ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

# SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 16 NO 8 SEPTEMBER 2015

## PREVENTING ROAD TRAUMA

Perth Hospital leading the way in a nationwide program **p38**

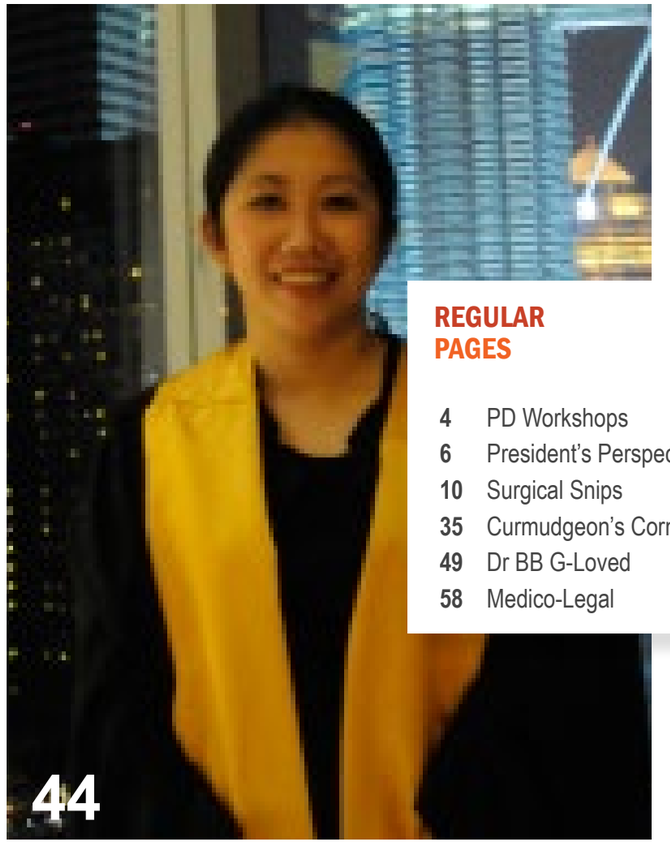
**RURAL SURGERY**
Bridging the urban versus rural divide

08

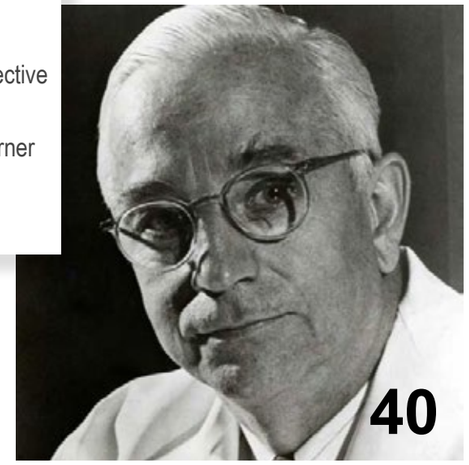
**WOMEN IN SURGERY**
Surgical opportunities through military service

20

# CONTENTS








**REGULAR PAGES**

4 PD Workshops
6 President's Perspective
10 Surgical Snips
35 Curmudgeon's Corner
49 Dr BB G-Loved
58 Medico-Legal

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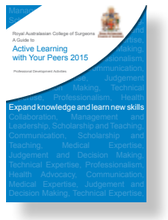
ON THE COVER:
Preventing road trauma, p18

**[12] EAG MEMBER PROFILE**
Ex Police Chief Ken Lay brings his expertise
**[16] NEWS FROM QUEENSLAND**
An update from Queensland Chair Owen Ung
**[20] WOMEN IN SURGERY**
Surgical opportunities through military service
**[22] INDIGENOUS HEALTH**
Indigenous Health Medal recipient Jonathan Koea
**[30] MERCY SHIPS**
Bringing hope through medial treatment
**[46] PROGRAMS IN MYANMAR**
Annual Scholarship to improve training outcomes
**[60] SAASM**
South Australian Audit of Surgical Mortality is celebrating 10 years

PROFESSIONAL DEVELOPMENT

# WORKSHOPS & ACTIVITIES

***Online registration form is available now (login required).***
*Inside 'Active Learning with Your Peers 2015' booklet are professional development activities enabling you to acquire new skills and knowledge and reflect on how to apply them in today's dynamic world.*




## Safer Australian Surgical Teamwork

**25 September - Armidale, NSW**
**10 October - Lismore, NSW**
**30 October - Wangaratta, VIC**

The Royal Australasian College of Surgeons (RACS) with the Australasian College of Anaethetists (ANZCA), the Australian College of Nursing (ACN) and Australian College of Operating Room Nurses (ACORN), is offering a combined workshop for surgeons, anaesthetists and scrub practitioners working in rural and regional Australia. The workshop focuses on non-technical skills which can enhance performance and teamwork in the operating theatre thus improving patient safety. It explores these skills using three frameworks developed by The University of Aberdeen, Royal College of Surgeons of Edinburgh and the National Health Service - Non-Technical Skills for Surgeons (NOTSS), Anaesthetists Non-Technical Skills (ANTS) and Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS).

## Acute Neurotrauma

**24 September - Cairns**

Surgeons will gain the skills to deal with cases of neurotrauma in the rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, the workshop teaches these skills using equipment typically available in smaller hospitals, including the Hudson Brace. Participants will develop a capacity to accurately evaluate whether on-the-spot treatment, using the procedures learned, is required.

They will also learn to perform, through demonstration and practice on human cadaveric material: a burr-hole procedure with Hudson Brace, craniectomy, craniotomy and tap-shunt procedure.

## Clinical Leadership Group Forum, "Surgery and the frail older person"

**9 October - Melbourne**

The Victorian Clinical Leadership Group on care of older people in hospital has just produced their 3rd Newsletter. It includes information about the inaugural CLG Forum, "Surgery and the frail older person" to be held on Friday 9th October in Melbourne. A full program and registration at **www.registernow.com.au**

For more information and to receive a copy of the newsletter or to be added to the mailing list, please contact Joanne Cairney, Project Manager on **(03) 9076 6885** or email **J.Cairney@alfred.org.au**

## Foundation Skills for Surgical Educators

**16 October – Hobart**
**17 October - Wellington, NZ**

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

## Keeping Trainees on Track (KToT)

**31 October – Adelaide**

This revised 3 hour workshop is aimed at providing professional development for Supervisors and Trainers in performance management of Trainees in difficulty. The workshop allows participants to explore strategies for diagnosing and supporting Trainees in difficulty, and helps them to understand the principles behind 'difficult but necessary' conversations.

## Acute Neurotrauma

**24 September – Cairns**

Surgeons will gain the skills to deal with cases of neurotrauma in the rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically–applied relief of pressure on the brain. Importantly, the workshop teaches these skills using equipment typically available in smaller hospitals, including the Hudson Brace. Participants will develop a capacity to accurately evaluate whether on–the–spot treatment, using the procedures learned, is required. They will also learn to perform, through demonstration and practice on human cadaveric material: a burr–hole procedure with Hudson Brace, craniectomy, craniotomy and tap–shunt procedure.

## Non-Technical Skills for Surgeons (NOTSS)

**13 November – Melbourne**

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


workshop

## October - December 2015

ACT
**2 December**
Clinical Decision Making, Canberra

NSW
**16-17 October**
Critical Literature Evaluation and Reasearch (CLEAR) Course for Consultants, Sydney
**16 November**
Foundation Skills for Surgical Educators, Sydney
**17 November**
Supervisors and Trainers for SET, Sydney

NZ
**9 October**
Keeping Trainees on Track, Auckland
**17 October**
Foundational Skills for Surgical Educators, Wellington

QLD
**24 September**
Acute Neurotrauma, Cairns
**29 September**
AMA Impairment Guidelines 5th Edition: Difficult Cases, Brisbane
**23 October**
Finance for Surgeons, Brisbane
**14 November**
Building Towards Retirement, Brisbane face-to-face workshop; Online - live via web link

SA
**31 October**
Keeping Trainees on Track, Adelaide

TAS
**16 October**
Foundation Skills for Surgical Educators , Hobart

VIC
**9 October**
Clinical Leadership Group Forum, "Surgery and the frail older person", Melbourne
**31 October**
Communication Skills for Cancer Clinicians: Breaking Bad News, Melbourne
**26 November**
Keeping Trainees on Track, Melbourne

*Global sponsorship of the Professional Development programming is proudly provided by Avant Mutual Group, Bongiorno National Network and Applied Medical.*

# THE BEST OUTCOMES

## The importance of ensuring high quality care

**DAVID WATTERS**
President

The older we are the more likely we are to have had a major procedure ourselves. Thinking back to your own experience, you probably selected your surgeon using insider knowledge of whom you could trust, either because your colleagues trusted that surgeon or because you knew of his or her work. Your choice will have been based on someone who had a reputation for managing their complications well, because the last thing you would want is to have an operation from someone that wouldn't recognise that a complication was occurring and then fail to intervene in a timely manner. It has long been said, "You know how good a surgeon is when you have seen him or her manage complications."

How many times have you heard from patients: I went to see Mr or Ms X because they are "the best? We need to change this perception about "the best" towards the reality that the vast majority of our Fellows are competent, perform to a high professional standard and have the wellbeing of the patient as their primary concern. To believe you are the best is a delusion; to entertain or encourage such perceptions in patients is inappropriate – it is poor form and shows little respect for your peers upon whom you depend.

Most surgeons deserve to be trusted. But in today's world there are ombudsmen, funders and health departments calling for disclosure and reporting of surgical outcomes. Their call is not unreasonable, so we surgeons should engage in the process. Cardiothoracic surgeons have led the reporting of outcomes at State, Region and National levels in many parts of the world. In some countries, notably the UK, outcomes are reported by individual surgeon. However surgeons in modern healthcare are team players, often team leaders, so their outcomes are dependent, particularly for major procedures, on the quality of perioperative care including ICU, or rehabilitation services. When considering fractured neck of femur, outcomes are often measured by survival, mobility and return to previous stage of independent living. One depends on multiple providers of care delivering prompt orthogeriatric perioperative management of comorbidities, excellent rehabilitation including physiotherapy at the weekends, as well as a timely and well performed surgical procedure. For a baby with a congenital anomaly the outcome will depend on both functional result and appearance and may involve dieticians, dentists, physiotherapy and/or speech therapy. So surgical outcomes reflect the quality of care delivered by multidisciplinary teams. Therefore it is much more appropriate to report surgical outcomes by service and hospital than by individual consultant. Multi-source feedback, peer review and surgical audit meetings are what should enable surgical divisions to be assured of the performance of their constituent individual surgeons.

The surgical outcomes that need to be reported should be appropriate to the procedure performed and the condition being treated. Whereas mortality is a reasonable outcome for much cardiac and colorectal surgery, it is hardly appropriate for patients undergoing surgery for most paediatric conditions, nor for ophthalmological procedures. Similarly, patients don't normally die after a tonsillectomy/adenoidectomy though there is a well recognised rate of unplanned readmission for delayed post procedure bleeding, often as much as 10%. It is important that we accept that all procedures we perform are subject to a complication rate and that even in a high quality service there will still be complications. So Health Insurers need to cover not only the procedure and episode of care but also include a reasonable allowance for complications and adverse events – they cannot always be avoided.

Surgical outcomes also need to be risk adjusted. Urgency, age, and comorbidity (ASA) are the most important, though for many conditions stage of disease is also highly influential. Today frailty measures or premorbid performance status are also relevant, particularly for surgery on the elderly. The numbers of cases for which a certain outcome is reported needs to be large enough so that complication or outcome rates are not widely variable because of small numbers or short reporting periods.

Ensuring high quality care and reducing variability of poor outcomes is fundamental to all medical colleges that focus on clinical standards. Indeed reducing variability of patient care has become a core strategic goal within the College of Surgeons of England's recently announced strategic plan. It is critical that reliable and accurate data can be obtained and used meaningfully by our surgical teams so that changes and improvements can be identified and monitored. The public, our patients and the funders of health care also have a right to full access to this information. This is a worldwide phenomenon and one that as surgeons and surgical leaders we need to support and encourage.

RACS certainly supports the public release of outcomes based data on surgical performance at a team, institutional or national level but there are caveats. The reports need to be valid, reliable and trustworthy so that surgeons and patients can be confident that reports accurately reflect the standards of health care.

RACS does not recommend the release of reports on individual surgeon performance as there is so much dependence on surgical teams and institutional support in the delivery of surgical care. Nor does RACS support league tables.

There is also no such thing as a zero complication rate. The surgeon who "has never seen a complication" has not done enough operating. Managing complications can be challenging and how we respond to complications provides also an opportunity to reflect and learn. It is for this reason that those funding healthcare need to factor in a complication rate, including unplanned readmissions and returns to theatre for the procedures and treatments they cover. And for the patient, they are best treated by the surgeon who knows them best, the one who performed the procedure. This is why surgeons need to provide continuity of clinical care, and be available to manage complications, or when appropriate coordinate and co-opt other relevant specialists to support them. This serves the patient's best interests.

PRESIDENT'S
PERSPECTIVE

## RACS Support Program

The College recognises that Trainees, Fellows and International Medical Graduates may face stressful situations on a daily basis. Coping with the demands of a busy profession, maintaining skills and knowledge and balancing family and personal commitments can be difficult.

**The College has partnered with Converge International to provide confidential support to surgeons. This can be for any personal or work related matter. Converge counsellors are experienced in working with individuals in the medical profession.**

- Support is confidential and private
- Four sessions per calendar year are offered (funded by the College)
- Assistance can be provided face to face, via telephone or online
- Services are available throughout Australia and New Zealand

**How to contact Converge International:**

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
- Email eap@convergeintl.com.au
- Identify yourself as a Fellow, Trainee or IMG of RACS
- Appointments are available from 8:30am to 6:00pm Mon-Fri (excluding public holiday)
- 24/7 Emergency telephone counselling is available.

Converge international

# A CAREER IN RURAL SURGERY

## Bridging the urban versus rural divide

**GRAEME CAMPBELL**
Vice President

Over 25 % of the population of Australia live in rural areas, however only 15% of surgeons live in these areas. This imbalance may be a contributor to the poorer health outcomes repeatedly documented for rural communities.

When I commenced practice in Bendigo, Victoria in 1991, rural surgery was at a crossroads. Rural Australia itself was faced with population loss and a steady erosion of services, as banks, legal and other professional services contracted into capital cities and larger regional centres.

The Provincial Surgeons of Australia had been meeting annually since the 1960s. This group had a shared vision of maintaining and expanding surgery across the whole country. This ultimately led to the formation of the Rural Surgical Training Program, initially chaired by David Birks, and later by me. Whilst the effectiveness of this program was never proven scientifically, a considerable number of graduates of that scheme now work in rural areas.

Looking around rural Australia now, the metamorphosis of the surgical landscape has been dramatic. Many rural centres are now exhibiting strong population growth especially across the eastern states. The erosion of banking and other services has been arrested. Rural Medical Schools have sprouted across the country, and medical students can now be found in almost every country town. Exposure to this style of practice is translating into stronger retention of doctors in rural areas. The number of rural general surgeons has been maintained, although nearly half of new rural surgeons are international medical graduates. Integrated cancer centres have been established in rural areas across several states, providing the facilities for the treatment of many cancers, much closer to where patients live. It is now acceptable to proudly stand up and declare: 'I am a rural general surgeon!'

So, what are the attractions of rural practice? There is something uniquely gratifying in walking down the street and meeting patients whom you treated many years earlier. They are usually extremely grateful, and will let you know this. Generally a commute to work is less than ten minutes. This means more hours in the day, which can greatly assist work life balance. It is possible to practice broadly within the specialty. This makes for an interesting practice and requires ongoing education. Our Annual Scientific Congress or ASC provides this extremely well. There are also opportunities for extended scopes of practice. This can include paediatric surgery, plastic surgery, and vascular surgery. RACS now has an excellent position paper emphasizing the need and appropriateness of both generalism, and extended scopes. There is a growing national recognition that these principles can be applied to medical disciplines as well as to surgery.

There has been a lot of discussion around the need for rural General Surgeons, however it is my belief that there is an even greater need for Orthopaedic Surgeons, Urologists, and OHN surgeons in rural areas. Some larger centres now attract Plastic Surgeons, Paediatric Surgeons and Vascular Surgeons. The timing has never been more opportune for any Surgical Trainee wishing to consider a rural career.

The situation across the Tasman is a little different. New Zealand has a more distributed population and its regional centres remain strong. There are only a few really remote hospitals. The need for surgeons in the regional centres is strong and IMGs play an important role. This also means there are lots of opportunities for local Trainees.

