Other areas of disagreement

In addition to the major end points above we looked at concordance in the other fields in the first line assessment forms. There were small differences in a number of fields but again these reflect minor differences of opinion among surgeons rather than errors of commission.

There were however major differences in opinion as to the appropriateness of critical care support provided to this patient sample. A closer look at these issues suggests a lack of clarity in the responses by the treating surgeon was a factor. The manner in which the question in the case record form is structured may contribute to this lack of clarity.

More detail is available on the website:
www.surgeons.org/Content/NavigationMenu/Research/Audit/VictorianAuditofSurgicalMortality/default.htm

Conclusion

This validation audit was undertaken to give some perspective on intra-assessor variation among surgeons reviewing cases reported to VASM. The numbers are small but the outcome must reassure us that the assessment process is generally functioning appropriately. The assessment process itself involves some degree of subjectivity, so 100 per cent agreement between observers would not be expected.

We will repeat the study looking at the agreement among independent assessors (initial assessor vs. validation assessor) performing second line assessments on the same case.
For further information +61 3 9249 1128 or email: vasm@surgeons.org.

Claudia Retegan, Project Manager

RESULTS

Perceived need for second line assessment.

Speciality	Initial Assessment n (%)	Validation Assessment n (%)
Cardiothoracic	0/3	2/3 (67%)
General Surgery	0/4	1/4 (25%)
Neurosurgery	0/1	0/0 (0%)
Orthopaedics	0/3	0/3 (0%)
Plastic	0/1	0/1 (0%)
Urology	0/2	0/2 (0%)
Vascular	0/2	0/2 (0%)
Total	**0/16**	**3/16 (19%)**

The table above indicates the agreement among assessors by specialty. The case selection process only audited cases that had been perceived not to require second line assessment. There was disagreement on the need for a second line assessment in 19 per cent of this sample. In each of these three cases the initial assessor had identified the relevant clinical issues but felt a second line review would not have been beneficial.

What are the projects of the College?

The Projects of the College are complicated, difficult and mysterious

I.M.A Newfellow

This month I am going to tackle the hardest of topics. I started writing this article 12 months ago but I left it. Mrs. Newfellow knows this weakness (or one of the many that I have). Over many years of procrastination, delays and missed deadlines, I have found that if something is too hard, too uncomfortable of too whatever, the best thing to do is to do nothing. Ostriches do this even better and positively ignore the problem. Often the pressing need for the thing will pass or someone else will get so annoyed that they will do it. It works – try it! But do not try this at home regarding things that Mrs. Newfellow, or her sisters, have an interest in.

The Projects of the College are complicated, difficult and mysterious, or as a famous man (no, not me) once said, "It is a riddle, wrapped in a mystery, inside an enigma; but perhaps there is a key." But then he was talking about Russia and although he said there is a key I am not sure that the Projects have a key.

I learnt at last Council meeting that there are two types of projects managed by the College. There are those that we do on behalf of other bodies and those that we do for ourselves.

An example of "others" would be the projects that we do on behalf of AusAid. An example would be the Timor Leste Project. An approximate count reveals that there are about 30 such projects at the present time with a total value over the life of the projects of $47 million.

What do I mean by "the life of the project?" Some projects may last one or three years and so the funding appears in several accounting years with the project appearing to make a large "profit" in one year and a "loss" in the next year, depending on activity and timing of the payment of costs. The important bottom line is that by the end of the project it must have covered all costs. I have emphasized "all" as there are costs other than the costs of sending people to East Timor and other places. There are the costs of administering the project. Someone has to make the plane bookings, coordinate with personnel overseas, lodge accounts and pay the bills. These costs must also be covered. (Oddly enough Mrs. Newfellow uses the same words – "These costs must be covered" – when we talk about my golf membership and the new spinnaker for the boat).

Then there are the projects that we do in which we have an interest which may be funded in part by an outside body. An example would be the Audits of Surgical Mortality. The funding for these comes largely from the state governments, but not entirely. The College will subsidise this by $45,000 this year. This is a lot of money but works out to $10 per active Fellow per year. The Council decided that this was an expenditure that was warranted in view of the benefits. If we look however at the projected costs of the audit to the end of the projects the prediction is for no costs to the College. So essentially we are providing some seeding funding to get it up and running.

"It is a riddle, wrapped in a mystery, inside an enigma; but perhaps there is a key."

I said that I had started writing this article a year ago and did my usual "ostrich" act. Well there is another such article in the wings – an article on ASERNIP-s. It has taken me ages to even work out the meaning of the acronym, let alone its functions. After conquering Projects I felt that there was a run afoot and I should do ASERNIP-s next month (I know you can hardly wait) but then the ostrich in me is taking over so don't wait too eagerly.

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Bi-National Colorectal Cancer Audit

CSSANZ members are encouraged to submit questions for consideration for the audit

Julian Smith
Chair, Research, Audit & Academic Surgery

The Bi-National Colorectal Cancer Audit (BCCA) has been established through a continued collaboration between the Colorectal Surgical Society of Australia and New Zealand (CSSANZ), the Research, Audit & Academic Surgery Division (RAAS) of the College and the BioGrid Australia. The aim is to create a large dataset containing Australian and New Zealand data for research and quality improvement purposes. This data will be used to advance knowledge and understanding of the optimum treatment for colorectal cancer and help ensure best practice.

Across Australia and New Zealand, there are a number of existing colorectal cancer databases which can potentially be integrated into the BCCA. This would minimise duplication of efforts and provide a source of comprehensive colorectal cancer data, along with existing projects and other new initiatives to establish further colorectal cancer data collection activities.

There are approximately 3000 episodes within the database. The number of contributions to the audit is increasing, and will continue to do so with the expected inclusion of retrospective data housed at a number of sites across Australia and data from New Zealand pending ethics approval.

Surgeons can enter data by sending paper forms with the minimum dataset (MDS) to the BCCA project team housed at the College. In Victoria and other regions episodes are entered onto the Australian Comprehensive Cancer and Research Database (ACCORD) at the local institution and linked into the BioGrid Australia data repository. With the anticipated development of web-based data entry, there will be a number of ways to contribute data to the audit:

- Data is entered online.
- Paper forms are completed and sent to the BCCA project team for data entry.
- Data is entered onto the Institution version ACCORD linked to BioGrid Australia.

Data collection can occur immediately; however, data entry can only occur once ethics approval has been secured. Ethics applications are made in any number of ways. The National Health and Medical Research Council (NHMRC) has now released version 2.0 of the National Ethics Application Form (NEAF), which can be imported into existing applications of the AU Red Infonetica ethics application process in New South Wales, Queensland and more recently Victoria.

The AU Red system has the provision for Site Specific Applications required as part of ethics approval within these regions. This is achieved only after the project is reviewed and approved by an ethical review body, constituted in accordance with the NHMRC National Statement on Ethical Conduct in Human Research (2007), such as a Health Research and Ethics Branch (HREC) (www.ethicsform.org/au/Help/Contact.aspx).

The BCCA continues to process these applications, with approximately 70 sites approved, in progress or pending. Annual reporting requirements are in place for all approvals, using a template from the HREC or a template which has been implemented by the BCCA. Other requirements to be met for continued ethics coverage include the provision of details for all publications, presentations, research and reports which are generated as a result of the activity.

The next step in the provision of information will see contributors receive an individual report based on the data they have contributed, across all regions where data collection is occurring. Reporting will be based on the MDS and will provide an opportunity for comparison at a unit, regional or national level. This has been achieved informally by some individual contributors who have compared their own results with the BCCA data analysis presented in the 2007-2008 annual report.

The Colorectal Cancer Audit Committee regularly reviews the MDS and incorporates other significant variables, which contribute to the collection of meaningful data. One particular area of interest in recent times is the collection of National Bowel Cancer Screening Program (NBCSP) data. The ability for surgeons to provide data as to whether or not a patient participated in a screening program and the review of the outcomes for this patient will provide a measure in the assessment of the effectiveness of these programs.

Preliminary data analysis from the regions participating in the audit has shown a difference in the Australian Clinico Pathological Staging (ACPS) stage of those patients who were diagnosed by NBCSP. This will continue to be a focus for BCCA staff, who will ensure that these outcomes are accurately measured.

Research and reporting will be based on the data; hence the quality of the data must be of the highest standard. This will require a comprehensive approach to quality control, including the provision of clear definitions for data fields, adequate validity checks, and methods to ensure data completeness and accuracy of data entry. This will be undertaken in collaboration with data contributors. Development and investigation of research questions will also be an important aspect of the audit. CSSANZ members are encouraged to submit these questions for consideration.

For further information please contact the Colorectal Cancer Audit Project Manager + 61 8 8363 7513 or colorectal.audit@surgeons.org

You can also contact Mr Andrew Hunter, Chair, Colorectal Cancer Audit Committee.

Vendra Severin, BCCA Project Manager

College Conferences and Events Management

Contact Lindy Moffat / lindy.moffat@surgeons.org / +61 3 9249 1224

AUSTRAUMA 2010

Trauma, Critical Care and Emergency Surgery Conference

Sydney Convention & Exhibition Centre, Darling Harbour, Sydney.
11 – 13 February 2010

Conference Convener: **Dr Valerie Malka**

Conference Themes:

- Humanitarian Aid
- Mass Casualties
- Neurotrauma
- Paediatric Injuries
- Trauma Radiology
- Animal Injuries
- Orthopaedic Emergencies
- Emergency General Surgery
- Damage Control
- Critical Care Nightmares

Contact: **Emma Thompson**
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perth '10

Annual Scientific Congress
Perth Convention & Exhibition Centre, Perth, Australia
4 –7 May 2010

Royal Australasian College of Surgeons

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

QLD REGIONAL COMMITTEE ANNUAL STATE MEETING

Hyatt Regency Sanctuary Cove
Friday 30 October – Sunday 1 November 2009

Convener- **Dr Maurice Stevens**

Dual Theme:
Changing Surgical Culture in the Public Hospital Sector
Surgical Outreach and Retrieval Services

Program highlights:

- Deputy Premier and Minister for Health Mr Paul Lucas will be in attendance on Saturday morning of the conference
- Free welcome BBQ (pig on the spit along the beach front) on the Friday evening
- Neville Davis Prize presentations
- David Theile Lecture
- Honoured Guest – Mr Glen Merry and Saturday Gala dinner
- Trainee activities and presentations on the Friday program
- Outreach programs such as Deadly Ears and Operation Smile
- Panel discussions with the Deputy Premier and Minister For Health
- Panel discussions on topics including: Fatigue Risk Management (safe hours), Surgery Connect and Cultural and Leadership issues between hospital administration and departments of surgery.

Provisional program and registration forms will be available in the coming weeks, costs for the meeting will be:

REGISTRATION $AUD
Inc GST STANDARD EARLY REGISTRATION
By 15 September 2009

Fellows $260 $200

Trainees & IMGs $130 $100

Medical Students/Other Health Professionals $60 $40

Accommodation will be available at Sanctuary Cove for $235 per night, accommodation can only be booked through registration forms available from the College, please email qldasm@surgeons.org

New draft legislation

The health profession national registration scheme

Michael Gorton
College Solicitor

Health Ministers throughout Australia have approved new draft legislation to give effect to a national scheme for registration and accreditation of health professionals. The scheme applies to a range of health professionals, including doctors, nurses, dentists, psychologists, chiropractors, optometrists and others. For the first time, health professionals will have the benefit of one national registration, applicable throughout Australia. The national scheme is also intended to enhance public safety and promote better standards of education and training of health professionals.

The draft legislation will establish new single national boards for each health profession. So, for example, there will be a single Medical Board of Australia.

The scheme also establishes the Australian Health Practitioner Regulation Agency (AHPRA), which will provide the administrative and management interface for the scheme, and provide resources for each of the national boards for each health profession. (College Solicitor, Michael Gorton, has been appointed by the Health Ministers, as a member of the Management Committee of AHPRA.)

Key features of the proposed national scheme include:

- Criminal history checks will be introduced.
- Mandatory reporting of unsafe practice or impairment, will apply nationally.
- Training and education of health professionals will be covered by the scheme, although still under the independent control of the relevant national board.
- Complaint handling arrangements will be centralised, so that complaints against health professionals are received through one channel. However, disciplinary processes may still vary from state to state as determined by State Government.
- The scheme introduces a new position, the Public Interest Assessor, who is to review all complaints. A complaint for a health professional will be reviewed by the relevant national board and the Public Interest Assessor. If the Public Interest Assessor thinks a complaint is more serious than the national board, the PIA view on handling the complaint will prevail. If the national board thinks it is more serious, the position of the national board will prevail. The outcomes in relation to complaints will be nationally consistent, so that definitions of unsatisfactory or unprofessional conduct will be the same throughout Australia, and the possible outcomes will also be nationally consistent.
- A single national register will be publicly available with an accessible website. The public will be able to check the registration status of any health professional, and whether any disciplinary action has been taken or any conditions imposed on their registration.
- Students in the health professions will also be registered for the first time. Arrangements for student registration will still need to be determined by the relevant national board.

The draft legislation is available for comment at present. It is envisaged that the new scheme will be operational by 1 July 2010.

For further information contact Michael Gorton at mgorton@rk.com.au.

PROFESSIONAL DEVELOPMENT WORKSHOPS 2009

In 2009 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities will assist you to strengthen your communication, business, leadership and management abilities.