As a rural surgeon, I have always felt able to contribute to RACS. A lot of the committee work is done by teleconference. Travel is something rural people are used to. It was great to see Tom Bowles, resident in Albany, chairing the WA State Committee, and Council has been blessed over recent years with input from John Graham, Simon Williams, and of course our current President.

Rural Surgery has a great future. Why not consider an Escape to the Country? Make contact with RACS on **+61 3 9276 7425**, or talk to any current rural surgeon. They're a friendly bunch and will be very keen to assist you.



# College Advocacy

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

## End of Life Choices

The Victorian government resolved in May 2015 to look into End of Life Choices. The Royal Australasian College of Surgeons (RACS) was invited to make a submission to this enquiry, which it did on 31 July 2015. As part of its commitment to standards and professionalism, RACS strives to take informed and principled positions on issues associated with the delivery of health services, and end of life choices are clearly in the RACS spotlight.

RACS made the following recommendations:

RACS will continue to educate and support surgeons in the multidisciplinary environment in which end of life decisions are made Patients and their carers should be assisted to develop realistic expectations of surgery, its objectives, and its potential outcomes.

- Members of the community should be better informed about Advanced Care Directives, and encouraged and assisted to put one in place before the need arises.
- Surgeons and other healthcare professionals should honour the wishes of the patient as expressed in an Advanced Care Directive.

and although the College does not have a position on euthanasia as an organisation, it does however require that its members act in accordance with existing legislation.

## NZ Performance Outcome Data

A ruling late last year from the New Zealand Office of the Ombudsman recommended that District Health Boards should make New Zealand data relating to the performance of individual surgeons publically available. The Medical Council of New Zealand responded by releasing a discussion paper on the value that such data may provide. At the end of June 2015 RACS provided comment to the Medical Council of New Zealand's discussion paper on the value of performance outcome data.

RACS looks forward to engaging in discussions on a framework for the release of surgical data. RACS acknowledges the public's wish for more information; however it says surgical data must be presented in a way that is both meaningful and useful. Raw data cannot describe how well a surgeon performs. There are many factors that affect the final result from a surgical procedure besides the skill of the surgeon. Without context, surgical data has the potential to be misleading and harmful.

College advocacy submissions can be viewed at:
**www.surgeons.org/media/college-advocacy**

Any comments can be made to the College at
**college.vicepresident@surgeons.org**

## Challenging stereotypes, one tweet at a time

The #ILookLikeASurgeon movement has taken off on Twitter, with thousands of surgeons, both female and male, uploading pictures of themselves to celebrate diversity in the profession.

The Twitter conversation about women in male-dominated fields began when software engineer Isis Angalee received negative feedback about her involvement in a company ad campaign, and started the #ILookLikeAnEngineer hashtag. Upon seeing the success of the movement, Dr Heather Logghe asked her Twitter followers whether surgeons should follow suit, and the #ILookLikeASurgeon hashtag was born. Surgeons from all over the globe have become involved, and are highlighting the many different faces of the modern world of surgery.

**#ILookLikeASurgeon**

## Action on quad bikes

The Royal Australasian College of Surgeons (RACS) have called for the Qld Government to act quickly on recommendations from the coronial inquest into quad bike deaths.

Queensland head of the RACS Trauma Committee Dr Richard Lewandowski said that major quad bike injuries are on the rise.

“Quad bikes are inherently unstable and leave very little room for rider error. Children, who are often more inexperienced and careless than older riders, can end up dead or diabled as a result,” Dr Lewandowski said.

*South Burnett*, 19 August


## Patient thanks

Plastic surgery patient Pete Fisher has thanked surgeon Swee Tan for repairing his beaten face three years after the traumatic event.

Fisher’s injuries were so bad that they were compared to a plane crash victim. Despite his injuries, Tan did not leave a scar on Fisher’s face.

“I’m very impressed by how far [he’s] come. [He] had courage and that courage has carried on through recovery,” Dr Tan said.

*The Press*, 18 August

SURGICAL
SNIPS


## MJA Report

Significant cultural change is necessary to make perpetrators of discrimination, bullying and sexual harassment aware that their behaviour will no longer be tolerated, a report in the Medical Journal of Australia says.

The report from RACS President David Watters and CEO David Hillis outline that leadership is required in understanding, taking responsibility, providing training, recognising the rights of victims, providing timely responses and confidential counselling.

“Medical colleges have a vital role to play in honouring the ‘societal contract’ that exists between the profession and the public,” the report says.

*Medical Journal of Australia*, 17 August

## Regular screening a must

Surgeon Mary Theophilus has reiterated the importance of regular colonoscopies after a patient’s stomach complaint turned out to be bowel cancer.

Michael Zirinio thought he had eaten too much chilli, but is now recovering thanks to keyhole surgery by Dr Theophilus.

“We have the National Bowel Cancer Screening program now and a lot of people don’t take it up.”

“The longer you leave it, the higher risk of having a stoma, surgery or major issue later on,” Dr Theophilus said.

*Guardian Express,* 11 August

# MEMBER PROFILE: KEN LAY

## The ex-police chief has a long history with addressing discrimination

Former Victorian Police Commissioner Mr Ken Lay has spent his 40-year working life in law enforcement saving lives and embedding cultural change across Victoria and within its police force.

Joining Victoria Police in 1974, Mr Lay rose through the ranks to become head of Road Policing in 2009, a leadership position that allowed him to spearhead a campaign that delivered four record low road tolls, a feat never before achieved.

In the wake of this success, governments and agencies across the world sought his advice on road safety strategies including the United Kingdom, Indonesia, Canada, New Zealand and Kuwait.

Appointed Chief Commissioner in 2011, Mr Lay worked to reduce the activities of Outlaw Motor Cycle Gangs and developed and implemented a new policing model designed to allow for a swifter police response to emerging threats and serious crime.

He is, however, best known for his work in tackling family violence within the community and racism and sexism within the Police Force.

In 2012, Mr Lay commissioned a ground-breaking report called Equality is not the Same which addressed the way Victoria Police engaged with diverse communities, particularly young men of African origin.

The strategies and protocols outlined in the work were widely acclaimed as representing a new direction for Victoria Police.

Two years later, Mr Lay commissioned the Victoria Equal Opportunity and Human Rights Commission to examine how members of the Police Force treat each other in response to a number of instances where male police had behaved in an offensive and unlawful way toward junior female colleagues.

The first of its kind in an Australasian policing context, this work is ongoing with research still being conducted to understand the breadth of the problem and how best to address the issue.

Before his retirement this year, Mr Lay also raised awareness of family violence and worked alongside the 2015 Australian of the Year Rosie Batty to call for a nation-wide investigation into protecting women and children from violence.

This work is credited with being one of the catalysts that led to the Victorian Government establishing a Royal Commission into Family Violence.

Upon his retirement, Mr Lay was appointed by the Prime Minister as the Chair of the Council of Australian Governments Committee to Reduce Violence against Women and their Children and as the Chair of the Prime Minister's National Ice Strategy Task Force.

This year he also agreed to serve on the College's Expert Advisory Group (EAG) established to investigate claims of bullying, discrimination and harassment in surgery.

A recipient of the Police Medal for 'distinguished service to policing', Mr Lay said he was drawn to becoming a police officer having grown up in a small country town where local police played key community roles.

He spent much of his early career at both uniform stations and Criminal Investigation Units in Melbourne and served in a number of country posts in Gippsland and regional Victoria.

Mr Lay said that looking back on his life in the Police Force he was most satisfied by the work done to reduce the Victorian road toll and his efforts to tackle sexism within the Force and family violence in the community.



EXPERT ADVISORY
GROUP

*"Treating people respectfully and decently should not be negotiable and I was interested in understanding a culture where some thought this was not occurring"*

"I was fortunate enough to lead the state's Road Safety Program when we achieved some quite exceptional results," he said.

"I have no doubt that there are people alive today because of the work done by the team I led and that gives me great satisfaction.

"I also felt enormously proud to be appointed Victoria's 21st Commissioner, mainly because it gave me the chance to implement things that were important to me.

"At times it was a challenge to take on racism and sexism in the force and there were some who argued that there wasn't really a problem, that such attitudes were held by only a very small minority of police officers.

"However, what was missed by these people was that the entire organisation was judged by their actions.

"Not only was it unfair to those affected by the behaviour, it was also devastating to the Force's reputation.

"I was of a very strong view that the key to change was admitting the shortcomings, talking publicly about the need for change and then relentlessly driving change through the organisation."

Mr Lay said that in his time as Commissioner, the issue of how to reduce family violence became increasingly important to him both as a policing and personal issue.

He said he chose to use his senior role to challenge men to change their attitudes and to spur organisations and the government to improve how they dealt with both the victims of such abuse and the perpetrators.

"I understood that family violence, and other forms of bullying and violence, was simply about entitlement, inequity and power," Mr Lay said.

"As a newly appointed Commissioner I was presented with a once-in-a-lifetime opportunity to tackle this issue and I didn't want to leave the job and think that I should have tried harder.

"I was very proud at my retirement dinner when the Premier of Victoria credited my advocacy as being a major driver in the creation of the first ever Royal Commission into family violence."

Mr Lay said he had agreed to serve on the College's EAG because of his interest in workplace culture, how cultural change can best be implemented and his commitment to equality and respect.

He said his close working relationships with the Federal Sex Discrimination Commissioner, Ms Elizabeth Broderick, and the Victorian Equal Opportunity and Human Rights Commissioner, Kate Jenkins, had helped him understand how workplace cultures can be "unmade".

"Major General David Morrison is quoted as saying 'the standard you walk past is the standard you accept' and I agree," Mr Lay said.

"I understand it is not easy to tackle issues such as bullying and discrimination but I believe that everyone needs to be treated fairly, no matter the environment, culture or place.

"Treating people respectfully and decently should not be negotiable and I was interested in understanding a culture where some thought this was not occurring.

"I agreed to work on this in the hope that my experiences within the Police Force could add to the enormous knowledge of the EAG members in challenging and testing the status quo of a professional culture."

*With Karen Murphy*

# NEW TO THE LIBRARY

## Donations and new items of interest in the library collection

The library is extremely grateful for donations from the authors of the following new books, which are now included in the collection. Please contact library staff to arrange for a loan of any of the below titles:

### Anthony Emmett FRACS. Autobiography of a Plastic Surgeon Artist and Philosopher

The author entered medicine and surgery through the family into which he was born. His childhood career began as the family "repair man" which fuelled his interest in the repair of all things. After starting to read his father's obstetrical and surgical book at the early age of 7, he had decided on surgery as a career by 9 years of age.

A 40 year career in medicine and reconstructive surgery led to an interest in sculpture and art and an accompanying interest in philosophy and writing.

The book includes chapters on times spent in England, New Zealand and then back in Brisbane. Other chapters in the section called "Excitement of Surgery" delve into the history on Plastic & Reconstructive Surgery and include Congenital Deformities, Surgery of Appearance, Malignant Skin Tumour and Cartilage Grafting.

The "Academia" section details the author's association with the University of QLD in Brisbane including collaborative authoring of 2 editions of a book on the subject of Malignant Skin Tumours based on the "Australian experience".

The latter part of the book explores retirement, art and philosophy through the eyes of the author.

*Kindly donated by the author.*

### Andrew Raftery, Michael Delbridge, Marcus Wagstaff & Katherine Bridge. Churchill's Pocketbook of Surgery

The fourth edition of this pocketbook provides a concise and didactic account of the essential features of the more common surgical disorders, at both a size and price to suit the pocket. The book covers basic principles, as well as providing essential information on aetiology, diagnosis and management, including pre-operative and postoperative care. The text covers the field of general surgery but also covers the basic needs of the undergraduate as far as the surgical specialities are concerned. The book will assist the student with the essentials of history-taking, what physical signs to elicit, the differential diagnosis, what investigations to order and how to treat the patient. The text is illustrated with line drawings and imaging.

A fifth edition is in the pipeline and will be made available online via Clinical Key once it is published

*Kindly donated by the one of the authors, Marcus Wagstaff FRACS.*



### Harry F Oxer. Any attempt is better than nothing: Australian Resuscitation Council – the first twenty five years

The author's major training is as a specialist in Anaesthesia and Intensive care with a career spent in teaching hospitals. He has represented St John at conferences on emergency and disaster medicine both nationally and internationally.

The ARC endeavours to secure for those who suddenly need life supporting First Aid, a level of community competence widespread enough to maintain the chance of successful resuscitation. The College is a sponsor of the Council.

The book starts with an overview of the organisation and moves onto chapters dealing with the genesis and conception of the ARC before dealing with its early life and growth milestones.

The author also wrote to a number of his colleagues from the early days asking for their thoughts and recollections of the early days. The replies from 9 different individuals are included in Chapter 7 and provide some extra colour and varying points of view to the book.

*Kindly donated by the author.*





# VICTAS ASM

## 16-17 October 2015, Hotel Grand Chancellor

**SU-WEN LOH**
Victorian Convenor


*Mr Jason Chuen (centre) presented medical students, Ainsley Lorych (left) and Joanne Green (right) with prizes of recognition at the 2014 Vic ASM. (L-R: Ainsley Lorych, Jason Chuen and Joanne Green)*

Collaborations across the Bass Strait are in full swing as we prepare for the inaugural 2015 VicTas ASM.

All sessions surround our theme of "Coping with change". Symposium 1 "The changing phases of a surgical career" will include presentations from differing perspectives and experiences. Symposium 2: "When push comes to shove" will include an update on the EAG from Graeme Campbell, RACS Vice President, which promises to be insightful and compelling.

Abstracts are now closed and being finalised. Various prizes in different categories are up for grabs for the best presentations.

We invite you and your family to join us on our Welcome Evening cruise to Peppermint Bay on Friday 16 October, a wonderful opportunity to socialise and network while sampling regional produce overlooking the beautiful waters of the D'Entrecasteaux. The G J Royal Lecture will be presented by A/P Hamish Ewing at the The G J Royal Dinner, Saturday 17 October.

Friday 16 October workshops include the Younger Fellows Workshop (details are forthcoming), VASM workshop and Foundation Skills for Surgical Educators.

We look forward to your company at what promises to be an informative and exciting meeting at a wonderful locale.

**Visit the Vic Tas ASM webpage for more info: http://www.surgeons.org/about/regions/victoria/victas-asm/**

# NEWS FROM QUEENSLAND

## Professor Owen A Ung brings his perspective to the Queensland Board

*(From left): Richard Lewandowski, Reno Rossato and Owen Ung*

**OWEN UNG**
Chair, Queensland Board

This is my first article for Surgical News since assuming the Chairmanship of the RACS Queensland State Committee (QSC). I look forward to the next 2 years with enthusiasm and have no doubt there will be challenges ahead. These are interesting times in surgery, as we face evolving technological advances, rising costs, but the need to face the reality of budgetary restrictions at a Federal and State level. Many Queenslanders had not expected a change of government at the last election let alone the incumbent. With changes of government come changes in health policy, and we as a College need to be ready to negotiate and work with the government of the day, constantly reminding them our willingness to engage in the development of policy related to surgical services in our State.

Waiting lists are a perennial problem in every jurisdiction. The impetus to deal with them at times, seems more to do with crisis management than forward planning. Significant investment in waiting list reduction ebbs and flows depending on the political cycle. Just prior to the departure of the last Newman Government, the Honourable Lawrence Springborg, then Health Minister, had announced a waiting list 'guarantee'. The policy was announced just before the last election. All patients seen at a public hospital would have their surgery within the prescribed time for the category of urgency. If procedures could not be delivered in the public hospital within the prescribed time, patients would receive their procedure in the private sector. The cost would have to be borne by the respective Hospital and Health Services (HHS). Understandably, administrators had some concerns about the potential for cost blowouts. Whilst a zero waiting list is an admirable aim, there were some doubts about the ability to successfully execute the plan. The current government has abolished that guarantee but are still focused on delivering waiting list reductions and wish to focus attention to the outpatient waiting list which of course feeds the surgical waiting list. Delivering surgery in an equitable, fair and efficient way without undue waiting times is of course the "Holy Grail" of public surgical services. We hope to have meaningful discussions with the State Government to achieve those common goals.

There are a number of avenues for channelling advice to the State Health Department. We must be apolitical, but I do hope government will engage the RACS QSC in an ongoing and productive manner. Queensland also has an active Surgical Advisory Committee that is broadly represented and informs Government. As state chair I will be accepting and invitation to join this committee. I have just attended the Statewide Surgical Services Forum on 17 July in Townsville, a meeting hosted by the Surgical Advisory Committee, which is chaired by Robert Franz. This is a good meeting to discuss important issues that affect surgical services across the State. Waiting list management was a highlighted topic of that Forum. The HHS across the State with the injection of additional funds and a lot of hard work and enthusiasm from the surgical departments made significant inroads into waiting list reductions. The challenges ahead are to maintain this, though history has shown that most wait list reduction strategies require on going attention.

Immediately following the Statewide Surgical Forum we held our Queensland Annual Scientific Meeting on Magnetic Island. It is just a 20 minute ferry ride from Townsville and a great place for a small boutique meeting with great speakers and enthusiastic delegates involved in robust discussion. The success of the meeting owes a lot to Mr David Watson our Regional Manager and Bernard Whitfield, our former Chairman who conceptualised and put the programme together. The day before, our Dean of Education, Associate Professor Stephen Tobin facilitated the Foundation Skills for Surgical Educators Course. There was high praise from the participants.

We decided to theme our meeting around current advocacy priorities of our Federal College, targeting such issues as domestic violence, smoking, alcohol and obesity. We are grateful that our President, Professor David Watters was able to attend and his forthright engagement really set the tone of the meeting. Professor Watters, in his opening adess embraced our era of subspecialisation but very much stressed the importance of generalism if we are to continue to deliver important and valuable acute surgery services to the community. In recent years we have very much accepted and endorsed the development of Acute Surgery Units at our Hospitals and the maintenance and delivery of such services is reliant on surgeons with general skills.

It is inevitable that there must be a cross over of subspecialisation and generalism and this could not be better demonstrated than the discussions around obesity management. Associate Professor Wendy Brown was invited from the Monash University Department Surgery and Alfred Hospital to headline a session with George Hopkins a Bariatric Surgeon at the Royal Brisbane and Women's Hospital. Bariatric surgery has become very much a subspecialisation that is still finding its place in mainstream surgery and in particular our Public Hospitals. The obesity epidemic is harming our population and associated with significant comorbidities, such as diabetes, cardiovascular disease, musculoskeletal disorders and there really is not a system that is not affected. Likewise, there is no facet of surgery not affected, as obesity is so prevalent in our community. Challenges faced by surgeons dealing with the obese patient have very much become the norm rather than the exception. Whilst it would obviously be preferable to lose weight by non-surgical means, Associate Professor Wendy Brown discussed the problems of weight loss by diet and maintenance of that weight loss and how lasting weight loss is rarely achieved.


*(From left): John Crozier, Stephen Tobin and David Sidhom*

Our first session of the day dealt with smoking and surgery and Ashley Webb an Anaesthetist from Melbourne with Masters of Public Health and long standing interest in smoking stunned the audience with the interactive presentation adessing the issue of smoking - one of "Titanic Importance". Professor Simon Chapman, a professor in Public Health at the University of Sydney was able to speak authoritatively about the public health implications of smoking and in particular the E-cigarettes hype which is bound to reach greater proportions in Australia. On the following day of our weekend meeting, alcohol was the focus and another learned Public Health Authority, Professor Jake Najman from the School of Public Health at the University of Queensland spoke authoritatively on the topic. The other speaker in that session, Mr Michael Thorn, is the Chief Executive of FARE, an organisation leading the efforts to stop alcohol related harm. He comes from a long background of advocacy for alcohol control and has a strong strategic policy background with extensive experience in strategic social policy, development and implementation. He has previously advised senior ministers in cabinet. Mr Ian Levers, General President and CEO of the Queensland Police Union and also a staunch champion of provision of safe working environment for the police in the community was able to offer an insightful policing perspective to the problem of alcohol fuelled violence.

These are all fairly meaty issues and to some extent we could only scratch the surface, but the enthusiasm was there to move forward and for surgeons to continue to advocate for ongoing cooperation with government and other organisations to curb these important contributors to ill health in our community. Whilst there are certainly other organisations in the medical sphere and elsewhere, that are very invested in these issues, surgeons have an enormous role to play. For instance Ashley Webb explained that smokers were most likely to give up if they were advised by their doctors in conversation and we should never miss the opportunity to remind our patients even in the briefest way. I was blown away by the quality of the sessions and I do not think that any delegate could say that they did greatly enhance their knowledge in these areas.

The meeting also dealt with surgery specific issues, such as training of our young surgeons into the future and preparedness for trauma situations. John Crozier, Chairman of the Trauma Committee was able to speak with authority on the dangers of quad bikes and gave us some insight into the planned inquest into quad bike related deaths. Nathan Brunott and fortuitously his wife Angela Robson have had some experience with burns and whilst not on the spot in Ravenshoe were able to give us many insights into the disaster which resulted in the loss of life and serious injury to 20 occupants of the Ravenshoe Cafe when a vehicle careered into LPG tanks. Nathan and Angela are surgeons from Cairns who had to organise resources around them to manage an influx of burns and trauma patients as the big metropolitan Burns Unit at the Royal Brisbane and Women's Hospital were already at capacity.

Reno Rossato OAM and his wife Jenny were our honoured guests. He recently retired from his position as Director of Surgery at Townsville Hospital. Prior to this he headed the neurosurgical department that he single-handedly established and was the sole neurosurgeon in North Queensland for many years. The thriving neurosurgical department is a legacy of incalculable importance. His dinner presentation was a fascinating jaunt through the history of neuro-imaging and totally captivated the audience.

*Reno Rossato OAM with Jenny Rossato*



# CONGRATULATIONS
## on your achievements

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

*MR MARK MOORE, AM, FRACS*

### Award of the RACS International Medal

Mr Mark Moore became a Fellow of our College in 1988. Mr Moore grew up in New Zealand where he completed his plastic surgery training. He came to Adelaide as a Senior Registrar at the Royal Adelaide Hospital (RAH) in 1987 and subsequently took up a Fellowship at the Australian Craniofacial Unit (ACFU). I guess the attraction to Adelaide's summer made him decide to settle here. Mark is now a Senior Consultant at the Womens' and Children's Hospital and RAH and runs a busy private practice.

Mark has been a visiting craniofacial surgeon to Hong Kong between 1991 and 1998, Christchurch NZ between 1995 and 2003 and Malaysia between 1999 and 2006. He has been a member of the RACS Board of Plastic and Reconstructive Surgery and past President of the Australia and New Zealand Society of Craniomaxillofacial Surgery.

Mark started visiting Darwin in 1997, when there was a need for a plastic surgeon. In 1999, he had the opportunity to meet Dr John Hargrave there. Little known to Mark this meeting would have a profound impact on his future, both professionally and personally.

Dr Hargrave AO, MBE, FRACS renowned leprosy doctor who, while based in Darwin for 40 years, began providing reconstructive surgery services to Eastern Indonesia. He trained with Dr Paul Brand in India and provided treatment to the indigenous community in the Northern Territory. He started medical missions to East Timor and Flores, Indonesia, by providing medication and surgery for patients with deformities from leprosy. Due to his consistent visits and determination to assist the local population, he developed a trusting relationship with the locals and nuns working in the hospitals. Mark accompanied Dr Hargrave to East Timor for a couple of visits. When Dr Hargrave retired, he handed over the reins to Mark. Mark continued his work but identified the need to help a large number of children and adults with untreated cleft lip and palate deformities. A number of severe post burn deformities existed as there was no medical/surgical treatment and no burn surgeons available to deal with severe contractures or provide the necessary long term care. With a team comprising of an experienced anaesthetist, a nurse and interpreter, Mark was able to provide a service to these patients. His 3-4 visits a year, at the expense of his practice in Adelaide, helped connect him with the local people and facilitated the training of local surgeons. As team leader and programme director, Mark has made more than 50 trips to East Timor and Indonesia and operated on more than 2000 patients. He has been supported in this endeavour by RACS and the Overseas Specialist Surgical Association of Australia.

Because of his commitment, dedication and service to East Timor and Flores, in 2007, he was awarded an AM.

*Citation kindly provided by Professor David Scott, AM, FRACS*

*The John Mitchell Crouch Fellowship is the premier research award of the Royal Australasian College of Surgeons. It is separate from Foundation Grants and independently funded. The Fellowship commemorates an outstanding younger Fellow of the College who died in 1977 on the threshold of a highly promising career. John Mitchell Crouch was a young surgeon who showed astute clinical, organisational and research abilities and this award is made to an individual who, in the opinion of Council, is making an outstanding contribution to the advancement of surgery.*

*Mark Moore and Michael Grigg*

# FOCUS ON UROLOGY

## Professor Gormley encourages Trainees to consider Urology as an area of focus

**MICHAEL NUGARA**
CEO, Urological Society of Australia
& New Zealand

In the United States Female Pelvic Medicine and Reconstructive Surgery has gone through board specialisation accreditation to become an ACGME certified program, and it's an area Professor E. Ann Gormley, Professor of Surgery (Urology) and program director of the Urology Residency at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire, encourages Trainees to strongly consider as an area of focus.

"We don't always make patients completely dry and we have to get patients to try multiple treatments before we get there, but for the most part our patients are very, very grateful and we do make a difference to the quality of their life so you can actually see some results both in the treatment of overactive bladder and the treatment of stress incontinence and prolapse."

"It's a field that's always expanding. There isn't a cure for stress incontinence or overactive bladder which means we're always going to be needed in this field," says Gormley.

"If you look at something like the treatment of prostate cancer, if they ever find a way to prevent it there's going to be a lot of urological oncologists with not much to do whereas our field is going to be there for the long term because there really isn't a lot of really basic science or research into why these problems happen.

"We still really don't have really good literature on overactive bladder and we really need to continue to amass betterstudies with more patients in them that would better increase the levels of recommendations we have for the various treatments we use."

Professor Gormley wants to encourage more Australian urologists to be involved with research in the field. "Some of the BOTOX® trials were done in Australia but for percutaneous tibial nerve stimulation and sacral nerve stimulation, that's an area where there could be much more research."

As a female urologist in a traditionally male-dominated field, Professor Gormley says that while gender shouldn't make a difference there can, however, be advantages.

"Women often want to see women physicians so in the field of female pelvic medicine being a woman has its advantages. There are other times where a woman might want to see me for some other issue, such as a renal mass, and I have to explain to them that they need to see the person who

*"It's a field that's always expanding. There isn't a cure for stress incontinence or overactive bladder which means we're always going to be needed in this field,""*

is best trained to see them and that gender shouldn'thave anything to do with choosing their surgeon."

At Dartmouth, Gormley was the first female faculty member in 1993. She's witnessed a significant change in the gender balance since.

"The growth of women in urology has been exponential. In July 2016 more than half of our trainees will be women. As the numbers of women in Urology increase we are doing a much better job dealing with trainees who take maternity leave and more importantly we are now more accepting of urologists, both men and women, who want to work less hours."

USANZ is grateful to RACS for this funding which has contributed to the success of our ASM scientific program.

*E. Ann Gormley*



ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

# Letters to the Editor

## "When is a Surgeon not a Surgeon"

I am writing regarding a short entry in the recent July edition of Surgical News (VOL 16, NO 6 / JULY 2015) in the section "Surgical Snips" on page 10. I have read the media release from Mr Secord which is quoted as saying:

*"The Royal Australasian College of Surgeons states: surgeons are doctors who have completed extra training in the surgical specialty of their choice. There are nine surgical specialities: Cardiothoracic Surgery; General Surgery; Neurosurgery; Orthopaedic Surgery; Otolaryngology – Head and Neck Surgery; Paediatric Surgery; Plastic and Reconstructive Surgery; Urology and Vascular Surgery".*

It should be noted that many of my colleagues who fall outside of these narrow parameters would certainly be qualified to deserve the title "Surgeon". These include but are not limited to the specialties of Ophthalmology, Obstetrics and Gynaecology and Facio-maxillary Surgery. Mr Secord has specifically quoted RACS in his private members bill and I feel this leaves our Fellowship open to heavy criticism by these specialties (and deservedly so).

I clearly understand the reasoning behind the bill and support regulation of the title of "surgeon" but I also feel more consideration should be given to this statement by RACS as it clearly fails to encompass appropriately trained and qualified specialist practitioners who also deserve the title "Surgeon" but who do not have a fellowship with RACS.

I should also declare a conflict of interest here as I am the current AMA (NSW) Councillor for the Surgeon Class and have been active in discussions regarding this topic within that forum.

I would request information on who to correspond with further regarding this position taken by our college.

Yours Sincerely,

Dr Fred Betros

(FRACS, MBBS, B.Pharm)

AUSTRALIAN ORTHOPAEDIC ASSOCIATION
MEDICO LEGAL SOCIETY

THE AUSTRALIAN MEDICO LEGAL COLLEGE

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

Combined Meeting of the
Australian Orthopaedic Association Medico Legal Society
Royal Australasian College of Surgeons Medico Legal Section
Med-Law Association of Australia

Crowne Plaza Hotel
16 Hindmarsh Square
ADELAIDE
SOUTH AUSTRALIA

Friday 20 and Saturday 21 November 2015

For details please contact Kevin Wickham, Conference Secretariat
Kevinwickham@iinet.net.au

*Hollian and WGCDR Alex Douglas with a patient in the Middle East Area of Operations, February 2010*

# SURVIVAL OF SELF

## Annette Holian has embraced surgical opportunities presented through the military service

Group Captain and Orthopaedic and Trauma Surgeon Annette Holian has experienced the highs, lows and everything in between as a surgeon in the Australian Defence Force (ADF).

In the years before joining the Air Force, Dr Holian had regularly visited developing countries as a volunteer with her paediatric orthopaedic team from Monash Medical Centre but felt she could do more in uniform.

Since June 2000, when she was appointed as an Officer in the Air Force, Group Captain Holian has undertaken five deployments in war-like operations and been a first responder at four natural disasters.

She served in East Timor and Afghanistan and has helped treat the victims of two tsunamis including the catastrophe that struck Banda Aceh, an earthquake in PNG and a typhoon in the Philippines.

Yet while she has saved the lives and limbs of many wounded soldiers and disaster victims, she has also headed a medical team tasked with the forensic retrieval and identification of the bodies of colleagues and friends killed in a helicopter crash off the coast of Indonesia.

Nine Australian Defence Force personnel were killed in the accident in 2005 when a Sea King helicopter ferrying an emergency medical team from HMAS Kanimbla, en-route to treat victims of a devastating earthquake, crashed on the island of Nias.

On board the ship, Dr Holian first treated the survivors before returning to the crash site to collect the bodies of the dead for repatriation and burial.

"Even though the accident was obviously extremely upsetting, at the time I became very clinical and focused on what we needed to do," she said.

"We knew there were three Air Force personnel among the dead and as anyone in the military will know, those in uniform feel like family.

"The victims were so badly injured that it was difficult to determine who was who so my approach was to work as long and as hard as we could, despite the extreme heat and humidity, to gather as much identifying evidence as possible so that their families would have their loved ones returned as soon as possible.

"That experience affected me deeply and I came to understand how difficult it is to talk about such events to people who were not there and it gave me an insight into why war veterans often say so little about what they have been through except to other veterans."

Following this deployment, Dr Holian returned to her civilian job as a Trauma Surgeon at the Alfred Hospital in Melbourne before again being called into action.

In 2008, she was the Clinical Director for the NATO medical facility in Tarin Kowt, Afghanistan, when Australia suffered one of its worst battle field incidents since the Vietnam War.

In the fading afternoon light, a group of elite SAS soldiers were ambushed in a barrage of rocket and machine-gun fire as they were returning to base after searching for Taliban insurgents and their bomb-making factories.

Nine Australian soldiers were wounded in the attack but made it to safety through the heroics of their comrades. They were then air lifted direct to Dutch/Australian Kamp Holland Hospital and others to the nearby US hospital before being transferred to the ADF surgical team.

There, Dr Holian activated the Multiple Casualty Plan, set up extra trauma beds and triaged the soldiers. The team operated into the night conducting surgery for chest and abdominal wounds and bullet injuries to limbs.

*"At times we had a Neurosurgeon and General Surgeons working on various injuries and all five Orthopaedic Surgeons working on the limbs and it was quite an extraordinary experience."*

She said that because the soldiers had high-energy bullet wounds, the injuries were complex and almost all of the injured required several visits to surgery to keep the wounds clean.

The speed of their transfer and the skills of the medical teams contributed to the survival of all the Australian soldiers involved in the attack.