SAT SET

3 October – Brisbane
15 October – Cairns (AOA ASM)
24 October – Lorne (VIC AGSFM)
1 Nov – Sanctuary Cove (QLD ASM)
10 November – Melbourne
17 November – Wollongong
20 November – Auckland (NZAPS ASM)
25 November – Perth

This three hour course is aimed at enabling supervisors and trainers to effectively fulfil the responsibilities of their important roles. SAT SET focuses on effective use of the workplace assessment tools that have been adopted as part of SET and explores strategies to improve the management of underperforming trainees and is also an excellent opportunity to gain insight into the RACS policies and processes, including legal requirements and the appeals process.

NEW Getting Patients Back to Work: Worksites, Injuries & Advice

14 October – Melbourne

This afternoon workshop takes place at the Ford Assembly Plant in Broadmeadows. Hear first hand what patients need from surgeons to make a successful return to work. Case-based discussion is followed by a factory tour so that you can provide more useful advice in regard to a patient's worksite capabilities.

From the Flight Deck

16-17 October – New Zealand

This two-day workshop is facilitated by an experienced doctor and pilot. It examines the lessons learned from the aviation industry and applies them to a medical environment. The program combines rigorous analysis of actual airline accidents and medical incident case studies with group discussions and an opportunity to use a full-motion airline training flight simulator. You will learn more about human error and how to improve individual and team performance.

Mastering Professional Interactions

28 October – Brisbane

'Doctor to Doctor' communication is increasingly identified as a significant source of litigation risk. This three-hour workshop focuses on how to deal with the potential areas of conflict which can occur when health professionals communicate with each other in stressful or sensitive situations. You will examine real life examples and generate appropriate responses and actions to reduce exposure in high risk 'Doctor to Doctor' interactions.

NEW Surgeons and Administrators: Working Together to Bridge the Divide

9 November – Sydney

This full day workshop focuses on a better understanding of the surgeon-medical administrator working relationship and development of more cooperative health service management. This workshop is offered in collaboration with the Royal Australian College of Medical Administrators. The key learning objectives are to:

- Have a greater understanding of the roles, responsibilities and priorities of surgeons and medical administrators
- Develop practical strategies for improving surgeon and medical administrator relationships

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: OCTOBER - NOVEMBER 2009

NSW

9 November	Surgeons and Administrators: Working Together to Bridge the Divide, Sydney
17 November	Supervisors and Trainers (SAT SET), Wollongong

QLD

3 October	Supervisors and Trainers (SAT SET), Brisbane
28 October	Mastering Professional Interactions, Brisbane
30 October	Mastering Intercultural Interactions, Sanctuary Cove (QLD ASM)
1 November	Supervisors and Trainers (SAT SET), Sanctuary Cove (QLD ASM)
15 October	Supervisors and Trainers (SAT SET), Cairns

VIC

14 October	Getting Patients Back to Work: Worksites, Injuries & Reports, Melbourne
24 October	Supervisors and Trainers (SAT SET), Lorne (AGFSM)
10 November	Supervisors and Trainers (SAT SET), Melbourne
13-15 November	Providing Strategic Direction, Melbourne
14 November	Communication Skills for Cancer Clinicians, Melbourne

WA

25 November	Supervisors and Trainers (SAT SET), Perth

NZ

16-17 October	From the Flight Deck, Auckland
20 November	Supervisors and Trainers (SAT SET), Auckland (NZAPS)

Further Information

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

Morgan Travelling Scholarship

Working in a foreign hospital has broadened my horizons and will influence my surgical practice for the rest of my career

Lindy Jeffree
New South Wales Fellow


Lindy Jeffree in Paris


Napoleon's tomb

It is 8am and the staff room fills with people wearing white coats. Everyone is talking at once and gulping impossibly small cups of coffee. Over by the window someone is smoking. The clouds move to reveal the top of the Eiffel Tower. This is the morning ritual at the hospital "*Necker Enfants Malades*" in Paris.

The daily meeting to discuss all the patients is one of the major differences between Australian and French medical practice. Everyone attends: six neurosurgeons, five trainees (including myself), two nurse unit managers and the ward secretary, the social worker, neuropsychologist, physiotherapist, neuroradiologist, two anaesthetist-intensivists and a variable number of students and foreign observers. The meeting is simultaneously a formidable management tool and an appalling waste of time. For the complex cases it is great to have input from the whole team, but the manpower cost of going through every case, everyday, could not be sustained in Australian practice.

After the morning "Staff" it is time to go down to theatre. As we set up, the surgeon is stamping his feet and swearing because the endoscope will not connect to the light source. Eventually someone finds the connector and the operation proceeds. The resident, who has been up most of the night, is berated for not holding the camera still enough. Many other problems are familiar: Instruments are missing from the sets, there is no money for overtime and not enough experienced nurses, and surgical training positions are used for service provision to the point of resident burnout. There is no obvious solution to these, predominantly financial problems.

The first thing I learn is that my Australian training has well equipped me to hold my own in one of the worlds most renowned neurosurgical departments. At first I am disappointed that I have travelled to the other side of the world to find that I have already been taught to treat patients the way they do. The main advantage of being in Paris, however, is that the hospital services a population equal to the whole of Australia with additional subspeciality and complex cases referred from elsewhere. This enabled me to see huge numbers of patients and operations. Pathology and management that I have learnt from books become familiar and commonplace.

There are obvious cultural differences between France and Australia. The French nurses gather each morning to share baguettes and coffee. One looks at my muesli, perplexed: "What are you eating? Birdseed?" she asks. They are aghast when I add milk to tea. There are differences in the clinical and surgical culture too. For example, projectile vomiting is thought to be of neurological origin and, legally, there has to be a 48 hour delay between the anaesthetic consult and elective surgery. I begin to wonder which of the essential elements of our surgical rituals are inexplicable nonsense to an outsider.

Although the principles of case management are the same as in Australia, there are many instances in which the details of treatment are not only different, but opposite, to what I am used to. In reflecting on how we can possibly achieve the same (good) results with such disparate treatment, I reach the conclusion that it is more important that the surgery is performed with care, than the exact details of the operation. Similarly, it seems that a surgeon who sees the patients every day, to measure the serum 'rhubarb', will have better results than one who is less attentive.

During the evening ward rounds at *Necker*, we could see the setting sun shining off the golden roof of Napoleon's tomb. From my last Sydney hospital I could see the surfers off Coogee beach. The difference in the two views symbolises for me an important difference between the two cultures. France is proud of its impressive history and long tradition. In Australia the emphasis is on present actions and enthusiasm for the future.

Working in a foreign hospital has broadened my horizons and will influence my surgical practice for the rest of my career. I am very grateful to Mr Brian Morgan for his sponsorship of the Morgan Travelling Scholarship, which contributed to making this possible. The scholarship is important not only for the financial support, but also as recognition from the greater surgical community that overseas experience is valuable.

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Straightening a Spine

A big team effort for one small boy, Alberto, who can now stand straight

Elvis Guterres, Alberto (front), Dulce Freitas, his older sister who accompanied him to India, their Aunt and carer (name to follow) and Sarmento Faus Corriea

Delivering specialist surgical visits and ensuring the smooth running of the Australia Timor Leste Assistance for Specialist services (ATLASS)Program is all part of a day's work for Elvis Guterres and Sarmento Faus Correia, the Timorese staff employed by the College of Surgeons' AusAID funded international development program in Timor Leste.

One of their recent tasks has been helping Alberto Matos Paivo Freitas, travel to the Ganga hospital, Coimbatore, India to undergo life changing spine-straightening surgery.

From organising medical visas and international money transfers, to reassuring and informing the family of ongoing developments; helping Alberto to stave off home sickness in a foreign country and providing a long distance translation service between Dili and Coimbatore so that the non-English speaking Alberto could communicate with his doctors and nurses, Elvis and Sarmento worked tirelessly to ensure that Alberto's experience was as trouble-free as possible.

Alberto's home in Gari-Uai, Baucau district is located approximately three hours east of the capital, Dili. The journey to India has involved a series of physical and emotional challenges as he and his older sister Dulce left Timor Leste and their family for the first time and spent several weeks at the Ganga hospital in Coimbatore, while Alberto underwent surgery.

The 16-year-old boy first presented to orthopaedic surgeon, Dr David McNicol, with a severe curvature of the spine during an Orthopaedic specialist visit to Baucau hospital supported by the ATLASS Program. Probably caused by tuberculosis, Alberto had lived with this problem since age four, however increased breathlessness and pain led the family to seek further treatment from the visiting Orthopaedic team.

The surgery Alberto required was not available in Timor Leste. Dr McNicol recalled a presentation he had seen at the Asia-Pacific Orthopaedic conference that had won an award for most innovative procedure. The topic: "New developments in straightening spines bent by tuberculosis" from a doctor at the Ganga hospital, Coimbatore, India. The talk discussed the benefits of a treatment approach that involved single spine-straightening procedure.

Contact was made with the Ganga hospital through the Children First Foundation (CFF) Australia, a not-for-profit organisation that supports international medical treatment for disadvantaged children. CFF also supported the costs of Alberto and Dulce's airfares and transfers.

The surgeons were able to treat Alberto with a single procedure called an 'Opening-closing Wedge Osteotomy'. This involves simultaneously accessing the affected portion of the spine from the front and the back. Latest technology in this area means that the spine can be straightened further than was previously thought possible without a risk of damaging the spinal cord as the spinal cord response is monitored at all times during the surgery.

The surgery and all related costs for Alberto and Dulce's stay at the Ganga hospital was subsidised through 'Project Swasam, a community outreach program provided by the hospital'. Swasam, a Tamil word is loosely translated as "Caring for life". The program provides spinal surgery free of charge to people affected by tuberculosis and unable to pay the medical costs required for treatment.

Doctors at the Ganga hospital agreed that the surgery was an outstanding success. Alberto's spine has now been straightened to 40 degrees from a previous curvature of 116 degrees.

Upon return to Timor and standing much taller, he will return to secondary schooling in Baucau district. He looks forward to being able to help his family and play sport with his friends without losing his breath. As a result of this surgery and the team effort to get Alberto to India and back to Timor he will be able to lead a more active and productive life.

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Chalice – poison'd?

Applying for the Director of Surgical Services sounds like an invitation to the 'Dark Side'

Professor U.R Kidding

My parents christened me Ulysses Reginald – rather dramatic don't you think? But it portrays an evil sense of humour for surely they must have known that I was always going to be known as UR (my medical student nickname was "number" often shortened to No – (as in no kidding!)

School was passable for me but I did like my Shakespeare. I even had some time in the drama productions. Macbeth Act I Scene VII still comes to my mind-

"But in these cases
We still have judgment here; that we but teach
Bloody instructions, which, being taught, return
To plague the inventor: this even-handed justice
Commends the ingredients of our poison'd chalice
To our own lips"

How did the rest go? If only I could remember...

The poison'd chalice came to mind recently. Go on they had said, "You would make an outstanding Director of Surgical Services, you have their respect. They listen to what you say. Even the anaesthetists don't disagree straight away. After all, you have that research background and have been a Head of Unit"

I must admit, my ego felt a bit flattered. After all, not many surgeons have an academic degree – never mind that I did an MS when I couldn't get a proper job as an accredited registrar. So many rats ago – laying down their lives for science. Also they do need my input, sort those management types out, and it was about time they listened to us surgeons. After all, we are vital to the hospital – the heart and soul. The entire place would grind to a halt if we didn't keep on contributing well beyond the commitment actually paid for.

It would only take a few hours a week they had promised. We will give you substantial support. We really do want this to be successful, were words I heard a few times. Everyone is acknowledging that the clinicians must be involved with establishing the strategic direction of our hospitals and our health care. Even that Garling chap who did the report in New South Wales, talked about healing the schism between management and the clinical staff. It made me feel as if I could be Secretary of State next.

I did talk about it a bit, I checked with the surgeons on the Unit, the nursing staff I had worked with for years, even on the home front. It was a touch frosty there. What about the salary? Well it is a bit less, (maybe a lot less). How are you going to keep a private practice going? What about the golf? Have you forgotten about your family? Can I book a time to see you? Are you experiencing a mid-life crisis?

The application date came closer. I just wanted to ignore it, it was all a bit hard, but the phone rang – the Chief Executive was on the line. There were lots of things to talk about for surgical activities. Oh, by the way... They really did need me...

I was not too sure how many applied. Invitations to the "dark side" are viewed a bit hesitantly. Director of Surgical Services of a major teaching hospital sounded like a given.

What do you mean, there is an interview? No-one had mentioned that. I have never been interviewed for anything. When I came back from overseas, my experience and qualifications spoke for themselves.

I always had the clinical issues under control and handled some research on the side. The medical industry always thought I gave a good talk, I used to receive a few invites to conferences. Why would I need an interview?

What would they ask me about anyway? It was the night before the interview and I had not thought about it at all until I bumped into the Director of Medical Services. He was heading home after the Medical Advisory Committee and I was heading back to theatre for another emergency case.

"Are you ready", he asked? "Sure" I replied trying to sound confident. "Got any last minute tips?" He looked at me as a child looks at a pet lamb being loaded onto the truck destined for the abattoir. He reached into his briefcase, took out a blank piece of paper and scribbled some notes.

I waved him goodbye and looked down at the paper. There was a list of undecipherables: KPIs, EBAs, CRC, DHS, ESAS, ESIS, QAP, ACHS, EQUIP, ACSQHS, and the only one I recognised, etc (later I was to learn these were TLAs and FLAs). Then followed Strategic Plan, Clinical Governance, Healthsmart, Riskman, and a few others.