The following year, one of the soldiers out on patrol that day, then Trooper Mark Donaldson, a member of the Special Air Service Regiment (SASR), received the Victoria Cross for deliberately exposing himself to fire to allow time for the injured to be taken to safety.

A second tour in 2010 to the same location was brought to an abrupt end when Dr Holian sustained a fractured shaft of humerus, requiring medical evacuation back to Australia.

Then in 2012, Dr Holian was deployed again to Afghanistan as the senior ranking officer in the first Australian Health Specialist Group to work with the US Navy at the NATO Multinational Medical Unit in Kandahar Airfield.


*Australian Health Support Group 1, at NATO Role 3 Multinational Medical Unit*

As the only Australian in the team of five orthopaedic surgeons there, Dr Holian worked alongside her US colleagues to save the lives of seriously injured soldiers.

She described the experience as greatly rewarding.

"After one particular incident, the US surgeons in the Kandahar unit needed extra support to treat a large number of very seriously wounded Marines," Dr Holian said.

"We rushed them into theatre and we all worked on each soldier at the same time because we knew we only had a maximum of 90 minutes on the table before we needed to get them into the ICU.

"At times we had a Neurosurgeon and General Surgeons working on various injuries and all five Orthopaedic Surgeons working on the limbs and it was quite an extraordinary experience.

"I discovered that the great advances in the past 10 years in trauma care in the Middle East have not come from new technology, but from doing what we already know, but doing it differently.

"Care there is centred on the Trauma patient and the hospital runs 24/7 to support them, not just in business hours. Patients are managed by one team from arrival, with consultant contact at every point and interventions provided by experts."

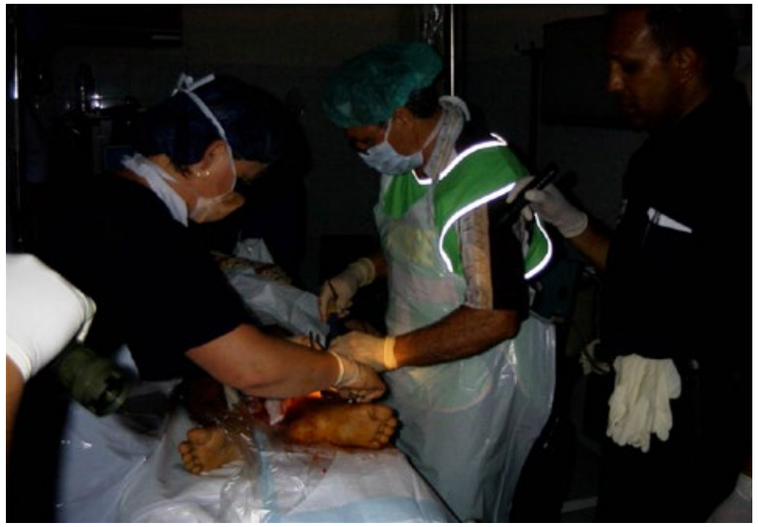
*Annette Holian*

A mother of three, Dr Holian has spent the majority of her working life at Monash Medical Centre, and the Alfred Hospital in Melbourne and for the past four years has been commuting to work at the Royal Darwin Hospital.

With a career-long interest in surgical education, she is an Early Management of Severe Trauma (EMST) Regional Director, an instructor in the Definitive Surgical Trauma Course (DSTC), the Advanced Paediatric Life Support (APLS) course and is currently developing the new AUSMAT Surgical Team course.

She is also Chair of the RACS Military Section, a member of the RACS Trauma committee and verification and DSTC subcommittees, is the past Chair of the Disaster Preparedness subcommittee and is a Governor of the Victorian Shrine of Remembrance.

Currently, she is working with the National Critical Care and Trauma Response Centre (NCCTRC) in Darwin to design and provide disaster response training for surgical teams rather than have specialty groups taught separately.



*Operating by torchlight, New Years Day 2005 in Banda Aceh*

Dr Holian said she had been drawn to Orthopaedic Surgery because of its practical and mechanical aspects but admitted that there might have been subconscious drivers behind the choice as well.

"I liked being able to fix problems and paediatric orthopaedics particularly appealed because it gave me a chance to help children with disabilities and disorders that affected their mobility," she said.

"Only later did I realise that it also gave me the ability to do procedures that my mother would have needed after she contracted polio as a child."

The first of two women in modern Australian medical history to be accepted into the Orthopaedic training program, Dr Holian said she was unaware at the time that she was breaching a male bastion but that it was quickly and repeatedly brought to her attention.

Her experiences within the specialty have made her an enthusiastic supporter of the RACS' investigation into bullying and discrimination.

"I didn't have any idea that women didn't do Orthopaedic surgery but it was soon made clear to me," she said.

"It was extremely male dominated when I began my training in 1986 and sadly there are remarkably few women in Orthopaedic surgery even now.

"I know I felt I had to work at a higher level throughout my training just to be accepted and I have often seen male registrars treating junior female colleagues unprofessionally, which I think is all about the role models they have been exposed to.

"I miss not being there to support those junior women now.

"For myself as a female consultant, it often felt that the more I did to be an 'equal' with the men the more poorly I was treated. I also believe that senior medical staff often seem to operate outside the HR system making it difficult to hold them to account or even seek natural justice.

"This stands in very stark contrast to my experiences in the military where I have always been treated as an equal with my male colleagues, been given the same opportunities and selected for deployments and promotions based on merit.

"I hope a lot of good comes out of the RACS investigation."

Now on an informal sabbatical as she completes a Masters of Surgical Education, Dr Holian said throughout her career in the Air Force she had taken consolation and encouragement from the words of former Governor General of Australia, Sir William Deane, which grace the entry to the Shrine of Remembrance in Melbourne.

The plaque reads: "ANZAC is not merely about loss. It is about courage and endurance and duty and love of country and mateship and good humour and the survival of a sense of self worth and decency in the face of dreadful odds."

*Serving in East Timor, 2000*





# IASSS 2015

## This year Australia hosted the International Association of Student Surgical Societies' second Surgical Symposium

**SIOBHAN FITZPATRICK**
Co-Convenor IASS 2015

From July 22-26, over 320 delegates from 6 continents, 12 countries and 27 academic institutions gathered at the University of Queensland's (UQ) St Lucia campus for what was the largest meeting of student surgical societies in the world.

The IASSS is a student-led not-for-profit organisation that connects surgical societies internationally. It is a novel platform that aims to promote surgical education and research; provide information and resources to all surgical societies; and encourage a culture of leadership, innovation and philanthropy, in order to achieve global surgical equality. Initiated in South Africa in 2013 the IASSS has developed rapidly over the last 2 years, and along with the establishment of the Australasian Students' Surgical Association (ASSA), it is a testament to the instrumental role that Australian medical students play in this global surgical society movement.

With the opening address provided by Professor Mark Smithers and Dr Bernard Whitfield, for UQ and the College, respectively, this student-led event was an unprecedented success. The 4 day academic program featured speakers from local, interstate and international hospitals, providing their unique perspective on the conference theme, "Inspiration; Innovation; Action".

The topics from our 20 esteemed speakers ranged from academic surgery with Dr Richard Hanney, to rural surgery with Dr Bill Glasson, to inspirational lessons from Professor Fiona Wood. The program also featured a touch of military medicine, with Captain Paul Luckin relaying tales of helicopter rescue and retrieval and Rear Admiral Robyn Walker addressing mental health.

The international guests were also well received, including Dr Sean Burmeister from Cape Town, Professor Shekhar Kumta from Hong Kong and Dr Shafi Ahmed from London. Dr Ahmed provided students with an opportunity to use the innovative Google Glass device, which will likely be the platform for transmitting real-time surgical teaching in the future.

In keeping with the global surgery theme, Professor David Watters also addressed the importance of universal access to safe and affordable surgical and anaesthetic care, which was well received by fellow speakers and students. It is a fundamental aim of the IASSS that by promoting the growth of surgical societies in both developing and developed countries, and by connecting these students to share information and resources, it is hoped that outcomes for patients worldwide will be improved.

As part of this aim, the IASSS provided a number of workshops to both actively develop and inspire students to improve their own basic surgical decision making and skills. The Skills program comprised of 19 different workshops from heart valve replacement workshops, to arthroscopy and leadership in surgery. Along with the research competition, Great Debate and the remarkably competitive Top Knife Surgical Skills Competition, the practical aspects of the symposium were very popular with our enthusiastic delegates, and we would like to thank all the tutors and adjudicators from the College who generously donated their time and expertise.

All in all, with spectacular social events held each evening culminating in a Gala Ball, the student delegates of the IASSS 2015 had a fantastic time learning and networking together in this celebration of global surgical education. On behalf of my valued Co-Convenor, Tayla Tatzenko, and the organising committee, I would like to thank the College and our Gold Sponsor, Griffith University, for assisting us with this conference, and I look forward to finding out the host for 2016.


*From left: Tayla Tatzenko, Associate Professor Marianne Vonau, Siobhan Fitzpatrick*

# EXPANDING EDUCATIONAL EXPERTISE

## A look into the 2015 ASC Surgical Education Stream

This year's Royal Australasian College of Surgeons (RACS) Annual Scientific Conference (ASC) included a Surgical Education program, convened by Prof Jeff Hamdorf, FRACS that not only exemplified the College's ongoing commitment to increasing its involvement and expertise in surgical education, but also provided fellows with an opportunity to benefit from hearing a number of eminent experts in the field.

**Themes explored throughout the program included:**

- Surgical simulation
- Surgical audit
- Teamwork
- Surgical training
- Professional competence
- Social media – benefits for clinicians and patients
- Human Factors
- Research papers from Surgical Education research

Prof Anthony Gallagher, Professor of Technology Enhanced Learning in the Application of Science to Simulation, Education and Research on Training (ASSERT) for Health, School of Medicine, University College Cork, Ireland; Emeritus Prof Richard Satava, University of Washington, Seattle, USA. Professors Gallagher and Satava have collaborated for over 20 years and across the Atlantic Ocean as they have worked in both the US and the UK on several aspects of simulation in surgical training.

Prof Gallagher presented two topics at the ASC on 'Surgical Simulation for Outcome-based Training' and 'Human Factors in Acquiring Surgical Skills'. Prof Gallagher's principal research interests currently include virtual reality, minimal access surgery, endovascular interventions, pacemaker implantation and validation of medical devices for training and assessment. He is considered one of the leading exponents and international experts in the world for the design, application and validation of virtual reality in medicine.

Prof Satava provided a brief history of simulation' as he was on the team that pioneered the first robotic surgery and first virtual reality surgical simulator. Other presentations included the British Journal of Surgery Lecture: 'Ethical Issues in Military Medical Research'; 'Measuring Surgical Competence'; and 'Tissue Engineering Update' (Military Section).

With the quality of presenters and range of presentation topics and themes, it comes as no surprise that the conference rooms were filled to capacity and offered standing room only. A larger auditorium may be required for next year's ASC to accommodate the likely audience.

A number of research papers were showcased as oral and poster presentations. These presentations offered a well-rounded range of surgical knowledge from medical students to the RACS Dean of Education. Nine of these presentations were considered for the Surgical Education Prize judged by Prof Jeffery Hamdorf, FRACS, Prof Tony Gallagher, and Dr Rhea Liang, FRACS. While there were many deserving presentations, the prize was awarded to Dr Pamudith Siriamnna, for his presentation on 'Validation Of A Virtual Reality Simulation Model For Laparoscopic Appendicectomy And Incorporation Into A Proficiency-Based Curriculum'.

### ASC Surgical Education stream 2016

Planning for the 2016 RACS ASC is well underway with a stimulating program being compiled by convenor Dr Rhea Liang. The main aim of the Surgical Education program is to translate developments from surgical education research into everyday surgical practice. The program has been extended to the full length of the Congress, allowing for more collaboration with other surgical streams. Topics such as leadership and the impact of shorter training hours will be explored. Attendees are sure to find something that appeals to them from the wide variety of sessions tailored to different career stages, different specialties, and different interest groups. Confirmed speakers include Prof Debra Nestel, Prof Stephen Billett, Prof Jonathan Beard (UK), Dr Rachel Kelz (US) and Dr Caprice Greenberg (US). There will also be two paper sessions designed to showcase the rapidly growing area of surgical education research. Prof Beard will deliver the Hamilton Russell Lecture.

We look forward to seeing everyone in Brisbane for a programme that is sure to inform, provoke debate, and enhance attendees' personal surgical practices.





# Academy Forum 2015

The Academy of Surgical Educators is proud to present the 2015 Academy Forum to be held on Thursday 12 November at the Amora Hotel in Sydney from 6.30pm – 10.00pm.

This year's topic will focus on People, Process and Performance: Human Factors. The evening will be convened by Associate Professor Stephen Tobin, Dean of Education and Professor Spencer Beasley, Chair, Academy of Surgical Educators and will feature preeminent thought leaders discussing progressive topics in medical education. Attendees will enjoy a three course meal and drinks whilst enjoying three quality presentations on Human factors.

Presenters at this year's forum include:

- Mr Phillip Truskett, FRACS - Chair, Training in Professional Skills (TIPS);
- Professor Francis Lannigan, FRACS - Chair, Non-Technical Skills for Surgeons (NOTSS) and Safer Australian Surgical Teamwork (SAST); and
- Mr Werner Naef - Director, Kalher Communications Oceania

The Academy Forum is an annual event for all interested and will include the presentation of the Academy Reward and Recognition Awards. The presentations will be recorded and made available to all Academy members on the learning management system.

Academy members are $100 and non-members are $125. To register online refer to the Academy website page. For further information please contact ase@surgeons.org.

# Academy Reward and Recognition Awards

The Academy of Surgical Educators would like to congratulate the winners of the 2015 Academy Reward and Recognition Awards.

This year's Supervisor/Clinical Assessor of the Year Awards recognise the exceptional contribution by a surgical supervisor/clinical assessor toward supporting Trainees or International Medical Graduates (IMGs). These were awarded to:

| | | |
|---|---|---|
| VIC | Supervisor/ Clinical Assessor | *Assoc Prof Frank Miller, FRACS* |
| NSW | Supervisor/ Clinical Assessor | *Dr Kim-Chi Phan-Thien, FRACS* |
| SA | Supervisor/ Clinical Assessor | *Dr Michelle Lodge, FRACS* |
| WA | Supervisor/ Clinical Assessor | *Prof Mohammed Ballal, FRACS* |
| QLD | Supervisor/ Clinical Assessor | *Dr Jon-Paul Meyer, FRACS* |
| NT | Supervisor/ Clinical Assessor | *Dr Stephanie Weidlich, FRACS* |
| ACT | Supervisor/ Clinical Assessor | *Dr Frank Piscioneri, FRACS* |
| NZ | Supervisor/ Clinical Assessor | *Mr Hamish Sillars, FRACS* |
| TAS | Supervisor/ Clinical Assessor | *Dr Scott Makie, FRACS* |

### Professional Development Facilitator of the Year Award

The Professional Development Facilitator of the Year Award recognises the exceptional contribution by a course facilitator teaching on Professional Development programming. This was awarded to *Dr John North, FRACS*.

The presentation of these awards will be made at the Academy of Surgical Educators' Annual Forum on Thursday 12 November in Sydney or at an alternative nominated event. These individuals will be profiled in forthcoming Surgical News editions.

### Sir Alan Newton Surgical Education Medal

Congratulations to *Mr Phil Truskett, FRACS* for receiving the Sir Alan Newton Surgical Education Medal at this year's Annual Scientific Congress.

# AGAINST THE TIDE

## Mr Jonathan Koea surprised his parents when he spoke of becoming a surgeon

*RACS President David Watters, RACS Indigenous Health Medal recipient Jonathan Koea and Lisa-Jane Koea*

General and Hepatobiliary Surgeon and Associate Professor of Surgery at the University of Auckland Mr Jonathan Koea this year became an inaugural recipient of the College's Indigenous Health Medal in recognition of his work to improve Maori health and support young Maori doctors.

The first locally trained Maori General Surgeon in New Zealand, Associate Professor Koea obtained his FRACS in 1997 before taking up a prestigious International Fellowship at the Memorial Sloan-Kettering Hospital in New York.

With high rates of Hepatitis B and C in the Maori population in New Zealand as well as significant rates of colorectal, bile duct, gallbladder and pancreas cancer, A/P Koea chose to specialise in liver and pancreatic disease so that he could bring much needed liver, biliary and pancreatic surgical skills back home and teach the next generation of Hepatobiliary Surgeons.