Well that almost did me. As I had the longest emergency case for ages, my mind went to the list of questions that I could possibly be asked.

The anaesthetist just laughed. She had a good friend who was into corporate strategic planning and rang him on the mobile.

What questions would you ask an applicant for a senior executive role of an organisation who would be responsible for the strategic direction, planning and budget control of a Division of over 200 people and a budget of about $60 million? A service that the Minister of Health keeps ringing the Chair of the Board about and the Minister is also said to send threatening letters about it to the CEO?

He listed the qualifications and attributes that he would look for in an applicant. I felt like I had jumped out of an aeroplane with that nagging feeling that I had forgotten something, and then the sudden dawning when I was already in free-fall.

Have you read the Strategic Plan? What does it say about your service? Do you want that to happen? If you were given the job, what would you do in the first 100 days and first

"What do you mean, there is an interview? No-one had mentioned that. I have never been interviewed for anything. When I came back from overseas, my experience and qualifications spoke for themselves."

year in the role? How have you managed any "change" in the past? Give us some examples of where you needed to ensure a colleague had his practice reviewed because of a high incidence of adverse events? A colleague was said to harass and bully some trainees – what would you do?

Made for some late night cramming. I had not read so much stuff so quickly since my Fellowship examination. I wish I could use a computer better – google might have helped.

I was sitting in the anteroom to the Hospital Boardroom. I couldn't believe it, I was actually quite nervous. It was almost as bad as the Fellowship examinations and this time, I knew the first question – and with moments to go I hadn't resolved the answer – "Why do you want this job?"

The door opened. I saw the interview panel on the other side. They smiled as one smiles as a delicious first course is placed on the table. Weak at the knees, willing myself not to trip, I walked in...

To be continued.

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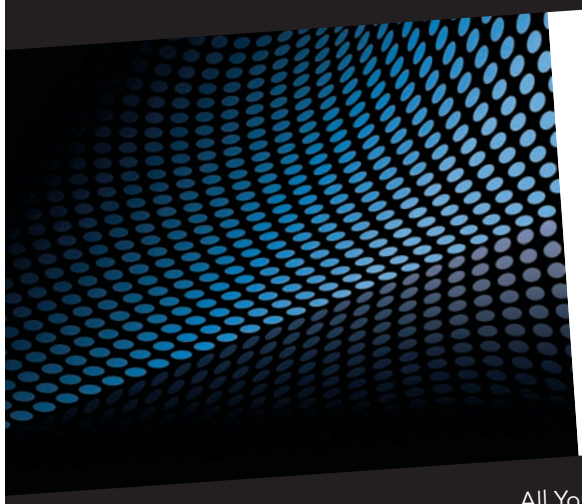
YOUNGER FELLOWS FORUM 2010

Swan Valley, WA, May 1-3 2010

The Virtual Surgeon – Embracing New Technologies



The 2010 Younger Fellows Forum is shaping up to be the most exciting Forum yet; offering an in-depth exploration of emerging technologies in surgery and information management.

The Forum's challenging program will explore emerging technologies in healthcare and training, credentialing of new technologies and future approaches to medical information management. Industry will be providing a 'show and tell' of the newest teaching technology while renowned surgical and community leaders will speak about building future mentoring and leadership paths.

Set at beautiful Vines Resort in the Swan Valley, Younger Fellows will have the opportunity to meet with peers, engage in robust discussion and try their hand at blending their own wine. We invite you to have your say, relax and enjoy a weekend of stimulating discussion.

Who?
All Younger Fellows of the College (within ten years of gaining Fellowship) are eligible to attend.

How?
Please complete the nomination form and return by fax or mail to the College Younger Fellows Secretariat.

Cost?
Free* This is a College sponsored event, delegates are required only to meet their travel expenses.

Applications close Friday 30 October 2009.

NOMINATION FORM

Name: _____

Sex: M / F Year of Fellowship:

Contact Address: _____

_____

Home Phone: _____ Bus Phone: _____

Mobile Phone: _____ Facsimile: _____

Email Address: _____

Specialty: _____

Proportion of clinical practice time: _____ % Public _____% Private

Have you previously attended a Younger fellows Forum? Y / N

Please attach a short professional biography for inclusion in the Forum program (maximum 150 words)

☐ STATEMENT (please tick):
I am a Younger Fellow of the Royal Australasian College of Surgeons (within ten years of gaining Fellowship).

Signature: _____

Date: ____/____/_____

Submit your nomination to the attention of the Younger Fellows Secretariat by Friday 30 October 2009:

Post:
Royal Australasian College of Surgeons:
College of Surgeons Gardens
250-290 Spring Street
EAST MELBOURNE VIC 3002

T: +61 3 9249 1122
F: +61 3 9276 7432
E:glenda.webb@surgeons.org

Thank you for your nomination to attend the 2010 Younger Fellows Forum.
Please note:

- Selection is finalised in January 2010. If your circumstances change and you wish to withdraw your nomination, please contact the Younger Fellows Secretariat.
- Delegates will be required to pay for the cost of their transport to Western Australia. Accommodation, meals, transfers and activities during the Forum will be covered by the College.
- The Forum is a delegate only activity. It is the general consensus of previous Younger Fellows Forum delegates that participants attend the Forum without their families (this condition also applies to Forum accommodation).
- Accommodation for delegates may be twin-share
- More information is available on the College website: http://www.surgeons.org/YoungerFellows

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One success breeds another

The SAT SET course has answered a need; it provides a forum to discuss training issues

Bruce Waxman
Chair, SAT SET Committee

The success of the surgical education module for Supervisors and Trainers in Surgical Education and Training SAT SET Course has spawned a new progeny! The College is now developing another three hour module, targeting Fellows who act as SET selection interviewers. This module will have a similar format to SAT SET and replaces the Interviewer Training workshop. It covers selection station interviewing skills; observation and recording; scoring; legal and ethical Issues. The course will be piloted in October 2009 and implemented in early 2010 so that selectors will be ready for the next round of SET interviews.

The SAT SET module has been adapted by the International Medical Graduate (IMG) Committee to upskill Fellows involved in delivering the IMG Pathways to Surgical Training. In addition, the Australian and New Zealand Association of Oral Maxillofacial Surgeons (ANZAOMS) is tailoring the SAT SET module to meet the needs of its own supervisors.

It does not seem that long ago that the College launched the SAT SET course. Indeed it was in Christchurch, New Zealand at the Annual Scientific Congress (ASC) in 2007, and now just after SAT SET's second birthday, at the 60th SAT SET course in Sydney on August 15 we had the 1000th Fellow attend one of our courses!

So why has it been so popular?

An analysis of participant evaluations can give us some clues. When asked to identify three key points that they gained from attending the course, the responses, in order of frequency, were:

- awareness of assessment guide lines for SET
- understanding how to use the competency-based assessment tools (mini Clinical Examination,(Mini-CEX) and Directly Observed Procedural Skills (DOPS)
- strategies for managing underperforming trainees;
- awareness of the College process and importance of documentation
- legal issues, particularly qualified privilege
- their role of supervisors or trainer

The SAT SET team - Kara Rooney, Emma Tubb, Bruce Waxman & Merrilyn Smith
Inset: 1000th participant Danny Cass receiving his prize of a bottle of wine from Robert Rae

SAT SET has answered a need. It provides a forum to discuss training issues and has given participants some useful tools for better managing trainee performance, particularly those who are underperforming. Supervisors and trainers play an active and pivotal role in SET and managing Trainees, so the course is helping surgeons to stay up to date with some of the latest developments in SET and surgical education in general.

The three hour format may be another reason for its success. It is accessible to time-poor surgeons, and conducting courses in collaboration with a regional or craft group conference has succeeded in 'capturing the captive' audience. Having experienced Fellows and Specialty Board chairs, or members as facilitators, has provided a ready source of advice and valuable information.

To identify whether our impressions of the success of the course are real, a survey has been undertaken by Professor Jeff Hamdorf (Western Australia A SAT SET Committee representative) through the University of WA. These results will be presented at the next ASC; where it all began.

The success of SAT SET has been a team effort combining College staff and fellows, who took the challenge and made the commitment. We give special thanks to Fellows on our committee; Robert Rae, Jeff Hamdorf, Fiona Lee, Marianne Vonau, Mellick Chehade, Sharon English and Jenepher Martin.

Further Information

Please contact the Professional Development Department on +61 3 9249 1106, PDactivities@surgeons.org or visit www.surgeons.org (select Fellows then click on Professional Development).

Returning to Perth

Abstract submission will open on 1 October, click on asc.surgeons.org

Campbell Miles
Annual Scientific Congress Co-ordinator

In 2005, the College held its first Annual Scientific Congress (ASC) in Perth in 10 years. We were the first major event in the just-completed, Perth Conference Exhibition Centre overlooking the tranquil blue waters of the Swan Estuary. The meeting was an outstanding success for all delegates and many chose afterwards to journey south to Margaret River and the other wine growing areas beyond, or north to Monkey Mia, Broome and The Kimberley.

In 2010, we return to Perth for the 79th Congress, under the direction of Michael Levitt, Congress Convener and David Oliver, Scientific Convener. Over 20 program conveners and the Perth Executive have, over the last 18 months, compiled an outstanding scientific and social program. At present, the invited Faculty comprises more than 35 leading surgeons from around the world. They will add their expertise to that of Fellows of our College and sister Colleges to present an outstanding educational meeting. Our industry partners continue to be important sponsors of the educational faculty supplementing the College Visitors whose attendances are funded from the annual subscriptions of Fellows and Trainees.

Meeting schedule

Monday 3 May
Convocation and Welcome reception

Tuesday 4 May to Friday 7 May
Scientific program
Masterclasses

Thursday 6 May
College Annual General Meeting
Congress dinner

The Section dinners will be on Tuesday and Wednesday night with the exception of the Medicolegal and Pain Medicine dinner, which will be on Friday night.

To succeed, the conference has to evolve and change to reflect current realities. With the establishment of the Trainees Association some years ago, the influence of Trainees on the meeting is to be expected, and welcomed. In Perth, there will be two sessions convened by the Association with content particularly relevant to our Trainees – topics for discussion include part-time surgical training, communications and technology, safe working hours, general versus subspecialty training and training in the private sector. The Younger Fellows and Trainees' dinner will be on Tuesday evening. An outstanding program of Masterclasses is again on offer.

Plenary program

After the successful trial at the Brisbane conference, the Tuesday plenary will commence at 8.30am but the plenary sessions on subsequent days will follow morning tea. The plenary program addresses important contemporary issues outside the operating theatre but which, none the less, impact upon surgeons and surgery. The presentations are scheduled to allow generous time for questions to panellists.

Tuesday: Are Surgeons Losing the Fight to control surgery?

Wednesday: What will the FRACS be like in 2020? How will we attract medical graduates to a surgical career? How will healthcare be delivered and will we be able to afford it with the current funding models?

Thursday: Professionalism in Surgery: behavioural issues for surgeons

Friday: The Future of Accredited Subspecialisation – will the FRACS be enough? Who should be providing accreditation; does subspecialisation presage the end of the generalist.

President's Lecture

The 2010 President's Lecture will be presented by Professor Barry Marshall, 2005 Nobel laureate and famous West Australian born in Kalgoorlie. Professor Marshall continues to contribute mightily to gastrointestinal research; he is an excellent speaker with a broad range of interests. Professor Marshall's lecture will follow the plenary session on Thursday, 12 noon.

This extremely distinguished Australian has received numerous awards on the international stage for his work on Helicobacter and gastric pathology. He was appointed a Companion of the Order of Australia in 2007.

New Associates Program

The Associates program has been strengthened. Attendance at the 'Beyond Surgery - expanding your horizons' program is now at no extra cost for Associates. Associates are very much encouraged to attend the sessions presented by the Senior Surgeons group and the Surgical History program. This is in addition to the program of external destinations highlighting the best that Perth has to offer.

Trainees' Research Prizes

The College supports and encourages Trainee research. In keeping with this, there are a number of research prizes awarded at the conference – the Mark Killingback Prize (Colorectal surgery), the Tom Reeve Prize (Endocrine surgery) and the Surgical Education Prize. The College will offer additional prizes for the best research paper presented by a Trainee in five other specialties. Eligible authors should indicate on the abstract submission site if they wish their paper to be considered for one of these research prizes.

Abstract submission

Abstract submission will open on 1 October. Log on via the congress website asc.surgeons.org Michael Levitt and David Oliver look forward to welcoming you to Perth – Always Perfect.

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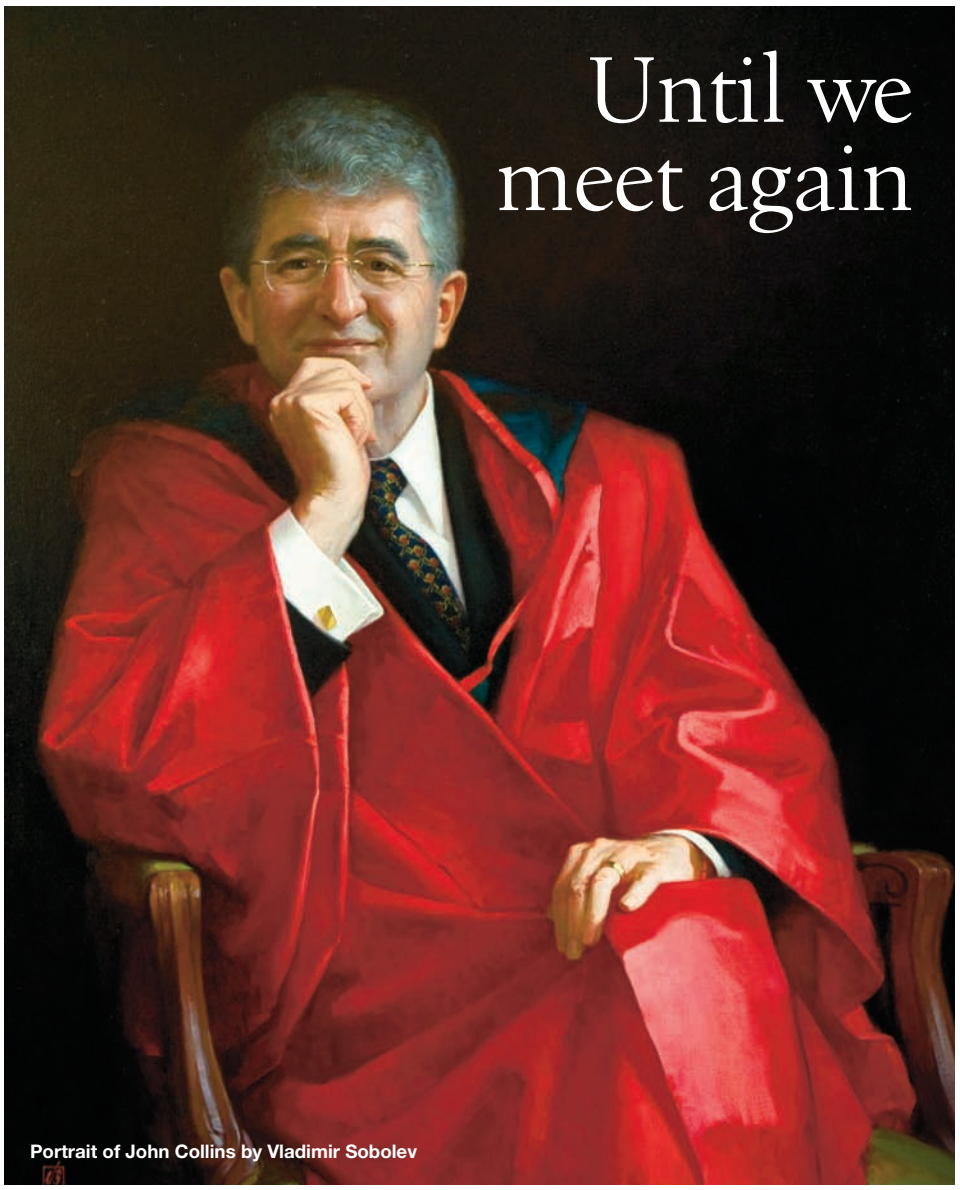

Portrait of John Collins by Vladimir Sobolev

The following is an address delivered by Dr David Hillis to the College staff at a farewell function for Professor John Collins after John's five years as the Dean of Education.

Professor Collins has now taken up his new role as Adjunct Professor at Oxford University.

I have been asked to say a few words on behalf of all the staff as Professor John Collins finishes in his role as Dean of Eduction. I need to highlight that this is not a farewell or a goodbye. This is an "until we meet next time" speech.

In preparing this I was struck by a number of things I could say to reflect the brilliance and dedication of John Collins

He left school in his mid-teens to work on his family's farm in Ireland. Returning to school he completed these studies to be admitted to University as a medical student. John graduated brilliantly from University with all opportunities before him.

Looking at an illustrious career in Obstetrics and Gynaecology he turned to Surgery as his true vocation. He decided to leave the United Kingdom because of the ongoing Irish troubles which were very prevalent at the time. He migrated to Auckland New Zealand with Jenny his wife, where he established a career in General Surgery eventually becoming recognised as one of the pre-eminent experts in breast cancer surgery, multidisciplinary care for breast cancer and one of the principal architects of the breast screening program.

At the same time he became respected internationally as an educational academic and undertook detailed cohort studies of Auckland University Medical School graduates.

However, I do not want to emphasise these things. They reflect the brilliance of the man that we have been so lucky to have in our midst over the past five years. However they do not fully reflect the man that I will remember.

I want you to reflect on three words, the first is surgeon, the second is Irish and the third is College

When you Google surgical personality it is amazing what you find. There are some who associate the surgical personality with words like extroverted, explosive, energetic and ambitious. They highlight the ability to act decisively on uncertain knowledge under time-limited situations and under incredible stress. People also emphasise a willingness to improvise when the unexpected occurs and in surgery the unexpected will certainly occur.

This provides dimensions to a Hemingwayesque hero who displays grace under pressure.

Surgeons are driven towards surgical excellence, surgeons are also driven to providing compassion, support, mentoring and nurturing of surgeons in training. While John has been Dean of Education it is no surprise that the Trainees have moved from being an amorphous group that the College interacts with to a focused core component of the College who are already our leaders and take their correct place in Council discussions. This same approach of support, mentoring and nurturing saw John being recognised by the Medical students of Melbourne University as the outstanding clinical teacher of the year. This is the memory I will have for the word surgeon.

Think of the word Irish. I am not wanting to get into Irish jokes territory. What I want to focus on is the most significant contribution that Ireland has made to the world, which is its people. For a country of five million people there is now estimated to be 80 million people who proudly tell of their Irish heritage.

There are some amazing people who directly acknowledge their Irish heritage. It may not be a surprise that John F Kennedy, President of USA had an Irish heritage, nor perhaps Ronald Reagan. On reflection I am sure the Irish would justify having Richard Nixon as an Irishman, after all there is a bit of a history of Irish rogues. However, I was personally surprised that Barack Obama has Irish heritage through his mother's side. And then I reflected that perhaps the greatest political orator of our age would have to have Irish blood. The Irish use words in ways that are as effortless as breathing.

The Irish have stories to tell, they create stories and myths, and they give warmth and character. They live poetry. They nurture the


John Collins


Jenny & John Collins

word like a precious child. This is the memory that I will have for the word Irish

Think of the word College. To many of us this is our employer, the name on the letterhead or the name on the signs.

However John is profoundly a Fellow of the College. This is his College, his home, his intellectual challenge. To many of us, the College is 50 metres away from Parliament railway station. To John the College is linked in an international federation of College structures that are dedicated to education, dedicated to standards and dedicated to surgical excellence. The College is not a place although it is one, it is not an employer although it does, it is a transformer of our efforts, and it is a focus of our intellectual, emotional and physical effort to improve the health care of the communities we serve. When I think of John Collins this is the memory that College will have for me.

Using these three words, having an Irish Surgeon on the College staff is not always easy. Indeed it is challenging. Whether you are being uplifted by the words of Oscar Wilde or reminded harshly of what Trainees and Fellows would really think about particular initiatives, John has shaken all of us. Kindly, but with vigour. He has admonished us for our lack of rigour but lead us with academic drive. He has refused to let us settle into the colonial backwaters but instead to break into the international front lines.

John, you will leave us just briefly I am sure, but enriched by memories of your charm, your personality and your uniqueness. You will go with our incredible appreciation for having lifted us far beyond what we may have achieved.

Can I on behalf of all of us try and wrap the words of surgeon, Irish and College into one short statement which is the Irish Blessing

May the road rise up to meet you,
May the wind always be at your back,
May the sun shine warm upon your face and rains fall soft upon your fields,
And until we meet again
May God hold you in the palm of His hand.

Thank you.

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Committed to international aid

As I approach retirement I feel a great sense of purpose visiting the Pacific Islands and feel I can make a small contribution

In a career which began in the mountains of Papua New Guinea (PNG) and which now spans 35 years, general surgeon David Freedman has ducked the spears and arrows of a tribal war and has worked around the piglets frequently brought into the wards by visitors.

He has collaborated with a laundry-man-cum-anaesthetist who, as an expert in post mortems, taught him how and where to look for unusual methods of murder such as the practice of perforating the rectum of a drunken victim with a spear. He has operated with only the flashes of lightening to guide him and has used a sterilised wire coat hanger to set a jaw.

In other areas of the South Pacific, Mr Freedman has treated the gunshot wounds of an escaped prisoner under the angry glare of a gun-toting army officer, provided reports on murder victims and spent countless hours attempting to explain the merits of surgery over the powers of witch doctors and traditional healers.

Based at the Victorian regional centre of Swan Hill, Mr Freedman remains passionately committed to international aid work, even as he approaches retirement. Recently he spent two weeks in the tropical paradise of Samoa as part of an AusAid funded College Pacific Islands Project visit. He talks to *Surgical News*.

What was the purpose of the trip?

We were asked to go Samoa to assist and support the General Surgical Teams at the Tupua Tamasese Meaole Hospital in Apia.

Who went?

On this visit I was accompanied by a surgical Trainee, Dr Luke Bradshaw, from St Vincent's Hospital in Melbourne. He gave valuable assistance and conducted many of the teaching sessions including lectures at the University Medical School.

What did you do there?

We participated in daily surgical ward rounds and twice-weekly grand rounds, we conducted out-patient clinics and assisted with consultations in the emergency department. We performed a number of operations including thyroidectomies, surgery for obstructive jaundice, laparotomies, hernia repairs and the stripping and ligation of varicose veins. We also gave a presentation to the medical staff on the diagnosis and management of common anal conditions, conducted teaching sessions and tutorials for medical students at the Oceania School of Medicine and assisted with, and advised on the purchase of some medical equipment.

How would you describe the condition of the hospital and the state of health services there?

The hospital facilities are quite poor by Australian standards. Apart from a lack of manpower and expertise, the physical state of the buildings is challenging. Despite this there has been a great improvement in infrastructure, equipment and manpower since my first visit here two years ago. This has been in no small part the result of considerable aid from donor countries. New buildings have been constructed and some of the existing facilities refurbished. The hospital has gained both a CT and ultrasound machine and the Chinese Government has supplied staff to operate and report on these investigations. However, much of the electronic equipment is difficult to service and, when such equipment breaks down, can take months to fix. There is no radiotherapy or chemotherapy performed in the country and many laboratory tests we take for granted in Australia – such as thyroid function tests – are not available in Samoa. Despite amputation being a common procedure for diabetic PVD, there are no facilities for prostheses.

What do you think of Samoa?

Although I have worked briefly in other South Pacific countries, notably PNG, Vanuatu and the Solomon Islands, Samoa remains my favourite. It is easy to understand why Robert Lewis Stephenson made it is his home and chose to reside in Apia where his old residence has become a tourist attraction. Samoa is breathtaking in its natural beauty with quaint villages full of brightly coloured houses set against the brilliant green tropical rain forest. The beaches are pristine with white sand and clear turquoise water. There is an abundance of marine life for snorkelling, which rivals our Great Barrier Reef and is only metres from the water's edge. The Samoan people are handsome in appearance and quite gentle, polite and graceful in nature.

What do you like about working in such countries?

I find the surgical work interesting and challenging in all these places. Surgical pathology is often more advanced than one finds here in Australia because of late presentation. Some patients are also prepared to first try traditional medical procedures before attending the hospital. We are also made very welcome as general surgeons because although the general surgeons in these countries welcome visits by the sub-specialities, they are few in number and relatively infrequent. As a result the general surgeons at times have to expand their surgical repertoires. For example, I understand there has been no urologist visit Samoa for almost 12 months. In general, the spectrum of surgery in the South Pacific Islands is a little different to that in Australia. There is a high incidence of abscesses, pyomyositis, tropical ulcerated osteomyelitis, as well as diseases like tuberculosis and leprosy. There are also regional differences in trauma cases, for example, the incidence of domestic violence is extremely high in Vanuatu and the Solomon Islands but very low in Samoa. Road trauma remains a major problem in all of the South Pacific nations.

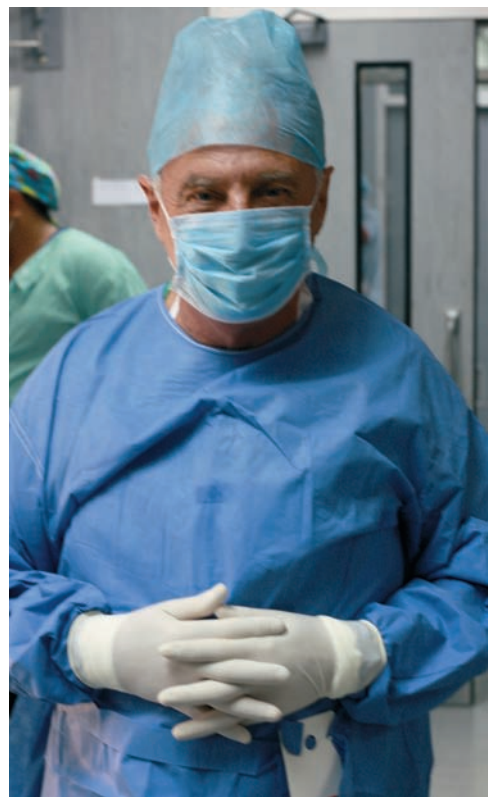
Top: Patient with a goitre, ready to be removed
Above: Patient happy after surgery

What is the role of the general surgeon in such aid visits?

The role of the general surgeon is pivotal in these nations as most operations are performed by them and there is a great lack of manpower in this regard. In Samoa, for example, with its population of 180,000 people, there are only two general surgeons and one orthopaedic surgeon. In Vanuatu, where I spent a month last year, there had been no surgeon in the country for six months before my arrival and there is now only one general surgeon working there, Mr Samson Mesol. Vanuatu has a population of 200,000.