While in New York, he completed a Hepatobiliary Fellowship and a Surgical Oncology Fellowship.

Since then, he has helped train 15 surgeons through Hepatobiliary Fellowships and he is now one of six Maori surgeons working in New Zealand with another six Maori trainees progressing towards their surgical qualifications.

Born in Taranaki on the west coast of the North Island, A/P Koea identifies with the Te Atiawa and Ngati Mutunga tribes through his father.

He has spent the majority of his working life consulting at the Auckland City and North Shore Hospitals.

Reflecting upon his career, he said that his decision to enter medicine was met with some degree of surprise by his journalist parents while his choice of a surgical career challenged the views of peers and teachers.

"Going through Medical School at the University of Auckland I was one of only eight Maori in a class of 105 students," he said.

"At the time there was a subtle pressure on us to act as representatives for Maori, to treat our own people as General Practitioners or take up various public health roles.

"I flirted with that for a while but I always wanted to do surgery and although I was swimming against the tide at the time I was lucky to find mentors within surgery and I have never regretted that choice.

"I have been fortunate enough to be able to train and specialise in Hepatobiliary Surgery but I've always enjoyed and retained a commitment to General Surgery. The surgeons I admired at the beginning of my career were all accomplished General Surgeons and it's important to be able to contribute - to staff an acute roster, treat acute patients and manage emergencies.

*"We believe it will be possible to eradicate Hepatitis C and possibly Hepatitis B within the not too distant future."*

"Working as a General Surgeon also means I maintain contact with junior doctors and am forced to read around a variety of subjects to maintain a broad knowledge base as well as in my area of special interest of HPB surgery.

A/P Koea spent three years in New York before returning home to help tackle the silent epidemic of Hepatitis infections that were having a particularly pronounced effect upon the Maori population.

At that time, New Zealand had one of the highest rates of Hepatitis B and C in the world with an infection rate of between five and six per cent in the Maori and Pacific Island population, compared to only 0.4 per cent in the broader community.

"I greatly enjoyed my time in New York but the longer I stayed the more I missed New Zealand and the more I wanted my children to grow up as New Zealanders rather than Americans," A/P Koea said.

"I also became increasingly determined to help lower the disease burden in the Maori and Pacific Island populations caused by Hepatitis and the resulting liver cancer.

"We are now very advanced in dealing with this disease through a national vaccine program delivered to newborn babies and through the comprehensive suite of treatments we can now offer from liver transplants and liver resection to anti-viral medications to screening programs.

"We believe it will be possible to eradicate Hepatitis C and possibly Hepatitis B within the not too distant future."

An original member of the College's Indigenous Health Committee, A/P Koea has worked throughout most of his career to push for improvements in the quality of health services delivered to Maori communities.

Such has been this commitment, that he became the inaugural recipient of the Eru Pomare Research Award which honours the legacy of Professor Eru Pomare and his contributions to gastroenterology and his commitment to high academic achievement by Maori.

The prestigious award is given to emerging leaders in Maori health and provides a stipend to help support doctoral or PhD research.

A/P Koea said the greatest changes effecting Maori health he had witnessed in his career to date had been the increase in the number of Maori doctors and a philosophical shift within medicine to embrace Maori issues as New Zealand issues.

"When I was going through training, Maori and Pacific Islander students made up only seven per cent of the medical student intake whereas now that is up to 20 per cent," he said.

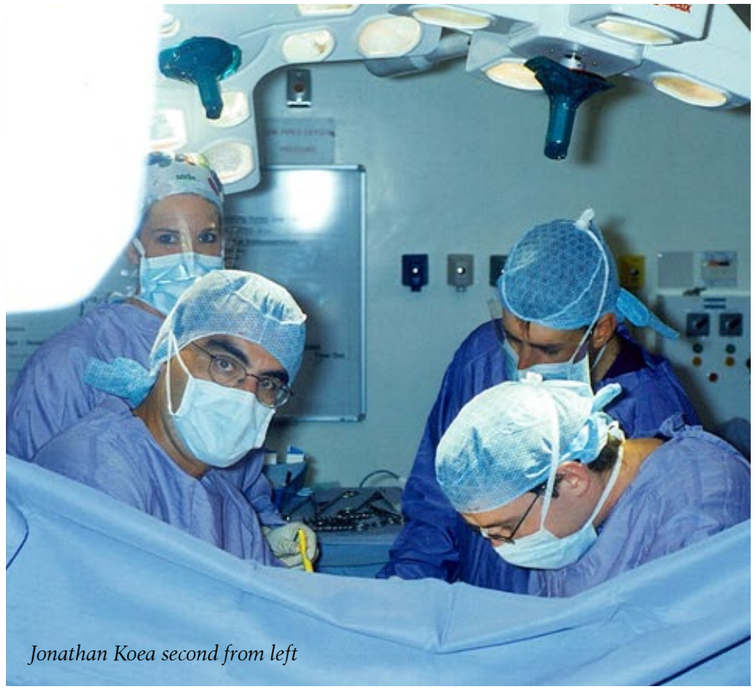
"That is a wonderful achievement based on an initiative developed through the University of Auckland Medical School called Vision 2020 which aimed to have Maori students comprise 20 per cent of all medical students by 2020.

"At the time this seemed an impossible aspiration but it has been achieved five years early.

"There is now a growing Maori middle class in New Zealand and the challenge for the RACS will be to connect with the increasing number of smart and motivated Maori medical students and entice them to pursue a career in surgery.

"There has also been recognition within medicine over the last 20 years that if there is a problem which affects Maori, it's a problem that affects us all and conversely that what is good for Maori is good for us all.

"This has led to a medical philosophy that recognises the importance – for everyone – of providing care that respects a patient's culture, language and family connections and gives patients the information, support and time they need to make informed decisions.



*Jonathan Koea second from left*

"At the same time Maori groups have taken the responsibility for addressing endemic health issues that continue to affect the community and they have set up Maori-specific medical centres from funds gained from treaty settlements.

"All these developments are enormously positive."

A/P Koea is a member of the Maori Medical Practitioners Association, a Fellow of the American College of Surgeons and is the Head of the Hepato-pancreatico-biliary/Upper Gastrointestinal Unit at North Shore Hospital.

He has conducted both Upper GI and Hepatobiliary research, research into the social determinants of health in Maori and the importance of attracting more Maori and Indigenous students into medicine.

Married with four children, A/P Koea said he was delighted to have received the Indigenous Health Medal.

"I really appreciate this recognition but I certainly never expected it," he said.

"I became involved in Maori health and research because it involved extremely interesting scientific and surgical aspects all of which had to be understood within a social context.

"That is challenging as a researcher but forces you to keep your research questions socially relevant and to be always looking to translate findings into a health gain for patients.

"My surgical mentors placed great importance on teaching the next generation of surgeons and I've been able to train 15 fellows in HPB surgery – many of whom are working in New Zealand after periods overseas.

"The fact that most towns in New Zealand now have a surgeon with hepatobiliary expertise is what I am most proud of because of the benefit it provides for patients.

"As you age your ideas of success change and broaden. I'm lucky my wife has put up with surgical absences and we have four wonderful children of whom I'm very proud. I am very grateful for their support."

*With Karen Murphy*

# MERCY SHIPS

## This unique outreach program brings hope and healing to Africa's poor

**SHEHNARZ SALINDERA**
RACSTA NSW Representative

Living the surgical life sometimes allows life goals to pass us by. Little did I know that surgery would present me with the opportunity for a life changing experience – To travel to Africa, and witness how modern standards of healthcare can be delivered to developing countries and remote areas efficiently and effectively.

The Africa Mercy Ship has no fixed location, no fixed employee body, and can be anywhere at any time: consisting of an 82 bed floating hospital and equipped with 5 state-of-the-art operating theatres, an ICU and accommodation for 400 crew and staff members from all around the world. Their mission statement is to deliver transformational surgery to Africa's forgotten poor, and they do it with style.

## Mercy ships - how does it work?

With an operational budget of $18million USD annually, Mercy Ships is a global organisation that is able to deliver elective surgery, train local health workers, and build local infrastructure in struggling African nations. It is a 'surgery only' hospital with many types of surgical services provided including orthopaedics, plastics, maxillofacial, ophthalmology, dental, gynaecological and general surgery procedures. Post-procedural follow-up and rehabilitation is provided by purpose build outpatient centres on land. In recent years the ship has been based in West Africa, but due to the Ebola crisis this year the Ship relocated to Madagascar. The queues for clinic visits can be kilometres long with patients travelling for days on foot to await their chance to undergo life changing surgery.

Ultimately the services that the ship can provide are still limited and so they do focus on those most needy, defined as the forgotten poor - those who are socially and economically disempowered because of their physical deformity or problem. This includes children with contractures and deformed limbs from burns, people with debilitating tumours or goitres and women with obstetric related fistulas. The primary objective is to be a catalyst for transformational development- the physical change being the starting point for emotional, economic and spiritual change. The Mercy Ships programs are holistic and encompass health, social, and educational activities, as well as local infrastructure and capacity building to facilitate long-term community change.

## Life on the ship

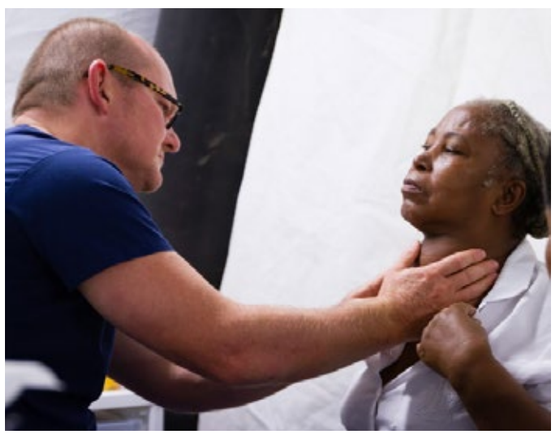
Life on the ship is fairly comfortable equipped with a swimming pool and Starbucks. You will meet crew from all around the world. The Mercy Ships' detailed application process ensures staff are prepared for life on the ship and integration into the surgical team. Standardised procedures and protocols ensure that despite different skill mix and training backgrounds patient care is of a high standard. The commitment to efficiency creates a very positive and uplifting working environment because everyone has a common purpose and your operating list is the focus of all activity on the ship.

## My Mercy Ships experience

My opportunity to be involved with this amazing organisation came about because my SET supervisor Associate Professor AJ Collins from Bega has been volunteering on the Mercy Ship for many years, focusing on thyroid surgery for large goitres. Thyroid disease is quite prevalent throughout Africa, in Madagascar specifically about 20%, with the most common pathology being Multinodular Goitre (WHO). This is largely due to Iodine and other micronutrient deficiencies (selenium and Vit A), general malnutrition, and high intake of thiocyanates (cassava, millet both common daily food staples). During my stay we undertook 20 hemithyroidectomies and 14 total thyroidectomies over a 20 day period. I also had the opportunity to observe Maxillofacial and plastics cases including large mandibular resections and reconstructions for Amelioblastoma and NOMA disease.

## Surgical challenges

Compared to Australian surgical practice thyroid gland hyperplasia encountered in Africa posed some very significant surgical challenges such as severe tracheal deviation, increased gland vascularity and deviated recurrent laryngeal nerve paths created by the mass effect. Although malignancy was less common overall we did encounter one serious case of metastatic papillary cancer with lymph node metastasis so significant that the patient, only 34yrs old, had significant imminent airway compromise. The Mercy Ship is not able to provide longterm follow up, so managing malignancy such as this is a very complex issue. As such cases like this are referred to the Ships MDT for discussion and ultimately the decision was made to proceed with surgery to debulk the tumour. The patient was also counselled on the nature of her disease and put in touch with the chaplaincy service. The patient was ultimately discharged without complication and with the chance to spend more time with her young children and family.



## How is Mercy Ships unique?

Global Surgery is increasingly becoming an area of interest for Australian Trainees and Fellows alike, with 78% of trainees identifying an interest in outreach and international work (RACSTA End of Term Survey). RACS International Portfolio activities extend throughout the pacific including PNG, East Timor and Burma. So when considering where to undertake your volunteer experience consider this: bringing a modern world operating theatre and hospital care to remote areas of the developing world is a considerable challenge, one that Mercy Ships takes in its stride, and hence provides a truly unique surgical environment.

## Learning and the way forward

Delivering affordable and accessible healthcare anywhere often requires thinking outside of the box. Not that I am suggesting Australia build a hospital ship and sail it around Cape York! But perhaps we can consider a 'surgery only hospital' as a valid model of care or diversifying the surgical team to improve medical services to surgical patients, as well as organisational cultural changes to improve our work environments.

The manner in which this organisation operates and has developed efficient systems demonstrates that it is possible to overcome massive logistical, financial and cultural barriers to not only deliver great surgery in remote, resource poor locations but to also create a meaningful and rewarding work environment and genuinely bring hope and healing to the Africa's forgotten poor, "In effect, our work is to walk along side the forgotten poor, facilitating and participating in their growth as well as our own".

# THE POSTMAN'S CHILDREN

## The extraordinary careers of the Marshall family

**MURRAY STAPLETON**
Victorian Fellow

These days we would consider it almost impossible to raise and educate a family of five children and have their education supported by the State by way of scholarships .

But much more than that, this Marshall family with a postman father and a home maker mother gave to the world, Betty, a general practitioner; Gwen, a teacher and later a physiotherapist; Robert (Bob), a general surgeon with a matchless talent, who was also a renowned anatomist and teacher: Vernon, Professor of Surgery and a pioneer in renal transplantation; and Donald who, for me is the finest plastic surgeon I ever encountered.

We surgeons need no discourse on the extraordinary surgical careers of Robert, Vernon and Don. Their names are etched on the Prosector's Honour Board at the Anatomy School at the University of Melbourne. Their achievements are recorded in so many places; their

Undergraduate education individually and collectively is studded with exhibitions, prizes and honours. Future generations of surgeons may not be aware that the craft of surgery has been enhanced by these three luminaries.

The question is: how did it come about and who bent the twig to produce such a family tree?

Why should I have an interest in the Marshall family? Let me explain my connection by my meeting with Don.

In 1969 I was a junior resident doctor at the Royal Melbourne Hospital. My ambition then was to be a plastic surgeon. My rotation roster had me posted to the Plastic

Surgery Clinic at the Peter MacCallum Clinic, a clinic set up to surgically treat skin cancers.

There were four consultant surgeons. In my first operating session I assisted an elderly, gruff and somewhat terrifying surgeon; another whose surgery made me wonder if I should continue with my ambition; and I can't remember much about the third.

There was one more to go. It was Mr. Donald Marshall. He came to the operating room, laughing with the nurses and all others who were present. He had the nursing staff eating out of his hand.

The case, I clearly remember was an excision of a rodent ulcer. Don took the scalpel. It appeared that the excision lines separated before the blade had contacted the skin. There and then, I aspired to be like him. Later, he invited me to be his partner. What greater reward could one be given to one who left a technical school at the age of 15 and in later life went back to night school to train in medicine.

Later, Don, John Anstee and I were in practice together. Morning tea conversations were led by Don whose catch cry was, "now listen to me, I know a fair bit about that subject!" If I had a surgical problem, Don's solution was always simple. Everything for Don had an easy option. He could see a solution to a problem that would have blinded his colleagues.

Let's look now at the family for surely it could not be by accident that all of the Marshall children excelled in medicine. Charles, the father, mother, Katarina. Charlie's ancestral roots go back to England, Katarina's to Barcelona, two places from which Australia received its own 'poor and huddled masses'. There appears to be no educated members in the ancestry which begs the question as to how it was that all of the Marshall children, not only were tertiary educated but all reached to the highest in medicine, one GP, a physiotherapist and three outstanding surgeons.

Dad was born of farming parents in Dunolly. He was one of a twin. Both he and his brother, Vernon left school at the age of 14 and both sat the examination to enter the Postal Service. Charlie's results were better than Vernon's. Ironically, Charlie entered the Postal Service as a messenger boy, whilst Vernon, with financial help from Charlie, continued his education to become a graduate school teacher and later, a principal.

Katie, the mother was also from farming stock. She became a rural school teacher.

Family life for the Marshalls was happy and through it all Charlie and Katie's mantra was for the kids to be educated. Theirs was one of the few houses with a library and all of the children became avid readers. Charlie was a self taught engineer. "He could do and fix anything". He, with help from Bob built their house. He loved music and read the classics: Tolkien, H.G.Wells, Dickens, Edgar Rice Burrows and Shakespeare He made a motor bike by cutting a two cylinder engine block in half and fitted it a bicycle.He made the family refrigerator and rose to be a Post Master.