What are the advantages and disadvantages of life in a regional centre?

I have worked as a general surgeon in Swan Hill for the past 33 years. I enjoy working with country people because in the main they are honest, hard-working and straightforward. A country medical practice has the added social dimension both with patients and staff, making any relationships more complex and interesting. However, the great disadvantage is the necessity of being on-call much more frequently than in a city practice. I have worked a one-in-two roster for 30 years, but over the past three, this has extended to one-in-four which is much more acceptable.



David Freedman in Samoa

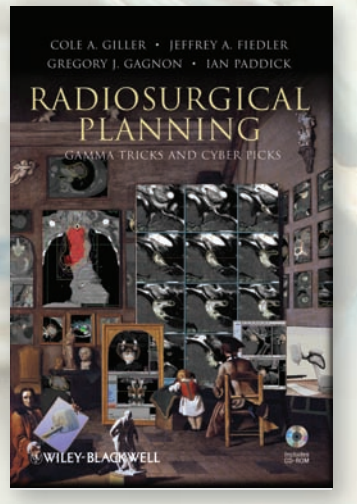
Why continue with international aid work?

As I approach retirement I feel a great sense of purpose visiting the Pacific Islands and feel I can make a small contribution. I recommend to any surgeon in a similar position to consider volunteering in the Pacific Islands Projects and I am sure he or she would find it a rich and rewarding experience.

The Surgeons' Bookclub

Welcome to The Surgeon's Book Club

Highlighted in this months issue are recent and new titles from across the spectrum of books available from John Wiley & Son.

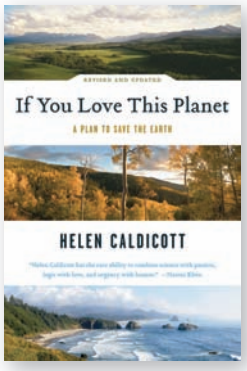


Book of the Month New
20% Discount

Radiosurgical Planning: Gamma Tricks and Cyber Picks
Cole A. Giller, Jeffrey A. Fiedler, Gregory J. Gagnon, Ian Paddick 9780470175569
July 2009 | HBK
~~AU$245.00~~ / **AU$196.00**

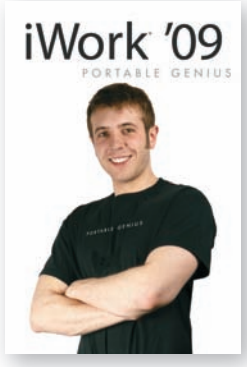
Radiosurgery is a complex procedure requiring the physician to construct a radiosurgical plan, i.e., a map that tells the radiation device exactly where to aim the beams of radiation. While there are plenty of books and articles describing radiosurgery's efficacy, until now there has been no instruction manual for those who wish to learn the secrets of its execution in common practice. This book is a self-contained treatment of surgical planning for beginners and a compendium of tips and tricks for experts.

Other Titles at 15%



If You Love This planet: A Plan to Save the Earth
Helen Caldicott 9780393333022 Sept 2009 | PBK
~~AUD $27.95~~ / **AU$23.76**

From the leader and spokeswoman of the antinuclear movement comes a revised and updated edition of this groundbreaking, widely acclaimed classic. Exploring dangerous global trends such as ozone depletion, global warming, toxic pollution, food contamination and deforestation, Helen Caldicott presents a picture of our world and the forces that threaten its existence. As always, she gives a prescription for a cure and cause for hope, rallying readers to action with the contention that our fight for the planet will draw its strength from love for the Earth itself.



iWork portable Genius
Guy Hart-Davis 9780470475423 August 2009 | PBK
~~AU$49.95~~ / **AU$42.46**

iWork is the office productivity suite created by Apple and includes presentation, word processing, and spreadsheet applications. In this book, Mac users will find essential information coupled with savvy advice on everything from simple tasks such as getting started with iWork and an overview of the shared features. Readers will be able to create presentations with Keynote, generate reports and analyse data in numbers, and format pages to create a variety of documents.

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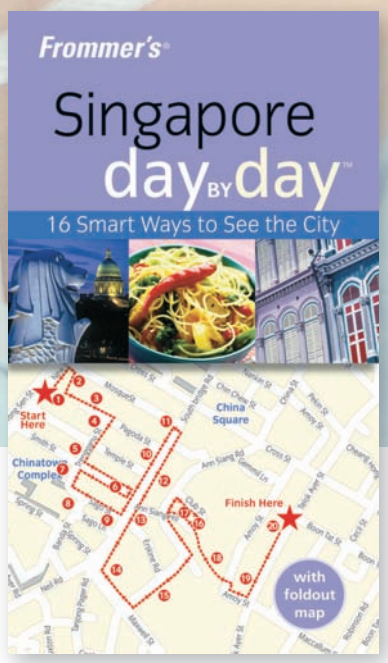
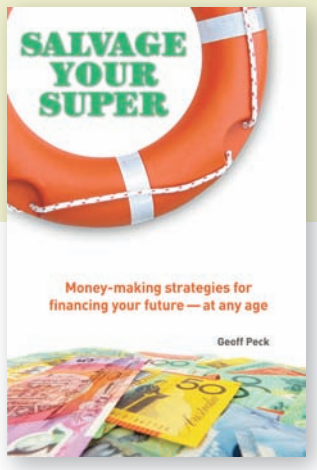


Leisure Reading

Frommer's Singapore Day by Day, 1st Edition
Heidi Sarna
9781742168555
July 2009 | PBK
~~AUD $19.95~~ / **AU$16.96**

Whether visiting Singapore for business, pleasure or just stopping over for a night or two, Singapore Day By Day offers visitors the opportunity to sample multiculturalism in all its exotic facets. Set out in sections including, Best Full Day Tours, Best Neighbourhood Walks and Best Dining, this book is the ideal for getting the most out of your stay in this fascinating city.



Salvage Your Super: Money-Making Strategies for Financing your Future - at any age
Geoff Peck
978-1742169477
June 2009 | PBK
~~AUD $32.95~~ / **AU$28.00**

The recent stock market crash saw a staggering $200 billion wiped off superannuation balances. Fortunately, you can do something about it. Salvage Your Super is a comprehensive guide to making the most of your super and retirement assets, regardless of your age or income. It offers sound advice on what to do with your super depending on your financial profile, and provides tangible solutions to help retirees reverse the recent downtreand in their funds without selling the farm. So don't just sit back and wait for things to get better – read this book and salvage your super!

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Starting a kidney transplant service

The success of the transplant service is an achievement for Nepal and its people

David Francis
Victorian Fellow

At eight o'clock on the morning of Friday 8 August 2008 a puja, or prayer ceremony, was performed by a Hindu priest in a small ante-room on the first floor of a wing of the Tribhuvan University Teaching Hospital (TUTH) in Maharajgung, Kathmandu, Nepal. Prayers and small offerings of food and incense were made to Ganesh, the ancient and greatly revered Hindu deity of learning, wisdom and wealth, who is said to have the power to remove obstacles and grant prosperity and success for new ventures. The ante-room was the waiting area in front of two newly constructed isolation rooms where future kidney transplant recipients would be nursed. Legend states that Ganesh (Figure 1) was decapitated by his father, Shiva, but his life was restored by transplanting the head of an elephant on to his body. Thus, Ganesh is a xenograft and so, considering the great qualities which he is said to bestow, it is not surprising that Ganesh has been adopted as the deity of transplantation in Nepal.

At precisely eight minutes past 8 a.m. on the same day, a 40-year-old lady was anaesthetised in one of the hospital's operating rooms, and an uncomplicated left donor nephrectomy was performed. The recipient was the donor's 36-year-old husband whose renal failure was due to upper urinary tract stone disease. There was great excitement in the packed viewing gallery and operating theatre, both of which were noisy with anticipation that a ground-breaking event was about to be witnessed. The room was hot and crowded (Figure 2) – there were four nurses, nine anaesthetic staff (including Dr Thomas Tan who had come from Melbourne to help with the anaesthesia), and 23 observing surgeons, doctors and medical students.

The almost constant stream of questions from fascinated onlookers was matched only by the frequency of their camera flashes. The donor kidney was transplanted uneventfully. There was applause when the kidney turned pink after revascularization and loud cheering when the first squirt of urine jetted from the ureter! This operation was the first kidney transplant to be done at TUTH and probably the tenth to be undertaken in Nepal, all previous cases being *ad hoc* and having failed either during or very soon after transplantation. A successful renal transplantation program had commenced in Nepal.

In 2006 I was asked by Dr Dibya Singh Shar, a nephrologist from TUTH training in transplantation at the Monash Medical Centre, to help set up a kidney transplant service in Kathmandu and to train the local surgeons in renal transplantation. Later that year I met Dr Shah and surgeons, as well as the Health Minister and officials from the Health Ministry. The requirements for a kidney transplantation program were identified and a plan was proposed and, over the next two years, infrastructure, manpower, educational programs and clinical protocols were developed.

Figure 1. Ganesh

There were significant obstacles, both bureaucratic and practical. Because of the previous disastrous attempts at transplantation, strict laws governed the practice of transplantation, so legislative changes were required. The Government required a transplant committee be formed to assess the capability of TUTH to do kidney transplants. The hospital and all surgeons involved had to be licensed specifically to perform kidney transplant procedures. The Health Ministry required establishment of a legal committee to verify that donor-recipient relationships were *bona fide* and within legal statutes. Drugs, sutures and perfusion fluid were delayed significantly *en route* from India. There is no tissue typing facility in Nepal, and so tissue typing and cross matching were done in India. Measurements of drug levels for monitoring of immunosuppression are not available in Kathmandu, and there is little experience in transplant histopathology. However, in spite of these challenges, the program commenced on 8 August 2008, eight being an auspicious number in Nepali folklore.

The aim was to initiate a transplant program which would be self-sustaining in the long term. It was essential that surgeons and physicians were trained appropriately in their own environment where resources and facilities are limited, and some patients have issues unique to the developing countries. During the five months that I stayed in Nepal, I performed the first few donor-recipient operations but largely taught and assisted four surgeons with the pre-operative assessment, operative management and post-operative care of kidney transplant patients and their live donors. I was also involved in undergraduate and postgraduate teaching, daily rounds, outpatient clinics, and giving presentations and reports at TUTH and to the Health Ministry.

The situation for people with kidney failure (and many other disorders) in Nepal is hardly imaginable to us in the West. The incidence of kidney disease in Nepal is unknown because many ill people never come to medical attention, especially in the mountainous areas

Above: Figure 2. The operating room during the first kidney transplant operation at Tribhuvan University Teaching Hospital. Top: Figure 3. A pavement pharmacy outside Tribhuvan University Teaching Hospital

which comprise 80 per cent of the land mass. There are no Western medical facilities in many hamlets and villages, and in many regions there is no transport infrastructure to get sick people to medical care. Hospitals and clinics are overcrowded, and waiting times are long. The cost of medical care limits the number of people who receive treatment. Nepal is one of the poorest countries in the world: while the central government spent 5.3 per cent of gross domestic product (GDP) on health in 2005 (approximately half the Australian figure), the GDP of Nepal is less than one per cent of that of Australia.

There is no public health system and patients are charged in public hospitals according to a rather loose means test. Patients purchase their own pharmaceuticals, dressings and intravenous fluids from pavement booths outside hospitals (Figure 3). Even relatively simple investigations and treatments are beyond the financial capacity of many. In Kathmandu, the cost of haemodialysis is approximately US$80 per session. The average annual *per capita* income in Nepal is US$270. Thus, the cost of haemodialysis is prohibitive for most Nepalese citizens and, of those kidney failure patients who are able to start dialysis, a staggering 87 per cent stop treatment within three months because of inability to pay. Dialysis costs are reduced by re-using dialyzers and opting for once or twice weekly or even 'SOS' treatment. The one-year haemodialysis survival figures for Nepal are not documented but a reasonable estimate would be about five to ten per cent, compared with the Australian figure of about 85 per cent.

Before commencement of the TUTH renal transplant program, the few fortunate Nepali people with money went outside the country, often to India, for either a living unrelated paid donor or living related kidney transplant. This was not an easy or safe undertaking, and there was no guarantee of a good outcome or even having a transplant. The cost ranged between US$50,000 and US$100,000; currently, the cost in Kathmandu is approximately US$2,800 for the operation, hospitalisation and initial drugs, and then approximately US$100 per month. There is a limited government subsidy for some transplant patients. Thirty-one kidney transplants have been performed in the first 10 months, with two recipient deaths (one unrelated to the transplant process), but otherwise no loss of transplanted kidneys – an outstanding result for a newly developed service in a third world country. Presently, nearly 100 donor-recipient pairs are awaiting operation.

The overall picture for people with kidney failure in Nepal has improved but remains bleak – only a minority has the condition identified and most cannot afford treatment.. The advent of a successful kidney transplant program has meant that transplantation is now a realistic option for many who would have died otherwise. Not surprisingly, the gratitude of all recipients, donors and their families was immense.

Establishing a transplant service at TUTH had an enormous beneficial effect on hospital morale, and was a significant advance for the nation. It also stimulated development of a kidney transplant program at another public hospital in Kathmandu. Clearly, many health issues need to be addressed urgently in Nepal and management of end-stage renal disease is but one of them. Further developments of infrastructure are needed before a deceased donor program can be established and before transplantation becomes available to an even greater proportion of the population. In keeping with the blessings of Ganesh for the favourable outcome of new ventures, successful kidney transplantation in Nepal is now a reality.

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SURGICAL
AUDIT

From little things big things grow

The de-identified data from the audit will be used to monitor outcomes nationally

Barry Beiles
MVSA Audit Committee representative

The Melbourne Vascular Surgical Association (MVSA) was founded in 1995 by the groundwork of Michael Grigg and Andrew Roberts. The vascular surgical audit commenced in January 1999 to enable confluence of existing audit activity of variable sophistication in the vascular surgical units at the time. This activity captured all public hospital vascular surgery and a sizeable portion of private vascular surgery in Victoria.

In 2002 a contractual arrangement between the MVSA represented by the College, the Baker Research Institute and the Department of Human Services (DHS) resulted in the establishment of the Melbourne vascular surgical quality initiative [MVSQI]. This produced annual reports detailing the risk-adjusted performance of vascular surgery in Victorian public hospitals. This examined outcomes in three main areas of vascular surgery; mortality after aortic aneurysm surgery, both elective and emergency, stroke and death rates after carotid endarterectomy and graft patency and limbs salvage following lower limb bypass. Reports have been produced annually since 2003 culminating with the termination of the contract after the production of the 2008 report.

Since the production of the initial report, results of Victorian vascular surgery have been excellent and these reports have been made publicly available on the DHS website. The MVSA audit has thus been collecting data for nearly 10 years and over 70,000 operations exist in the database currently. This activity is part of a complete audit loop and has an algorithm for dealing with the underperforming surgeon. This database has been used extensively interstate as its local success has spread.

As an extension of this audit the Australian and New Zealand Society for Vascular Surgery (ANZSVS) voted overwhelmingly in 2007 for the introduction of a bi-national vascular surgical audit, in which participation was a requirement of ongoing membership of the society. This audit has been granted Commonwealth privilege as a quality assurance activity and has obtained ethics committee approval for the collection of data for this purpose in compliance with privacy legislation. It is also recognised as an approved audit for CPD purposes by the College. This is scheduled to commence as a web-based database collecting all vascular surgery procedures from the first of January 2010. Development of this application was undertaken with the formation of a representative sub-committee of the ANZSVS using a commercial software developer. The MVSA audit will thus cease to exist from this date.

This is an exciting time for vascular surgeons in Australasia. The de-identified data from the national audit will be used not only to monitor outcomes nationally but will also be submitted for incorporation into the Vascunet database, which collects data from eight other European countries and has received only Victorian data to date.

IN
MEMORIAM

Information about deceased Fellows

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

Alan Hugh McJannet NSW
Roneal Naidu AUCKLAND

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

Informing the College

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

ACT	Eve.edwards@surgeons.org
NSW	Beverley.lindley@surgeons.org
NZ	Justine.peterson@surgeons.org
QLD	David.watson@surgeons.org
SA	Daniela.giordano@surgeons.org
TAS	Dianne.cornish@surgeons.org
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The Fothergillian Gold Medal

The medal is awarded once every three years by the Medical Society of London

Keith Mutimer
Honorary Treasurer

In the June issue of *Surgical News* the Heritage Report was about the presentation of several items of memorabilia of Sir Thomas Dunhill, given by members of the Peel family. Among these was his Fothergillian Gold Medal. There may be some who have not heard of this award. The Medal was instituted by John Coakley Lettsom in memory of John Fothergill (hence its name), to be presented by The Medical Society of London.

The Medical Society of London

The original Society had been founded by John Fothergill in 1752, but it failed to survive its founders. The present Society was founded (or refounded) by John Coakley Lettsom in 1773. Its constitution was unusual for its time in that its membership was not restricted to one branch of medicine or a particular class of practitioner, but was open to physicians, surgeons, apothecaries and accoucheurs. Its aim was to be a forum where medical knowledge and research could be shared equally and without prejudice, and today its objective is "the Advancement of the Sciences of Medicine, Surgery and those branches of Science connected therewith".

The Society's rooms were originally in Bolt Court in the City of London, but in 1873 it moved into its present building, known as Lettsom House, at 11 Chandos Street, Cavendish Square W1. It is the oldest medical society in England.

John Fothergill (1712 - 1780)

One of the most famous medical practitioners of his day, John Fothergill was born in Wensleydale, into a Quaker family. Throughout his life he held firmly to Quaker ideals, and was very active in the Society of Friends, especially with the Quaker colonists in Pennsylvania.

He graduated MD in 1736 from the University of Edinburgh. As an impecunious graduate tramping the boards in St Thomas' Hospital, he saw the rewards of success, and thought them worthwhile. In a letter to his brother he wrote "I could not look upon an overgrown doctor, lolling in his chariot, wealthy at the expense of his fellow citizens' lives, without tacitly imagining whether such a state would not mightily become me".

The achievement of such success could be measured in years to come by the roll of his patients, which included the Speaker of the House of Commons, Lord Clive, the Earl of Dartmouth, John Wesley and the Burney family. He was kind and good-humoured, characteristics which could be masked by his rigid formal bearing, the product of Quaker manners. Fanny Burney described him as "an upright, stiff, formal-looking old man. He enters the room and makes his address always with his hat on... of the most enormous size I ever beheld". Fothergill wrote a classic work on sore throat, which included the first authoritative account of diphtheria, in 1748. (The College has a copy in the Cowlishaw Collection.) He also worked enthusiastically to promote the drinking of coffee.

John Coakley Lettsom (1744 - 1815)

Born on a Caribbean island, Lettsom was sent to England by his parents when he was just six years of age. He was placed in the care of Samuel Fothergill, a Quaker preacher and brother of Dr John, who brought up the young Lettsom and eventually arranged for his apprenticeship as an apothecary. After graduating Lettsom went to London and came under the tutelage of John Fothergill, and the two formed a lifelong attachment. Lettsom modelled himself on his patron and mentor, and published his collected works in 1784 under the title *Works of John Fothergill.....with some Account of his Life*. (The College has a copy of this also in the Cowlishaw Collection.) As an act of filial duty he reconstituted the Medical Society of London, and in 1784 instituted the Fothergillian Gold Medal. In his letter of proposal to the Society he wrote "To preserve the memory of illustrious characters by some permanent memorial, is not

"Fothergill wrote a classic work on sore throat, which included the first authoritative account of diphtheria, in 1748."

only grateful to the friends of the deceased, but excites in the living that commendable emulation, which leads to great and virtuous actions".

The Fothergillian Gold Medal

The Medical Society of London accepted Lettsom's offer of a Medal, and drew up a set of Regulations in accordance with his wishes. The Medal was to be awarded annually to the candidate who submitted the best essay in answer to a question proposed by the Society. The essay was to be written legibly in Latin, English or French. Entry was not restricted to Fellows of the Society, but was universal. Judging would take place on the 8th of March, that being Dr Fothergill's birthday.

In reality, the award did not work out the way Lettsom had intended, as he had failed to provide the Society with the means to fund it. The Medal itself was gold, to the value of 10 guineas, a considerable amount of money. The Medal was awarded at irregular intervals six times in Lettsom's lifetime, in 1787, 1790, 1791, 1795, 1801 and 1803, and then it lapsed. The 1791 recipient was Lettsom himself, and in 1803 it was given to Edward Jenner, whose work on vaccination Lettsom had supported.

The Medal was revived in 1824, nine years after Lettsom's death. It was still the Fothergillian Medal, but a strange transformation had taken place. It was no longer in memory of Dr John Fothergill, but of one Anthony Fothergill, who seems to have been no relation. He practiced as a physician in Northampton, and was obviously well-regarded in his time, as he was a close friend of Lettsom and of his namesake Dr John, with whom he regularly corresponded. When he was proposed for membership of the Royal Society, his seconder was John Fothergill, and his third sponsor was none other than John Hunter. In 1803 he gave up practice in England and moved to Philadelphia, but was forced to return home by the War of 1812. He died in 1813, leaving his papers and £1000 to Lettsom. He also left £500 to the Medical Society of London to endow a medal, to be awarded annually or triennially, for the best essay on a medical subject. Once again, the award has not turned out quite the way Anthony Fothergill intended, for none of the distinguished recipients has ever had to produce an essay in order to gain the Medal. Recipients have included Sir Victor Horsley (1896), Sir Frederick Treves (1905), Sir Arthur Keith (1923), Sir Thomas Dunhill (1941) and Russell (later Lord) Brock (1953).

Today the Medal, now called simply the Fothergill Medal, is awarded once every three years by the Medical Society of London in consultation with the Royal College of Physicians.

References

Booth, C.C.: 'The Fothergillian Medals of the Medical Society of London', *Journal of the Royal College of Physicians of London* Vol.15 No.4 (1981), pp.254-258.

Geoff Down, College Curator

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Deep brain stimulation surgery

Many neurological conditions such as Parkinson's disease, depression and epilepsy can be treated with deep brain stimulation

Mr Christopher Lind of Perth's Sir Charles Gairdner Hospital has become one of the few surgeons in the world now doing deep brain stimulation surgery while patients are under general anaesthetic.

In most other neurosurgical units conducting deep brain stimulation surgery, patients are still required to remain conscious so they can speak to surgeons during the operation to help guide them in their placement of the necessary electrodes. Forced to listen as the tops of their skulls are removed and then asked to recite the alphabet or move their fingers, the procedures can often be traumatic for the patients and difficult for surgeons.

But now, Mr Lind and his team from the Perth-based Neurofinity Surgical NeuroDiscovery Group are using a state-of-the-art technique in which high resolution Magnetic Resonance Imaging (MRI) scans of the patient's brain are taken and examined the day before surgery with computer software then used to work out exactly where the electrodes need to be placed.

Used in particular as a treatment for conditions such as Parkinson's Disease, the procedure then involves the insertion of one or two thin electrodes into the brain to re-programme the signals causing tremors or chronic pain. The new technique, pioneered by Professor Steven Gill of Frenchay Hospital in Bristol, means the surgery takes less time, requires less staff and reduces patient trauma.

"Doing such surgery on a patient who is awake means that the surgeon needs to communicate with the patient which can be both bizarre for them and difficult for us. You also need, as a surgeon, to be able to interpret short-term effects of brain stimulation during surgery and try to relate those to predict long-term effects," Mr Lind said.

Chris Lind with his children, David and Emily

"However, although performing deep brain surgery under general anaesthetic is often seen as the central advantage of the MRI-directed guide tube technique, I think there are other reasons the method is a significant advance. By implanting a temporary stylette into the brain target and then performing MRI, the neurosurgeon can document exactly where electrode contacts are located in the brain.

"This means that brain recordings and the effects of stimulation can be very accurately attributed to particular brain structures. It also means that surgical targeting can become very reproducible from one patient to the next.

"We have used this new technique for the last three months and the results have been very promising. We will be presenting these early results at the Movement Disorder Society of Australia annual meeting later this year and at the ASC in Perth in 2010."

Mr Lind said he chose to become a neurosurgeon after becoming fascinated with science in his teenage years growing up in regional New Zealand and after reading the biographies of such pioneering luminaries of science as Louis Pasteur, Robert Koch, Watson and Crick and Ramon y Cajal.

Wanting to become a pioneer himself, wanting to add to the sum of knowledge, treat fascinating conditions and wanting to use his hands, neurosurgery seemed to him the perfect fit. He moved to Dunedin to complete his medical degree and there met the first of his neurosurgical mentors – Professors Sam Bishara and Grant Gillett - who encouraged him to take up neurosurgical training in Auckland.

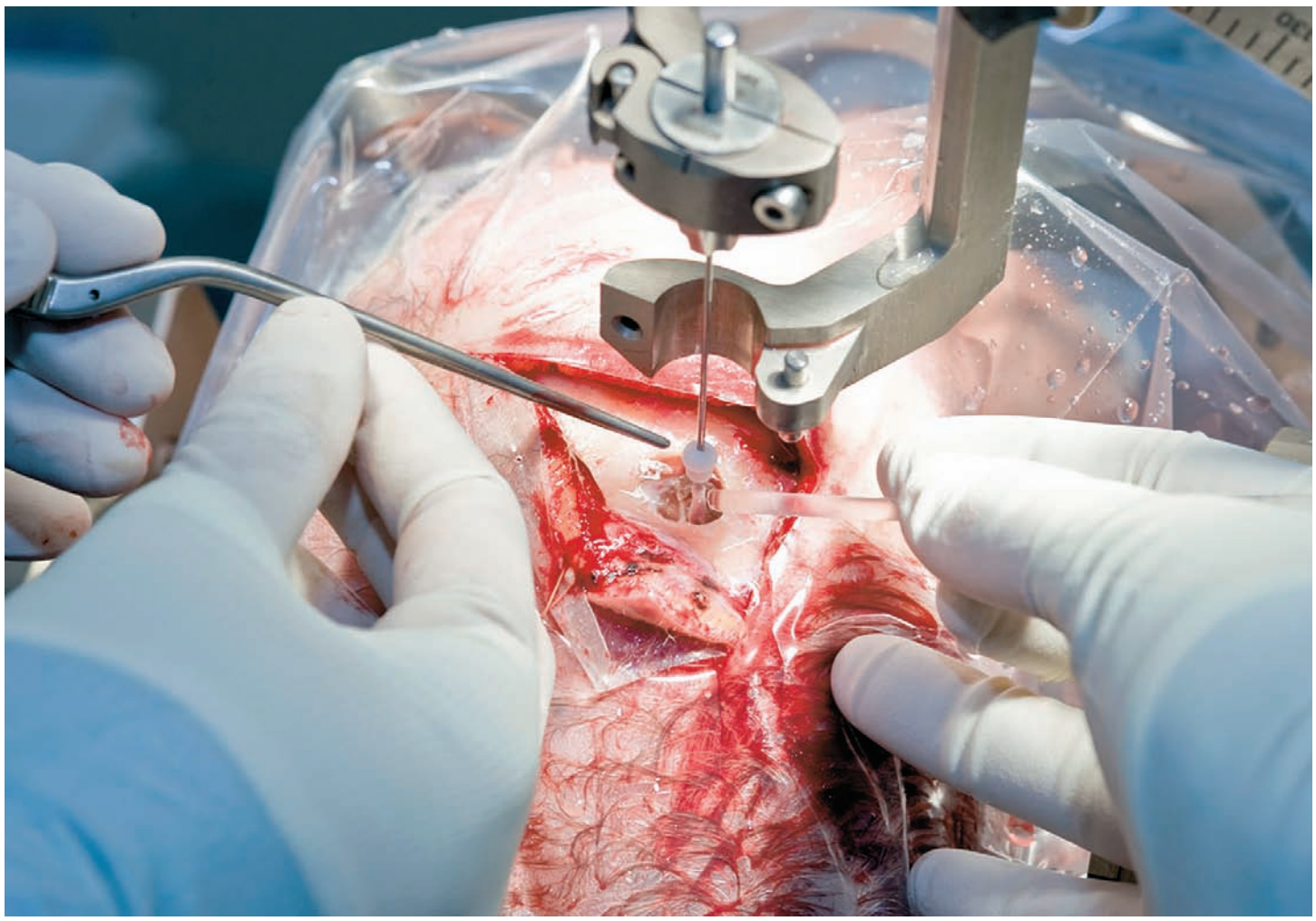
"I spent the first half of my neurosurgical advanced training in Auckland and learnt a huge amount from all the neurosurgeons there," Mr Lind said.