"Dad was sentimental, arrogant, quick tempered, a sport lover who enjoyed educating those in the Postal Service who aspired to higher things". He encouraged, particularly Don to excel

*From left: Gwen, Donald and Vernon Marshall*

in sport and encouraged Don to strive to be an Australian test cricketer.

Mother was the 'go to' person in any dispute with Charlie .She was the home maker and warmed the nest to comfort and encourage the children.

Charlie and Katie never forced the children to be the best though they knew that that was expected of them. They raised five children; one child, Douglas died in infancy of renal failure. One income could never have educated the children. They relied on scholarships and a Commonwealth living allowance. Their progress was encouraged by their loving and completely family oriented parents who were determined to provide what they could to ensure the lives of their children were better than theirs.

But why Medicine? Conversations around the dining table suggest that Charlie observed that the one in the community for whom the respect was greatest was the doctor. Never did the children hear their father telling them to be doctors.

Betty was the eldest child. Why she studied medicine is not clear. She graduated at a time when a university education was for the privileged and enjoyed mostly by males. But her textbooks and no doubt her conversations about being a doctor may have sowed the seed for the others. Both she and Bob tutored Vernon and Don as they progressed with their education. Gwen was different. She yearned to be involved in the Arts. In her later years when she considered a career change she remembers Charlie saying to her, "How about physiotherapy, I think that would be good for you?" Gwen had no idea what physiotherapists do, but, because her dad thought it would suit her, she did it with "total confidence and satisfaction".

Robert could silence anybody with forceful logic on countless subjects including anatomy, heliskiing and mountaineering.

And what of the dividend received by the Government for its generosity? A general practitioner, highly respected professor of surgery and teacher, a general surgeon with few peers, a world class plastic surgeon, and a physiotherapist and fine artist. Have we not been richly rewarded because of what was given to them all? Such an outcome flies in the face of the current politician's mantra, that if you want a university education then you will have to pay for it. Should that have been the policy when the postman's children were seeking an education, then the world, and medicine in general would be the poorer.

These Marshall children did not come from an educated family tradition or an established talented gene pool. They came from two parents who wanted the very best for their children and Australia was prepared to give what was necessary. How rich the reward for so many.

# UNIVERSAL CARE

## Specialist Colleges come together to advance Universal Access to Safe, Affordable Surgical and Anaesthetic Care when needed in the Asia Pacific Region

**PHILL CARSON**
Chair, RACS Global Health

On 26 October 2015, the Royal Australasian College of Surgeons and Lancet Commission on Global Surgery will convene a public Global Health Symposium to address the challenges and barriers to improving health systems and surgical services in many low and middle income countries.

Safe surgery and anaesthesia are vital to effectively treat much of the global burden of non-communicable diseases and injuries and contribute to the provision of safe child-birth where complications arise. Yet an estimated 5 billion of the world's population are unable to access safe surgery when they need it, and only 6% of the 313 million procedures performed annually are done in the world's poorest countries.

The evidence base for emergency and essential surgical care being necessary for any health system is sound. The Global Initiative for Emergency and Essential Surgical Care has succeeded in translating it into policy with the help of many countries, together with Colleges, Societies and NGOs representing surgeons and anaesthetists. In 2015, the Millennium Development Goals, which never mentioned surgery, will be replaced by the Sustainable Development Goals. The health goal, Universal Health Coverage by 2030, includes surgery and the reporting of surgical indicators – a big win for all those people needing essential, safe surgery. A WHO World Health Assembly Resolution on strengthening emergency and essential surgical care was passed by 194 member nations in May 2015. This resolution was critical because Ministers of Health are guided by the recommendations of the WHO when implementing healthcare decisions for their country. But it will require significant and sustained political commitment and substantial investment of resources by individual countries, to put policy into practice and improve surgical care at the country and regional level.

In late 2013 the Lancet launched a Commission into Global Surgery with the goal of promoting Universal Access to safe, affordable surgical and anaesthesia care when needed, where access encompasses safety, affordability, timeliness and capacity to deliver. The College is collaborating with the Lancet Commission to advance this agenda.

The Symposium Program will focus on four key issues outlined in the recent Lancet Commission on Global Surgery report as being critical to achieving universal access to safe surgery and anaesthesia by 2030: Strengthening health systems, Solving workforce issues, Sustainable financing of health care systems and Ensuring sufficient quality and safety.

The discussions at the Symposium will inform an Asia Pacific Leaders' Forum at the College on 27 October. The Forum will be attended by representatives from specialist colleges in the Asia Pacific including the Australian and New Zealand College of Anaesthetists, Australian Society of Anaesthetists, Royal Australian and New Zealand College of Obstetrics and Gynaecology, Royal Australasian College of Physicians, Pacific Islands Surgeons Association, College of Surgeons of Indonesia and Singapore College of Surgeons and a group of key decision-makers from throughout the region. This Forum will be tasked with developing a roadmap for professional colleges in the Asia Pacific, in promoting universal access to safe surgery, to 2030.

Registration for the public Symposium on Monday 26 October is open to health practitioners, public health specialists, trainees and medical students and the general public. Please refer to www.surgeons.org for details or contact stephanie.korin@surgeons.org to register.

The Symposium is sponsored by the RACS Foundation for Surgery and the Australian and New Zealand College of Anaesthetists and the Australian Medical Council.

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

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# DOGS AND OWNERS

## Curmudgeons not easily wooed by any species!

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and it is dogs. Now I don't mean all dogs but some dogs – and particularly their owners. We curmudgeons are of such an age that we all had dogs as kids. But they were real dogs – dogs that ran and played and barked and sniffed and cocked their legs (and worse). They were dogs, just dogs – not South American hairless hunting dogs or similar exotic and useless breeds. These exotics are the types of dogs that need special diets and structured exercise programmes (and personal trainees and dog psychologists I suspect). They are not dogs, not real dogs.

Our dogs were black or brown and were tough. They did not need special 'Drizabone' coats in winter (at $150 a shot) or special dog pellets. They ate what was left over and slept on someone's bed if they were cold (if the person was cold I mean, not the dog). They had proper names such as King, or Prince or Blackie or simply Dog, not Charlotte or Hector or Priscilla.

Now my problem is that 2 months ago Mrs. Curmudgeon decided that we needed a dog. Why, I don't know. I was sure that it would dig holes in my lawn and eat the camellias. I would have been happy with a black dog that ran and barked and ate whatever but she said we needed to get a retired greyhound in the interests of dog preservation. Its name? – well there is another issue – Petarina Wheelstake. She was called "Pet" for short. Now that is a silly name – so I started calling her "Meg". It is purely a coincidence that it is also the name of one of Mrs. Curmudgeon's friends whom I do not like.

I have been left to look after this animal whilst Mrs. C is at work. As she is not fully trained she has to be under my eye in the study as I write this piece. This enforced guarding caused me to look up a few facts about greyhounds

They were found as decorations on ancient Egyptian tombs (which is why they are sometimes called pharaoh hounds)

- They first appeared in Britain about 500 BCE with some Celtics invaders
- One landed in Australia in 1770 with Captain Cook and Joseph Banks
- They have a higher cardiac output and stroke volume and a higher proportion of fast twitch muscle fibres than any other breed of dog
- They are second only to cheetahs in speed at 65 kph (one reference said that pronghorns are faster but we curmudgeons don't mind ignoring inconvenient facts particularly if we have never heard of pronghorns)
- During the reign of King Canute the common man could not own a greyhound under penalty of death

We curmudgeons are not easily wooed by females of any species but Meg is something special. She follows me everywhere, and I mean everywhere. She looks lovingly at me and (almost) follows my commands. When you think about it we curmudgeons are not "common men" and so are entitled to have greyhounds. King Canute would have been pleased.

## IN MEMORIAM

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

**Graham Peck**
Victorian Fellow

**Labeeb McGuire**
Queensland Fellow

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under *In Memoriam* on the College website **www.surgeons.org**

### Informing the College

If you wish to notify the College of the death of a Fellow, please contact the manager in your regional office:

**ACT:** Eve.Edwards@surgeons.org
**NSW:** Allan.Chapman@surgeons.org
**NZ:** Justine.Peterson@surgeons.org
**QLD:** David.Watson@surgeons.org
**SA:** Daniela.Ciccarello@surgeons.org
**TAS:** Dianne.Cornish@surgeons.org
**VIC:** Denice.Spense@surgeons.org
**WA:** Angela.D'Castro@surgeons.org
**NT:** college.nt@surgeons.org

# CASE NOTE REVIEW

## Timing of second-look laparotomies is important

**GUY MADDERN**
Chair, ANZASM

An elderly patient was admitted to hospital with recurrent small bowel obstruction. The general surgical registrar diagnosed and appropriately managed the patient with intravenous fluids and nasogastric (NG) tube aspiration. The following day the patient had a computed tomography (CT) scan of the abdomen. The assessor's analysis of the images suggested the patient had small bowel obstruction consistent with an adhesion.

The patient failed to settle with conservative management within a 48-hour period and underwent a laparotomy and adhesiolysis by a consultant surgeon. The operation report noted dense adhesions, and two or three bands were divided which were thought to be causing the small bowel dilatation. Complete adhesiolysis was not performed.

The patient failed to settle postoperatively and had a series of repeat CT scans and gastrografin follow throughs. A second-look laparotomy and complete adhesiolysis was performed six days later. Total parenteral nutrition was commenced and an NG tube left in situ. The patient did not experience any abdominal pain. The high NG aspirates persisted and a gastroscopy was performed two weeks after the second laparotomy. The iSOFT report stated there were large amounts of fluid, which was grossly dilated with the suggestion of luminal narrowing, possibly extrinsic. On the basis of this investigation the patient underwent a laparotomy and a Roux-en-Y gastrojejunostomy three weeks following the second-look laparotomy.

There were dense adhesions throughout the abdomen and multiple serosal tears. A gastrojejunostomy was performed with a feeding nasojejunal tube. The patient leaked from several of the enterotomies and underwent several laparotomies throughout the next few days. Each time attempts were made to suture close the enterotomies and the abdominal wall was closed until the fourth or fifth laparotomy, when the abdomen was left open. There are no further operation notes available to me, but according to the intensive care unit comments, the patient did undergo further surgery in the abdominal wall. The patient eventually died.

### Comment:

Division of adhesions can be a difficult and complex procedure. It could be argued that a complete adhesiolysis should have been performed at the first operation. The second-look laparotomy was performed within a week of the first laparotomy and complete adhesiolysis was performed at this time and was probably appropriate.

Following adhesiolysis, some patients develop a prolonged ileus. At no time between the second and third laparotomy was there abdominal pain. This is consistent with an ileus rather than a true obstruction.

It appears that the decision to perform a Roux-en-Y gastrojejunostomy was based on the endoscopy of a dilated D1. It was brave to undertake this radical operation in such a patient. This was three weeks following the second-look laparotomy, where adhesions were known to be very unfavourable and the timing questionable. A more appropriate course may have been to maintain the patient with an NG tube given that the patient had no abdominal pain and to wait at least six to eight weeks.

Once the patient was on the pathway of laparotomies and inadvertent enterotomies, the inevitable happened. Attempting to close the abdomen each time probably increased the chances that the patient became septic.







# ASOHNS 2015 ASM

## Another successful annual meeting


*Keynote Speaker Dr Paul Krakovitz from the USA addressing delegates*

The 65th Annual Scientific Meeting of the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), held in Sydney in March this year was rated a highly successful meeting.

There were around 680 attendees all up, including 60 international participants,30 of whom were from New Zealand with the other 30 representing a total of 13 countries.

The meeting was held at the historic Australian Technology Park, which worked well as the venue for both the meeting and exhibition components and offered attendees a different perspective and environment.

In keeping with the meeting's theme, Excellence and Innovation, invited Keynote Speakers, Drs John del Gaudio, Paul Krakovitz, Bert O'Malley from the USA and Dr Robert Vincent from France, delivered excellent presentations that reflected the body of their work.

They were supported by other renowned international and local speakers, all of whom contributed significantly to the meeting's success.

Apart from the main scientific program, satellite meetings focused on Endoscopic ear surgery, Indigenous ear health, paediatric ENT airway update, the Australasian College of ENT physicians meeting, an assessment of Obstructive Sleep Apnoea and a microscopic otology skills and temporal bone course.

A combined total of almost 600 attended sub-speciality breakfast sessions, which were exceptionally well received and were evaluated as "Excellent" from up to 86 per cent of attendees across all sessions.

The trade exhibition added further value to the meeting with highly interactive and hands-on opportunities for delegates to assess the latest products and services available.

A well-designed phone app helped delegates easily plan their time to make the most of the meeting.

ASOHNS is extremely grateful to all those who worked so hard to make this meeting a success, especially Associate Professor Larry Kalish (Convenor), Associate Professor Nirmal Patel (Scientific Convenor), members of the Organising Committee, all speakers, exhibitors and sponsors.

**For further information, please contact Lorna Watson, Chief Executive Officer, ASOHNS Ltd on:**

**(02) 9954 5856**

**lornawatson@asohns.org.au**


*AHSONS ASM 2015 Delegates and Trade Exhibition*

# ROYAL PERTH HOSPITAL - LEADING THE WAY IN ROAD SAFETY

This article previously ran in the May issue of the Journal of the Australasian College of Road Safety

**SUDHAKAR RAO**
Director of Trauma
Royal Perth Hospital

As a surgeon for more than 20 years, I have seen first-hand the impact of road trauma. The injuries that I have seen at Royal Perth Hospital's State Adult Major Trauma Unit have been some of the most devastating youth-related road trauma that I have encountered. Already this year more than 30 people have lost their lives on Western Australian roads.

Added to this terrible toll, more than 100 others have sustained critical injuries in road crashes. Last year, WA had the worse fatality rate of any other Australian State, with young males continuing to be over-represented with 80 to 86 per cent of major trauma aged between 15 and 24 years of age.

My experience in seeing the impact of road trauma on young people led me to look at ways that we could raise awareness about the importance of road safety. Royal Perth Hospital is the first hospital in Australia to roll out the P.A.R.T.Y (Prevent Alcohol and Risk Related Youth) Program which is a licensed Canadian Program running in around 100 hospitals globally.

The success of the Royal Perth Hospital Program has seen us expand it into regional areas including Bunbury, Denmark, Geraldton and Albany, and after our success, a number of states across Australia have also established the program.

Since commencing in 2006, our reality-based Program has won numerous awards and we have seen more than 8,500 Western Australian teenagers come through the program. Attendees learn about traumatic brain and spinal cord injuries, and meet trauma patients in the intensive care and trauma wards. The Program addresses social and safety issues around drug and alcohol use, violence, aggression, and encourages teenagers to learn first aid.


*P.A.R.T.Y Programs take a preventative approach to road trauma and young people*


The 2014 Royal Perth Hospital Trauma Registry data shows that road safety continues to be a key issue for youth aged between 15 and 24 involved in a major trauma. The Program content therefore includes a significant focus on road safety including seatbelts, safe cars, driver behaviour/distraction, helmets and other protective gear for motorcyclists and cyclists. We continue to evolve our program to ensure that it is evidence based and reaches our vulnerable teens that are most likely to exhibit risk-taking behaviour.

The Program continues to be overwhelmingly popular and evidence to date has shown that it is not only cost-effective but also reduces the risk of youth committing to violence or traffic related offences, injuries and death. The Perth program is estimated to cost $1,000 to run each week, while the health costs of a quadriplegic are estimated at roughly $8 million for the rest of their shortened life.

The Royal Perth Hospital team is proud of our program as we are making a real difference in raising awareness of the impact of reckless decisions on the road. It is a very rewarding experience as we have changed lives and witnessed the impact the Program has on participants, some of which may have ended up in our in our care if they didn't experience the reality of road trauma.

**Highly Effective P.A.R.T.Y. programs are also being run in the ACT, South Australia, Victoria, NSW and Queensland.**

**P.A.R.T.Y. HQ**
http://www.partyprogram.com/

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# "THE CHIEF"

## Owen H Wangensteen

**PETER F. BURKE**
Specialty Editor -
Surgical History:ANZ JSurg.

In his own words, Owen Harding Wangensteen entered the medical profession "through the portals of pigs and manure, a goodly spread of each."

He was born on a farm in Lake Park, Minnesota on September 21, 1898. He did farm chores while his brothers did the hunting: "they learned to hunt and I learned to work", he said, "and I think I got the best of the deal."