In 2005, Mr Lind moved to Perth with his family having been impressed by the work being done out of the neurosurgical unit at the Sir Charles Gairdner Hospital and in 2006 he was offered the chance to stay on in Perth to work predominantly in functional, spinal and cerebrovascular neurosurgery.

"I learnt how to implant deep brain stimulators from Mr Peter Watson with whom I continue to work when possible," he said. "He is one of those surgeons who has great economy of movement and is one of the most efficient operators I've worked with."

Since then, Mr Lind has established the Neurofinity Surgical NeuroDiscovery Group, a research group established to refine the development of exquisitely accurate delivery of electrodes and catheters to brain structures, to translate research from the laboratory to the bedside and to promote neuro-scientific discovery.

"Having embarked on an academic career,



During constant irrigation to avoid cerebrospinal fluid loss, a guide tube is being delivered over a stereotactic probe during posterior subthalamic region deep brain stimulation for Parkinson's disease

"By implanting a temporary stylette into the brain target and then performing MRI, the neurosurgeon can document exactly where electrode contacts are located in the brain."

I greatly appreciate the support shown to the research group by the College. Two of my research fellows have been funded through the College Foundation for Surgery scholarships and I have benefited from the Foundation's support of research undertaken by SET Trainees ," he said.

"This funding has had a huge impact as I have found it very tough competing with full-time scientists for early career research grants, so the support from the College has given our Surgical NeuroDiscovery Group a very good start."

And as his boyhood heroes must once have thought, there is so much waiting to be discovered.

"The brain still holds many mysteries but we are entering an exciting era of surgical neurodiscovery," Mr Lind said.

"For example, the MRI-directed guide tube technique is well suited to implanting catheters for the delivery of gene therapy or stem cell therapy both of which hold hope of future cures for a range of neuro-degenerative disorders. We are now also realising that many neurological conditions including Parkinson's disease, depression, dystonia, torticollis, obsessive compulsive disorder, epilepsy, tremor, chronic pain and Tourette's syndrome can all be treated with deep brain stimulation.

"The list of conditions being treated with this technique and the different brain structures now being probed means that we have a clearer understanding for the first time about how many of these parts of the human brain actually work."

Mr Lind said he enjoys life in Perth with his wife Tina, a General Practitioner, and their two children and visits New Zealand when possible not only to catch up with friends and family but to continue his on-going collaborations with New Zealand scientists.

"I support the All Blacks in rugby and Australia in cricket so I guess I enjoy the best of both countries," he laughed.

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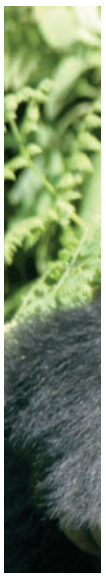
Neurosurgical ward round, Dr Kate Drummond (Melbourne)


Conference room Kigali with 110 Rwandan doctors in attendance



Medical and surgical emergencies

SWB ran a very successful conference in Rwanda in the second week of July

The conference ran over three days, with Specialist without Borders (SWB) also sponsoring the third day, a science and research day. The title of the meeting was Medical and Surgical Emergencies.

There were 15 consultants from different countries who all volunteered their time to teach. From Australia they were 11 surgical consultants, covering general, gynaecological, vascular, orthopaedic and ear nose and throat (ENT) surgery. There was a dentist from Tasmania, an American physician, an American ENT professor, a Canadian Anaesthetist, as well as an Italian/American immunologist. In addition, a group of nurses accompanied the doctors and ran concurrent nursing and teaching programs, also very successfully.

The conference was held in the Serena Kigali, and is located in the centre of the capital city Kigali, which was important given the vast distance that many of the doctors had to travel to come to the conference. Over 110 African doctors committed to the three-day event.

The conference was divided up into 20-minute lecturing segments. This was considered an important feature to maintain interest over the three days. Topics covered the range of emergencies that most might encounter in their particular specialties covering both undergraduate and postgraduate material. The full program can be reviewed on the SWB website: www.specialistswithoutborders.org.

SWB has numerous educational objectives of which many were realised at this conference, which can be viewed on the website. There was the successful interaction between visiting consultants and African doctors, and an effective exchange of medical information at both the formal conference level and the informal teaching level. This was judged by both conference evaluation forms and direct communication feedback from the doctors involved. There was a high level of medical knowledge and teaching efficacy displayed by all consultants who participated, with an ongoing adaptation through the understanding of where students/doctors were at with their local knowledge

An educational baseline has now been developed, from which the current consultants are able to change the level of medical education required in the future. Professional and personal relationships have developed, which will allow ongoing exchange of medical information and the exchange of African doctors in specialty training. It is hopeful that the current format will be developed into a much more effective model in the future given the significant input. It is now appreciated that any future conference seminars should run over four days with one of those days given to a structured clinical instruction module (SCIM) followed by assessment. We also hope to develop a module/curriculum which will allow the progressive development of medical education from a baseline such as was established in this instance. This would also allow a standardisation in the presentation of education at both the graduate and undergraduate level by other consultants who might request to be part of an ongoing SWB medical education program

The establishment of relationships in an informal situation around the conference created invitations to ward rounds at the large public teaching hospital opposite the conference facility. Many of the consultants found this particularly rewarding, and were able to contribute in a significant way on the ward rounds. It also meant that consultants were introduced to students and new graduates, allowing the development of bilateral ongoing educational relationships, and possible exchange teaching. Some consultants were then taken out to the peripheral hospitals, which allowed them to evaluate facilities outside the


Lunch with silverback mountain gorillas, at two metres


African dancers at Gorilla Nest Lodge

capital. While there was a significant difference in what was available in the poor peripheral hospitals, it also provided an avenue of potential development with visiting western consultants, especially within orthopaedics.

The invitation to teach at the medical school for a few days provided the opportunity for visiting consultants to understand both the conditions under which students were taught and patients were treated. The medical school is located very close to the Burundi border. This is about a three-hour trip from the capital Kigali. There is a 500-bed hospital associated with the medical school which has a catchment area in excess of one million people. The SWB team was welcomed into a pre-ward round meeting and then invited to be part of a teaching ward round. The lack of structure and teaching on the ward round was a surprise to many consultants, as the ward rounds were left to the junior doctors and were basically working non-teaching ward rounds. There was great satisfaction when the SWB specialists turned their working ward rounds into teaching ward rounds, which was hugely appreciated by the students and doctors.

There were also other aspects which made this trip special. The visit to the gorillas was an amazing highlight. Trekking through the bush to be able to sit with a 200 kg silverback gorilla and his family of many females and children, as they milled around you and looked you in the eye from one or two metres distance I'm sure is a memory that will remain with everyone forever. The photos are worth a thousand words.

The teaching conference was successful on many fronts and has established a very firm platform on which to progress the concept of graduate and postgraduate teaching through SWB. Not to be undervalued is the experience of sharing with a group of consultants, who are all like-minded in wanting to improve medical education by giving of their time and effort, perhaps best summarized by Kate Drummond, neurosurgeon: "What a joy it was to interact with colleagues who work in such a different place but with whom we had so much in common in terms of clinical, personal and training challenges. We could all have so much to offer each other in the future." There was also a camaraderie which will remain with many for a considerable number of years and hopefully promote an individual response to the medical education in developing countries.

There was a real enthusiasm amongst specialists that this was an effective way that they could contribute, a way that fitted into their otherwise very busy lives. There was a consensus that this was also a very effective way of improving medical standards in areas where there are those who do not have the higher education facilities that are taken as the accepted norm in Australasia. Concept teaching in this format should be developed and exported into countries who want to supplement their own medical education with visiting specialists.

SWB then will now work to develop the educational model, to refine it with feedback from the specialists who participated and to look to expand it not only into Africa but the Asia Pacific. Those specialists who are interested in teaching will be invited to register through the SWB website, while industry will be approached to provide further corporate sponsorship, thereby allowing these seminar conferences to be conducted at minimal cost to the participating doctors. Those organisations who feel that they might well benefit from such a teaching program will be able to contact the committee of SWB through the website to arrange country/organisation-specific teaching conferences/seminars/workshops/assessments.

SWB wishes to thank the following specialists
Professor Inis Bardella – physician/Denver/USA
Dr. Bill Bevins – emergency physician/USA
Dr. David Birks – surgeon/Melbourne
Dr. Corrado Cancedda – immunologist physician/USA
Dr. Kate Drummond – neurosurgeon/Melbourne
Dr. John Gan – vascular surgeon/Port Macquarie
Professor Jegan Krishnan – orthopaedic surgeon/Adelaide
Professor Suren Krishnan – ENT surgeon /Adelaide
Dr. Cristy Norton – dentist/Hobart
Professor James Smith – ENT surgeon/USA
Dr. Frank Stenning – surgeon/Sydney
Dr. Julie Williams – anaesthetist/Canada
Dr. Peter Zelas – surgeon/Sydney

Written by Paul Anderson, Director, SWB

PROVINCIAL SURGEONS


Robert Fitridge


BINH NGUYEN


Lovelace Osei Tutu & Philip Carson

PHOTOGRAPHS BY JOHN ALOYSIOS HENDERSON


Peter Hughes, Bob North & John McKee


Barry Alexander & Graham Stewart

Infections in Surgical Practice

Ollapallil Jacob
Convenor, PSA

The 45th Provincial Surgeons' of Australia (PSA) conference was held this year in Australia's most famous outback town, Alice Springs, on Wednesday 29 July to Saturday 1 August 2009.

Alice Springs is nestled between the East and West MacDonnell Ranges, in the geographical centre of Australia, surrounded by dramatic semi-desert landscapes, steeped in Aboriginal culture and pioneer history. It was a perfect setting for a very successful meeting. Alice Springs was an eye-opener for many of the delegates, finding a modern city with most urban facilities in the middle of nowhere. The PSA was held at the state of the art Alice Springs Convention Centre and entertained delegates and associates with very unique and exciting social activities reflective of Alice Springs multi-cultural society.

One hundred and forty delegates, including 95 surgeons from remote areas, plus Trainees and medical students attended the conference. The scientific program was of top-notch quality and was well balanced. Some of the sessions were well regarded for their quality, such as the plenary on 'Surgical infections'. The conference theme, 'Infections in Surgical Practice', caused lengthy discussions and informative presentations and the one-day workshop on the 'Management of High Risk Diabetic Foot' was highly educational. Professor David Armstrong, the Professor of Surgery at the University of Arizona, USA, enthusiastically led the workshop.

The conference was fortunate to have invited speakers, Associate Professor Philip Carson, a General Surgeon at the Royal Darwin Hospital, along with Professor Robert Fitridge, the Head of Vascular Surgery at The Queen Elizabeth Hospital, Adelaide.

The delegates were toured through Alice Springs Hospital and many were impressed with the Renal Dialysis Unit, which is one of the largest in the country.

Don't miss next years PSA conference in the relaxing and peaceful rural setting of Cable Beach, Broome. With the theme "Work Life Balance" you must mark Wednesday 1 September to Saturday 4 September 2010 in your diary for what is expected to be another popular and productive meeting.

Preliminary Notice –

Surgical Research Society Annual Meeting

The Surgical Research Society 46th Annual Scientific Meeting will be held in Adelaide on **Friday 20th November 2009.**

The meeting will be titled

"Australasia's Got Talent – in Surgical Research".

This meeting is open to all who are involved in or who are interested in research, including surgeons, surgical or medical trainees, researchers or scientists.

Call for Abstracts:
Abstracts must be submitted no later than Wednesday 30th September 2009.