He learned to work hard, to stick to a task and that the day starts early in the morning; his Norwegian heritage taught him a strength of character which he preferred to call "consecutiveness":

Owen's mother died when he was only seven and a close bond developed between he and his father. Owen had planned on becoming a veterinarian: the family farm had 50 sows that could not farrow their young; not only did young Owen safely deliver about 300 piglets with his own hands, he had read about vaccination for anthrax, obtained this vaccine and prevented further loss of livestock.

Owen's father insisted that his son become a doctor and Owen commenced at the University of Minnesota's Medical School in 1919, in a class of 73 students, seven of whom were women: it was not until he had attended his first lecture by Dr Arthur Stachauer, Chief of Surgery, that he resolved to undertake surgical studies.

Under a wartime accelerated programme he graduated from medical school at the top of his class in 1921.

He interned at the University's Elliot Hospital and then as no fellowship was available in surgery he accepted one in internal medicine: this fellowship carried with it a requirement to work on a research problem in the laboratory and he was thereby forced into research which proved to be an absorbing interest for the rest of his life.

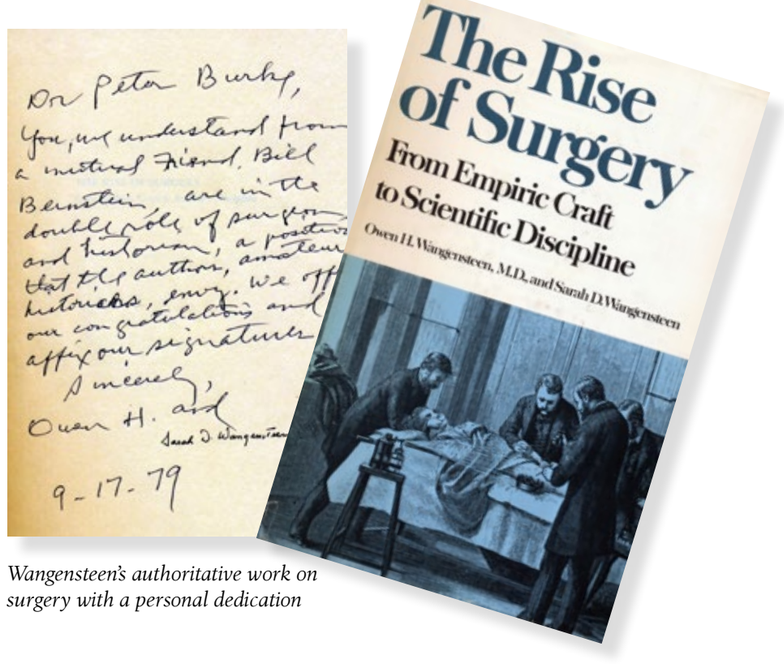
In 1924 he undertook a year-long surgical fellowship at the Mayo Clinic under Henry S. Plummer and William Mayo where he commenced work on his Ph.D.thesis, 'The Undescended Testis: an experimental and clinical study'. He returned to Minnesota in 1925 to complete this study and a classmate recalled that, "when Owen took his Ph.D. exam, the examiners finally gave up. They couldn't ask him anything he couldn't answer".

The University was seeking a replacement for Dr Stachauer, as Chief of Surgery: potential candidates who had trained under Halsted at Johns Hopkins reportedly made disparaging comments such as: "There is nothing here and never will be", referring to surgery at Minnesota.

The Dean of the Medical School then recommended that Wangensteen be named full-time head of the department of surgery, an unprecedented suggestion. In 1926, aged 27, 'OHW', as he was known by his friends and staff, was promoted from instructor to Associate Professor and undertook a year's preparatory study in Europe, observing Prof. Fritz de Quervain, Kocher's successor, and assisting Prof. Leon Asher at the Physiological Institute, in Bern, Switzerland.

Both these gentlemen instilled in Wangensteen an appreciation for history, physiology and research in surgery: study began with an exploration of the problem from an historical standpoint followed by research for answers for the future.

Finally in 1930 Wangensteen became head of the department of surgery at a time when not only the University of Minnesota, but also other academic institutions, were moving from clinical, part-time faculty to full-time teachers: with the support of William Mayo he was promoted to full professorship in




*Wangensteen's authoritative work on surgery with a personal dedication*

*Owen H Wangensteen*

1931 and served as department chair for 37.5 years until his retirement in 1967.

Wangensteen then developed a program that required surgeons to conduct research and he held the philosophy that you recruited the most talented students you could find and then found the funding to support their research interests. In his capacity as a teacher, Dr. Wangensteen employed the 'Socratic' method, which he used to foster independent thought and research amongst his students. Beyond the classroom, he believed that surgeons were split into two distinct groups, "those who see what they believe and those who believe what they see": he was passionate in trying to produce the latter.

Although many of his residents went on to do remarkable things, there is no doubt that the most dramatic surgical advancements at Minnesota occurred in the area of open heart surgery: in the Wangensteen environment it was no accident that this surgery began in Minneapolis, rather than in Boston, New York, Philadelphia, Chicago or Rochester.

Dr Norman Shumway developed the technique for heart transplantation and Dr Christiaan Barnard performed the first cardiac transplant in South Africa in 1967. Dr F. John Lewis led the world's first successful open heart surgery in 1952 using hypothermia; Dr C. Walton Lillihei developed the technique of cross-circulation in 1955 for open heart surgery, and Dr Richard A. DeWall introduced the 'heart-lung machine' a year later.

Wangensteen was a highly energetic individual who was described as having 20 original ideas a day but perhaps his most significant achievement was the Wangensteen suction apparatus developed in 1931. It is a modified siphon that maintains a constant negative pressure to remove gases and fluids from the stomach and intestines after surgery and other injury: it has been estimated that this device has saved hundreds of thousands of lives.

The apparatus was never patented because, according to Mrs Wangensteen, Owen felt it was wrong to personally profit from his invention and that his concepts and inventions should be available for the benefit of all.

The poet Ogden Nash wrote:

"*May I find my final rest in Owen Wangensteen's intestine,*
*knowing that his masterly suction will assure my resurrection.*"

Publication of research findings proved difficult because the popular opinion of the day was that surgeons did not do research with results to publish: Wangensteen's encouragement of young surgeons led to the establishment of the Surgical Forum of the American College of Surgeons in 1940. The Surgical Forum that he developed sought to bring together surgeons and students of surgery to communicate their expertise and learn from each other's research and questions. At the time of proposing the forum, Dr. Wangensteen argued, "*why should not these* [young students interested in surgery] *have the opportunity of an audience from surgeons and why should surgeons be denied the privilege of hearing young men, in their formative years, recite their own accomplishments*"?.

Wangensteen wrote of his own disappointment when papers he had

written on the conservative management of bowel obstruction were rejected by well-known surgical journals and an instance where one of his papers was sent to four publishers before it was accepted.

Although Wangensteen viewed himself as a plumber of the alimentary tract, "I have worked at both ends, but largely in between", at the time of his death on January 13, 1981, aged 82, his department had produced more than 60 full-time professors of surgery or heads of department.

Some of the tenets of Wangensteen's philosophy were summarised in an article written by one of his students, Richard F. Edlich, 'Reflections on Wangensteen's Academic Village', published in the American Journal of Surgery.[1]

Some of OHW's observations included; "The chief responsibility of heads of departments is to create an atmosphere friendly to learning", and "The ability to incite in students and young surgical protégés a love of learning is a more important quality for an academic surgeon than wizardry with a scalpel".

Wangensteen noted that for 20 centuries medical students on graduation had recited the Hippocratic Oath, acknowledging publicly their responsibilities on being admitted to the family of physicians: Owen Wangensteen felt that its corollary, a "Teachers Oath" should be developed, as in his view, the responsibility of teachers to students far outweighed the obligation of students to teachers.

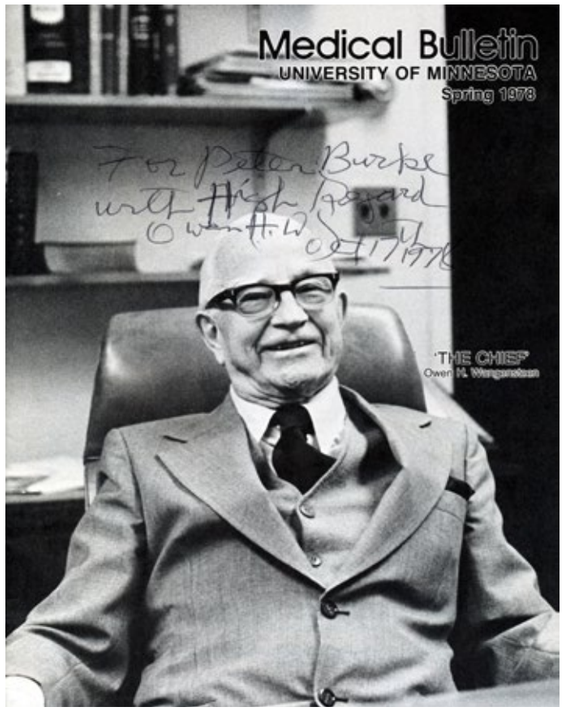
Portion of his proposed oath reads: "May greed for money never cross the threshold of our minds. May each of us through prudent and thrifty living come to know the satisfaction and contentment of sharing our bounty with good causes and especially with institutions of learning that created for us the priceless opportunity of spending our lives in the service of our fellow men and women".

Wangensteen wrote prolifically throughout his career; he was the author of 'Intestinal Obstruction', long considered the Bible on the subject: he was co-editor of the journal 'Surgery' from 1937 to 1970 and authored or co-authored more than 600 papers published in professional journals.

He and his wife Sarah wrote 'The Rise of Surgery: From Empiric Craft to Scientific Discipline' , published by the University of Minnesota Press in 1978, after twenty years of research and four years of writing.

Mrs Wangensteen was emeritus senior medical historian for the University of Minnesota and was managing editor of 'Modern Medicine' magazine for 15 years.

Owen's name is now perpetuated with 'The Owen H. Wangensteen Historical Library of Biology and Medicine' at the University of Minnesota, a section of the University's 'Bio-Medical' Library: it houses rare and historical volumes, more than 20,000 in number, dating from the 15th century to 1900 in superb climate controlled conditions: his ability to extract philanthropic donations greatly assisted the rapid growth of




*"The Chief's" autograph of the Medical Bulletin for Peter Burke*

this marvellous library and the many specialist subject areas include 'Surgery', 'Ophthalmology', 'Cardiology' and subjects as disparate as the 'History of Tuberculosis', Paediatrics and Physical Medicine.

Honours and awards were showered on Owen during his lifetime, too numerous to enumerate here, suffice it to say, not just from the U.S. but the entire surgical world.

The late Dean of the Minnesota Medical School, Harold S. Diehl said of Wangensteen, "Just what yardstick should one use in measuring his achievements- the most important contributions for relief of intestinal obstruction following abdominal surgery; the surgical treatment of gastric and duodenal ulcers; his pioneer work in the field of heart surgery; his distinguished achievements in the field of cancer surgery, and the many improvements he made in surgical techniques and procedures. What I would emphasise is his ability to inspire and develop young men, it is an ability which great teachers possess and through which they gain a type of immortality."

At the time of his death 'OHW' was working on yet another book, 'Grew up on a farm'. There is no doubt that he would have made an outstanding farmer.

**Reference:**

**1.** Edlich RF. '*Reflections on Wangensteen's Academic Village*'. Published in the American Journal of Surgery. 1981:141:601-4.





# BROADENING HORIZONS

## Covidien Younger Fellows Travelling Fellowship Grant

**MAYUR KRISHNASWAMY**
Victorian Fellow

After completing vascular surgery training in 2013, I spent six months in the cardiovascular unit at the University Hospital Zurich, Switzerland. The unit specializes in treating complex thoracic and abdominal aortic pathology, and services a population of around 3 million people. The UHZ also developed one of the first endovascular ruptured aneurysm programs in the world and has been involved in pioneering and improving endovascular techniques.

My first day in the hospital was an eye and ear opener – the ward round integrated Swiss, German, French, Italian, English and Spanish. Doctors came from all over Europe to work here, and on average spoke three languages. The multicultural nature of the medical team enriched the experience for me, and I learnt of the pros and cons of health care systems in Europe and Central America.

Aortic pathology was treated in a hybrid suite incorporating high end vascular imaging with full open operating capabilities. During my time there, I learnt alternative techniques in the management of arch aneurysms, thoraco-abdominal aneurysms and aortic dissection. Innovative endovascular concepts including novel debranching techniques formed an opportunity to broaden my surgical armamentarium. Interestingly, standard EVAR was performed as a day procedure.

The approach to management of ruptured aortic aneurysms was impressive. Paramedics and Emergency Physicians allowed permissive hypotension until arrival in hospital and eventual surgical treatment. A CT scanner was attached to the resuscitation room, providing scans within minutes. Aortic occlusion balloons could be placed under imaging in the resuscitation room. An operating theatre in the emergency department allowed for treating the most unstable patients, whilst the hybrid lab was the preferred destination for the more stable. Stent graft repair of the ruptured aneurysm (rEVAR) was performed under local anaesthesia with adjunctive techniques such as chimney grafts as required. During my time there, I learnt much about the management of abdominal compartment syndrome, perhaps the Achilles Heel of rEVAR.

The UHZ has a reputation for clinical research and development, with a well equipped research laboratory. Under the guidance of Professor Mario Lachat, I studied clampless anastomotic techniques applicable to cardiovascular surgery, with simulation on porcine aorta. Promising results were obtained for a balloon-assisted anastomosis in heavily calcified, unclampable vessels.

Whilst post fellowship training overseas can be a challenging time financially for a young family, the Covidien Travel Grant and a RACS loan made this possible. The experience both in and out of the hospital was fantastic. I look forward to maintaining my new professional affiliations and friendships in Europe over the coming years. These help to keep the world of surgery more closely connected and benefit us all. I encourage other young surgeons to take similar opportunities in the future.

The Covidien Younger Fellows Travelling Fellowship Grants will be available for travel in 2016. Applications for the 2016 Grants will open in September. Further information, including how to apply can be found on the College website:

**www.surgeons.org/member-services/scholarships-awards-lectures-prizes/research-and-travel-scholarships/covidien/**

# A MODEL OF CARE

## Dr Aileen Yen experienced teaching methods of a different kind on her scholarship travels

General Surgeon Dr Aileen Yen spent a year conducting laparoscopic surgery at the Colchester Hospital in England and building her advanced laparoscopic skills at the attached, state-of-the-art ICENI Centre.

With funding provided through the Murray and Unity Pheils Travel Fellowship, Dr Yen completed a Laparoscopic Colorectal Fellowship in 2014 at the Colchester Hospital, the designated colorectal cancer hospital for the eastern region of the UK.

While there she also trained and conducted master-class training at the ICENI Centre, a laparoscopic skills training centre established by joint Directors Professor Roger Motson and Mr Tan Arulampalam, both of whom are international pioneers of laparoscopic surgery.

A joint venture between Colchester Hospital University Foundation Trust and the Anglia Ruskin University, the centre acts as a focus for laparoscopic surgical research and training throughout the Eastern region of England.

Named after the local Celtic tribe who once inhabited the region, the ICENI Centre provides training to both surgeons and surgical Trainees across all specialties including Colorectal, General Surgery, Gynaecology, Urology and Vascular Surgery.

In recent years it has published research into the laparoscopic total mesorectal excision following long course chemoradiotherapy for locally advanced rectal cancer, training higher surgical trainees in laparoscopic common bile duct explorations and laparoscopic colorectal cancer surgery in obese patients.

Dr Yen, a General Surgeon with an interest in Colorectal Surgery, is now back in Australia and working at the Hawkesbury Hospital in Sydney.

She said she had wanted to work at Colchester and the ICENI Centre to both improve her advanced laparoscopic skills and learn how to establish and sustain such a teaching institution.

"Due to strong industry and academic support, the ICENI Centre is well known in the UK for its laparoscopic training courses and symposiums," she said.

"It has a simulation theatre and eight laparoscopic simulation stacks incorporating animal and rubber models to teach course participants.

"I also had the opportunity to learn some of the business skills involved in establishing this very successful teaching institution and how it is sustained through teaching, industry support and fund raising.





"That kind of collaboration is not common in Australia so the year working there gave me the chance to see what can be achieved when industry and medicine work together."

Dr Yen undertook her Fellowship under the supervision of Mr Tan Arulampalam.