Convenor:
Professor Guy Maddern

For further information contact:
Jessica Jeffery
Administrative Officer
Tel: +61 8 8363 7513 / Fax: +61 8 8362 2077
Email: jessica.jeffrey@surgeons.org

To *talk* or *not* to talk?

Have you ever had good or bad experiences with a patient complaint?

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We are looking for volunteers in NSW who share their experience in a confidential interview, which is part of an international PhD project undertaken by Katja Beitat.

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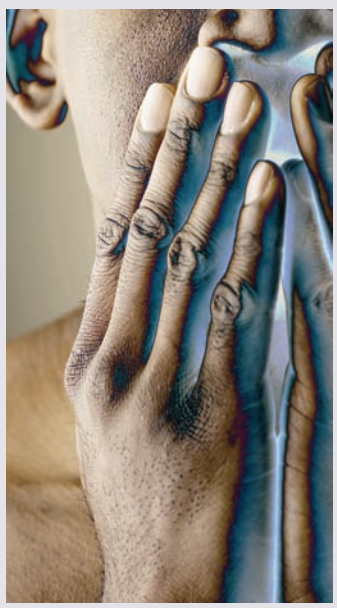
The study is part of the PhD project undertaken by Katja Beitat for the University of Leipzig/Germany in association with the University of Technology Sydney.



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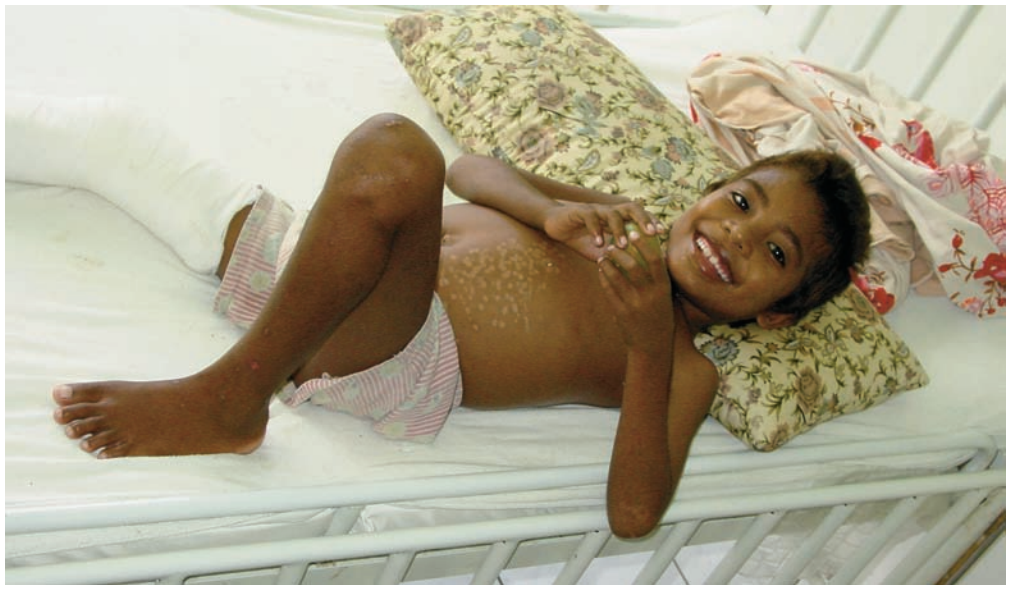

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Factitious disorders

Musings about Munchausen Syndrome, are there three types?

Felix Behan
Victorian Fellow

On a recent theatre list I had an interesting clinical experience even at my age. In the Anaesthetic room a patient was awaiting surgery. My registrar was not there with me to present the details on his line of management. He had mentioned beforehand that this lady had presented for removal of something off her leg.

When I addressed the patient in this context, my question was "now what am I removing today?" She said "I have a scar on the leg at a skin graft site and I was told you could possibly fix it". Previous attempts at serial scar revision had been unsuccessful. People knew I have successfully closed similar defects in melanoma patients with the usual keystone technique.

Like any experienced surgeon, I exposed the whole lower limb to examine it and found, to my horror, she had a donor site dressing on her upper thigh. On further questioning, it transpired, this had been there for six months. I then glanced at her notes on the anaesthetic bench. There were five volumes, each about five inches thick – "a warning sign". At this stage the alarm bells were ringing and I asked her "why have you been in hospital so often?" suspecting some major clinical catastrophe like nephrotic syndrome. She gave a history of repeat overdose needing ICU admission. It transpired she was seen in our unit six months earlier and it was found that she has been putting oven cleaner on the skin graft donor site.

I took her into theatre and manually debrided the wound under general anaesthesia and dressed it with the usual donor site techniques, reinforced with soft topical non-removable dressings, and signed it "not to be removed without my permission". I heard that she had later that evening discharged herself. This clinical history stimulated me to recount the story of some of my other Munchausen experiences over the last three and a half decades, and three cases in particular spring to mind – I wonder if this is the statistical average (one every ten years and I would welcome other comments).

The second case makes an interesting narrative, in the 1980's. In those days the medical administrator allowed us to transfer insurance patients to the private domain. Over a two month period a general surgeon and I operated on this young man a number of times. He had sustained abdominal injuries in a motor vehicle accident, a perfectly credible story until I later questioned the multitudinous mature abdominal wall scars – another warning sign.

"As one of my mentors and later colleagues said years ago "Plastic surgeons are sometimes described as psychiatrists with knives" – but not always."

Three days before discharge he asked a young nurse for $15 so that his clothes could be dry-cleaned. I asked the young lady some months later whether she had ever received her money. She was never paid.

Some years later, I was doing Monday morning rounds when I encountered the same individual, recently admitted again with abdominal trauma. Needless to say he signed himself out within the hour when I confronted him.

A further story relates to a nursing aide who burnt her finger on a steriliser. The registrar in the Emergency Department referred her to me for grafting (which failed), which was repeated and failed a second time before doing a cross finger flap. The resultant stiff finger years later resulted in a ray amputation of the middle finger, by another specialist, as I discovered when she came back to me for a medico legal report seeking compensation for this work related injury.

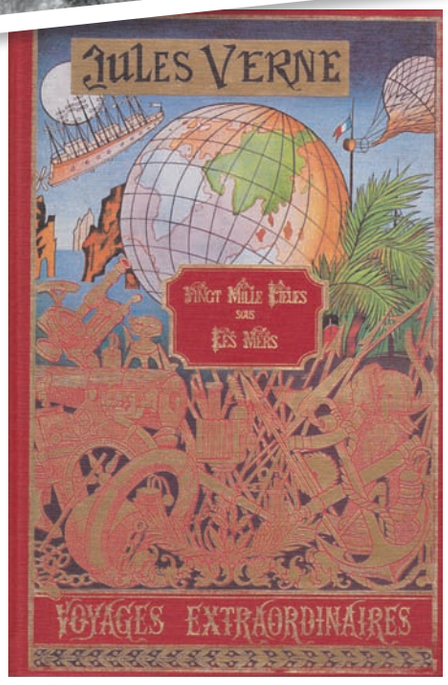
As we know musing is gazing meditatively and reflectively in a literary context. This led me to ponder the Munchausen syndrome. Whether by proxy or direct involvement in the public or the private sectors, this psychiatric disorder is classified as a factitious sequence of clinical episodes - fancied, feigned or self-inflicted-. It is interesting how this eponym arose: Richard Asher in 1951 was the first to describe such self-harm, recalling Baron Munchausen in an article in the Lancet. He mentioned how the Baron had a list of fantastic stories, beyond belief, reflecting daring exploits, quite unbelievable. In his obituary in the British Medical Journal, it was mentioned how Asher respectfully dedicated this syndrome to the Baron

The Baron served in the Russian military forces against the Ottoman Empire and acquired a reputation for witty and exaggerated tales and became the subject of numerous texts published in 1862 by Gustav Doré, from balloon flights, to taming wolves to shooting flocks of ducks and being mauled by bears (en.wikipedia.org).

However the idea occurred to me that this recollection had a similar ring to another particular person who also wrote about fictional and fanciful adventures. He was far more readable and he became the second most translated author of all time, (second only to Agatha Christie). Having written *Journey to the Centre of the Earth* in 1864, then *20,000 Leagues Under the Sea* in 1869, and *Around the World in 80 days* in 1873 – none other than the great Jules Gabriel Verne (1828-1905)

He lived along the Loire Valley. At the school of St Donation College, one of his tutors in drawing and mathematics was possi-

Gustav Doré's Munchausen illustration



20,000 Thousand Leagues under the Sea

bly the French inventor Brutus De Villeroy who invented the first US submarine, the USS Alligator. Verne came under the influence of Alexandre Dumas and Victor Hugo, who offered him advice about his writing. The acceptance of his novels only improved when he met Pierre Jules Hetzel, who recommended a little comic touch and more happy endings to make the novels sell.

In 1863, Verne foreshadowed the events of 150 years with his story Paris in the 20th century, a novel about a man who lives in a world of glass skyscrapers, high speed trains, gas powered automobiles, calculators and a world-wide communication network. What's new. This unpublished work stayed in the family archives, and was discovered by his grandson and published in 1994. It brings to mind the Hemmingway quote that "Paris is a moveable feast", and you had only to see the Champs Elysees on Bastille Day this year with the Sikh battalion marching down in unison in their blindingly white turbans and tunics with regimental colours on their epaulettes, with their bronze complexion it was a sight to behold. Paris is spectacular! Verne was an honest romantic in his narratives whereas Munchausen's extravaganzas bred absurdity.

Regarding my recent Bordeaux experience, as I often hunt into the old antiquarian book stores in the old cities (and there are more stories coming about the medical text books I found). On one such occasion when visiting such a bookstore I asked whether there were any available books by Jules Verne. I pronounced his name with a slight English inflection. They looked at me as if I were an uneducated foreigner trying to pronounce French and struggling at that. I repeated my request and likewise got the same response. Finally the three people behind the counter, when they appreciated what I was saying burst into laughter and repeated my question with beautiful French intonation. Phonetically it is spelt "Vairne", embarrassed I walked away somewhat belittled, a little wiser, and a little wealthier as I did not buy anything. Who could?

When somebody asked me recently why I write these stories I again have to quote Hemmingway who said about letter writing "It's a swell way to keep you from working, yet you feel you have done something". As a result I now have found out there could conceivably be three types of Munchausen syndrome, one by proxy which have a strong paediatric flavour, those from the public domain which are "hospital hoppers" and the third group which we strike in private practice are paying customers seeking perfection from a surgical procedure which realistically is beyond the realm of possibility even at the third scar revision attempt. As one of my mentors and later colleagues said years ago "Plastic surgeons are sometimes described as psychiatrists with knives" – but not always.

The Robert Danis Prize

Stephen Deane is internationally recognised as the pre-eminent trauma care specialist in Australia

Ian Civil
New Zealand Fellow


Stephen Deane

International Surgical Week was the 43rd World Congress of Surgery for the International Society of Surgery. Stephen Deane was awarded the prize at the International Surgical Week in Adelaide earlier this month

The Robert Danis Prize will be given to the surgeon, author of the most important and personal work in connection with surgical treatment of fractures (orthopaedic treatment excluded) and in connection with techniques, clinics or experimentation of fracture treatment and with the pathophysiology of trauma in general.

Stephen Deane has been a singular contributor to the field of trauma care internationally, predominantly in the fields of education, systems of care, and governance. As Senior Lecturer in Surgery at one of Sydney's largest hospitals, Westmead, in the 1980s Stephen pioneered many aspects of care now integral to the trauma center/trauma service model. It was during this time that he was the leading figure in the introduction of the Advanced Trauma Life Support (ATLS™) course to Australasia and subsequently supported its introduction to a number of other countries in the region.

As well as being a foundation member of the International Association for the Surgery of Trauma and Intensive Care (IATSIC), Stephen was part of the group that initiated the Definitive Surgical Trauma Care (DSTC) course. As one of the guiding hands he has contributed significantly to the refinement and promulgation of this course which is now delivered in over 20 countries of the world, training over 3000 surgeons. Also within IATSIC Stephen has been involved in the development of the National Trauma Management Course (NTMC) and has on a number of occasions travelled to India to deliver this program.

Professor Deane has held full Chairs in Surgery at the University of New South Wales since 1992 and more recently at the University of Newcastle. He has spoken and published widely. He has been sought after not only for presentations in the field of trauma but also for trauma service and system reviews requiring balance and wisdom. Stephen has been involved in governance activities with the Royal Australasian College of Surgeons having a multitude of roles over nearly ten years culminating in the Vice-Presidency in 2007. At the same time he has had a significant role with the ANZ Chapter of the American College of Surgeons, being Chapter President from 2000-2005 and an elected member of the Board of Governors from 1999-2004. Stephen has been on the International Relations Committee of the American Association for the Surgery of Trauma since 2006, and of course IATSIC, of which he was President from 2001-2003.

Stephen is internationally recognised as the pre-eminent trauma care specialist in Australia and has made sentinel contributions to systems of care, education, and governance. He is a worthy recipient of the Robert Danis prize.

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Cut-Resistant Glove Liners

Spectra® polyethylene sterile personal protective gloves.

Ansell's Cut-Resistant Glove Liners are made with Spectra® polyethylene fibre, a material 17 times more cut resistant than latex, providing superior cut resistance and protection during rigorous procedures while maximising your dexterity and comfort. This glove liner is an ideal protective underglove for orthopaedic, trauma, vascular procedures, and for any other surgeons concerned about safety and appropriate hand protection. Protect your most important asset with Ansell's Cut-Resistant Glove Liners.

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