She said that the Colchester Hospital had a commitment to doing minimally-invasive surgery where-ever possible for both elective and emergency cases which meant that she had the opportunity to conduct a large number of elective laparoscopic colorectal surgeries, emergency general surgery on call and endoscopy under surgeon-administered sedation.

"I was exposed to almost solely laparoscopic and minimally invasive colorectal surgery, transanal endoscopic microsurgery and scopes under sedation administered by the surgeon," she said.

"Such surgery was supported by advanced equipment, including excellent quality 5mm 30- degreed scopes, three-dimensional monitors and an infrared surgeon-controlled camera.

"The quality of the teaching at the ICENI centre and Colchester Hospital was superb.

"They take a modular, systematic approach to training at Colchester with each aspect of each procedure broken down into individual steps in theatre with each step then analysed afterward to see if improvements could have been made.

"This method of training at Colchester and the ICENI Centre means that most surgeons doing laparoscopic surgery in the UK conduct operations in much the same way which is quite different to Australia where many surgeons work quite differently with the same technology."

Dr Yen also said the Colchester Hospital had a unique staff member role of a laparoscopic nurse practitioner.

She said the nurse, Mrs Jane Hendricks, had 20 years of laparoscopic surgery experience and not only conducted research and endoscopies but also helped lead the hospital's Enhanced Recovery Program (ERP).

"Colchester adheres to the true spirit of enhanced recovery with a lot of investment put into pre-operative preparation," Dr Yen said.

"In the spirit of ERP, patients make a verbal contract with the hospital that they will do all they can to be fit for surgery while the hospital commits to doing everything possible to minimise interventions.

"Patients are encouraged to lose weight and improve their fitness before admission, they are given energy drinks before theatre, they are fed relatively soon after their operation and allied health professionals see them early to get them moving.

*"...The quality of the teaching at the ICENI centre and Colchester Hospital was superb."*

"While it may involve more interactions with the patient it did work and most patients, even those who had undergone complex procedures, were able to go home within three to four days.

"Ms Hendricks played a pivotal role in all this work, conducted twice-daily rounds with surgeons and registrars and was invaluable in the theatre yet to my knowledge no such nurse practitioner role exists in Australia."

Dr Yen said that while the Fellowship had improved her advanced laparoscopic surgical and endoscopic skills, the most invaluable aspect had been learning how to develop successful systems that benefited patients.

"It was a great honour for me to work under the supervision of Mr Tan Arulampalam," she said.

"He describes the Colchester as a Colorectal Finishing School in that he concentrates not just on transferring laparoscopic surgical skills but also teaching leadership and communication skills and the importance of collaboration.

"The year I spent in the UK has changed my approach to operating and running a practice in terms of team building and putting safety nets in place – after all, a successful surgeon is only as good as the supporting team members.

"I was totally thrilled when the College accepted my application and I thank the Pheils family for the opportunity to travel to Colchester and to spend time in the beautiful surrounding region known as 'Constable Country'."

The Murray and Unity Pheils Travel Scholarship was established following a donation made by the late Professor Murray Pheils to assist a Trainee or Fellow to travel overseas to obtain further training and experience in the field of Colorectal Surgery, or an overseas surgeon wishing to come to Australia or New Zealand to undertake Colorectal Surgery training.

*With Karen Murphy*

### SCHOLARSHIPS AND AWARDS

- **2014: RACS Murray and Unity Pheils Travel Scholarship**
  Colchester Hospital and ICENI Centre, UK
- **2003: Department of General Practice**
  Sydney Medical School, University of Sydney
- **1998:Golden Key International Honour Society**
  The University of Sydney Chapter
  Accepted into the University of Sydney Chapter

# DISEASE AT GALLIPOLI

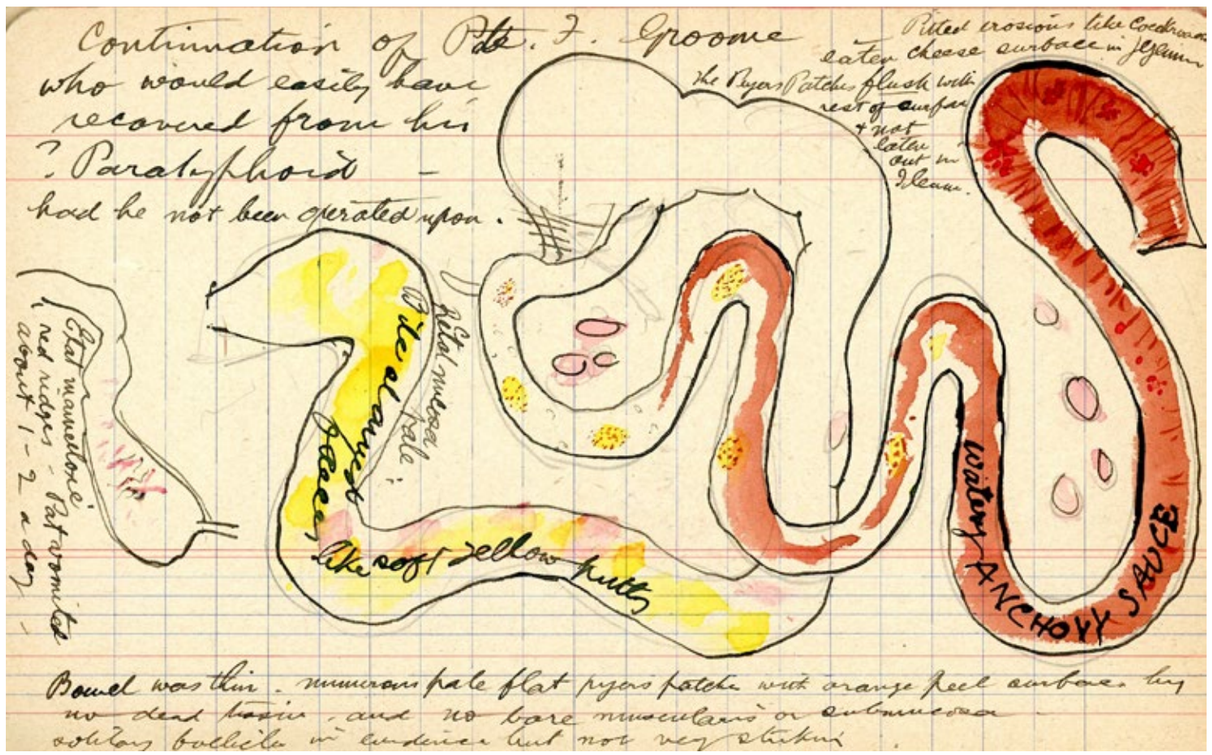
## The August Offensive

DAVID WATTERS
AND ELIZABETH MILFORD

*Flies were breeding on the thousands of bits and pieces of bodies strewn around-several hundred hectares of countryside-and on hundreds of unburied corpses.... faeces, food scraps, dung from the mules,-donkeys and horses, as well as dead animals, added to the breeding grounds.*

Infectious diseases were a constant scourge amongst the troops at Gallipoli. Measles was in evidence in the first transport convoys and there were always cases of influenza and mumps. Pneumonia and respiratory infections were so prevalent that on 25th April the Australian Stationary Hospital capacity on Lemnos was full of cases with disease even before battle casualties were incurred. As a result the hospital and converted troop (black) ships had to transport casualties to Egypt in April and May. It was recorded that 354 soldiers had died of respiratory conditions like Tonsillitis and Bronchitis before leaving Australia and 217 deaths were recorded at Gallipoli.

Respiratory disease took its toll on the medical officers. Wilfrid Giblin, the C/O of the I Australian Casualty Clearing Station contracted a respiratory illness in May and was out of action for a month. In June, his colleague, John O'Brien battled with pleurisy then suspected tuberculosis – he was eventually sent back to Australia and did not return to Gallipoli. While working with the 7 Fd Amb, in September 1915 Thomas Ross was afflicted by Spanish 'flu and briefly evacuated to Egypt. Scarlet fever and diphtheria became widespread amongst the arriving reinforcements for the August offensive, resulting in a small isolation hospital being established at Mudros, Lemnos.




*Paratyphoid from Archibald Watson's diaries*

As the weather got warmer in June and July, respiratory infectious diseases were eclipsed by the outbreaks of gastro-intestinal disease. Although causing only 184 deaths during the campaign, the morbidity from them was far greater. Several accounts indicate that recovery took at least three months and many never returned to the front line. Charles Ryan was so seriously ill with dysentery that he was reported as dead – he was evacuated to Egypt and then England. William Kay succumbed to dysentery in September 1915, briefly returned to Gallipoli, then contracted paratyphoid and was sent to England for the rest of the year.

Gastrointestinal diseases reached their peak incidence of 100 per thousand troops in September 1915. They included enteric fevers, typhoid or more importantly paratyphoid, dysentery and diarrhoea. Claude Morlet wrote:

*Everyone seems sick today! Whitburn has dysentery – Sawyer has malaria with a temperature of 105. Major Shaw has eczema and a tummy ache. Pierre has gastritis and Richie, my batman, has diarrhoea!*

Although diarrhoea and dysentery were listed as being more prevalent than enteric fever, there was limited success in trying to determine the exact cause. Caused by the contact with contaminated food and water, amoebic dysentery was being clinically diagnosed as the passage of blood and mucous. From September troops were treated with emetine hydrochloride with some deaths possibly caused by this drug. Later it was recognised that in fact what was being diagnosed as dysentery may often have been paratyphoid

Surgeon General Williams had insisted that all troops be vaccinated against typhoid but because combined vaccines were untrusted, so there was no vaccination against paratyphoid. Working at the 3 AGH at Lemnos, Charles Martin managed to isolate the bacteria in cases of paratyphoid. In early 1916, this eventually led to the use of a combined vaccine.

Venereal disease was another problem. Although its true incidence was unknown, it was perceived to be very high. Personal inspections were made revealing that the incidence was actually fairly low, demonstrating the importance of the need to respond to facts and data rather than subjective perceptions and prejudices. During the war the attitudes to these infections changed significantly with soldiers being encouraged to take adequate precautions to prevent infection but also to report confidentially, for treatment. The punitive measures of loss of pay and the branding of paybooks were gradually lifted and eventually it was recommended all penalties be abolished. The experiment in Langwarrin, where a hospital for venereal cases in Victoria was transformed from what was essentially a prison camp in 1915, to a true convalescent hospital by the end of the war, proved successful. Until the advent of penicillin twenty five years later, venereal disease remained a huge problem for troops serving in all theatres of war.

## Ferdinand Campion Batchelor

Hon Lt Col (1850-1915) MRCS, LSA 1871, LRCP Edinburgh 1871, MD Durham 1885

### *EARLY LIFE*

Ferdinand Batchelor was born on Norfolk Island and educated in England. He attended Guy's Hospital Medical School and graduated in 1871. He immigrated to New Zealand in 1874 and in 1877, he was appointed to the honorary staff at Dunedin Hospital where he held particular responsibility for abdominal and gynaecological surgery. He returned to England to complete an MD before accepting an academic appointment to Otago University in 1886, a position he led until 1909. Batchelor was acknowledged as a leading expert in bacteriology and in the techniques of diagnostic x-ray imaging as well as being one of the most experienced abdominal surgeons in New Zealand. In 1890 he publically criticized what he saw as poor infection control practices in Dunedin Hospital, and following a Royal Commission of Inquiry that returned a 'neutral' report, he was not reappointed to the staff of the hospital.

### *GALLIPOLI*

On the outbreak of war he immediately volunteered and sailed with the Main Body. On arrival in Egypt he was placed in charge of NZMC efforts to control venereal disease amongst the troops. Soon after the Gallipoli campaign began, he was taken ill and admitted to hospital in Cairo before being repatriated home in July. Ferdinand Batchelor died suddenly in Dunedin in late August 1915. A grandson, 2/Lt F Batchelor, served in 2 NZEF, dying of wounds in Italy in 1944.

*Andrew Connolly*

## (Sir) William George Dismore Upjohn

T/Lt Col, OBE, (1888-1979) MBBS, Melbourne 1909, MD 1912, MS 1913, FRCS 1919, FRACS 1927 Otago1903, FRCSEd 1906

### *EARLY LIFE*

William Upjohn was born at Narribri, New South Wales and was educated at Wesley College and the University of Melbourne. He served as aresident at both the (Royal) Melbourne and (Royal) Children's Hospitals before taking up a part-time position as Stewart Lecturer in Anatomy at the University of Melbourne, and entering private practice with Frank Cole, one of Melbourne's pioneer pædiatricians.

### *GALLIPOLI*

In 1912 Upjohn was commissioned Captain in 28 LHFA. Appointed Major in theAAMC in May 1915, he served as pathologist to 3 AGH on Lemnos during the latter part of the Gallipoli campaign. Using 3 AGH's well-equipped pathology laboratory, he investigated the dysentery and paratyphoid epidemic that ravaged the Australian troops. In early 1916, he contracted typhoid.

### *AFTER GALLIPOLI*

In April 1916 he was moved to France with 2 AGH at Wimereux and was soon promoted to T/ Lt Col. In August 1917 he gained a respite posting to 3 AAH at Dartford, but in December was posted back to France. Re-joining 2 AGH and stayed there until January 1919, when another new posting sent him to England. He was discharged in February 1920. In France he became particularly concerned with the means of controlling gas gangrene, a common consequence of infection in the intensively manured and highly churned up fields there.

### *PROFESSIONAL LIFE AFTER WW1*

After the Armistice he studied at the London and Middlesex Hospitals, and gained his Fellowship of the Royal College of Surgeons. Returning to Melbourne in 1920, Upjohn was appointed surgeon to outpatients at both his old hospitals, the (Royal) Melbourne and Children's. He resigned from the Children's in 1927 when he gained the position of surgeon to inpatients at the Melbourne, which he was to retain until his retirement in 1948. In 1942 he succeeded Sir Alan Newton as deputy-chairman of the Central Medical Co-ordination Committee, which controlled the allocation of medical manpower to meet military and civilian needs during WW2. He was also a visiting surgeon at 115 AGH Heidelberg.

*Geoff Down*

*(From left to right) Victor Hurley, Alan Newtown, William Upjohn. Photo Credit: Royal Melbourne Hospital*



# RED SULPHUR

## Safe only in small doses

**DR BB G-LOVED**

I must introduce you to two of my less usual patients. Selene is a somewhat alternative and colourful lady just as one would expect of a woman who aspires to be a lunar goddess. She serves dinners to selected guests on barmy nights when there is a young moon rising serenely over the sky. Her vegetarian cuisine look delicious, artistically layered in crescents across red glass plates. Her partner John Jakob, perhaps her ideal match, is a man whose head belongs in the clouds, searching for glimpses of reality amidst a cumulus of woolly thinking and an alternative perspective on life and the universe. In recent years they were keen to start a family but John Jakob's semen quality was poor and he suffers from Hashimoto's thyroiditis.

They asked whether John Jakob should take selenium supplements.

Selenium is the 34th element of the atomic table with a molecular weight of 68. It is a chalcogen like oxygen, sulphur, tellurium, polonium and livermorium. It was discovered by sulphur chemists Jöns Jakob Berzelius (1779-1848) and Johan Gottlieb Gahn near Gripholm, Sweden, in 1817. They noticed it smelt more like horseradish than arsenic, the latter typical of tellurium, naming their discovery after the goddess of the moon. Today selenium is used in glass, solar cells and photocopiers. But it is also an essential element of health, particularly for the thyroid, CNS cardiovascular system and fertility.

Inorganic selenium is a rare element present in the form of selenide, selenite or selenate, one form being red sulphur. Organically, selenium is present in the essential amino acids - selenocysteine and selenomethionine. Selenoproteins (SelP), synthesised in the liver, act as potent antioxidants and free radical scavengers throughout the body including the CNS. The most common ones are Sel P, H W, O, T & M.

The recommended minimum daily intake is some 60-70mcg, perhaps 120-160mcg is ideal and more than 400mcg would be dangerous. Unless you're a vegetarian like Selene and John Jakob, there's little likelihood of Westerners becoming deficient. There's about 90mcg in one Brazil nut. Other rich sources include tuna, salmon, halibut and red meats.

The acute symptoms of toxicity are fatigue, dizziness, irritated mucous membranes, headache, nausea, and pneumonitis. Chronic symptoms of excess include alopecia, deformed nails, fever, abdominal pain, diarrhoea, hepatomegaly, ataxia, and paralysis.

Selenium can be measured in serum (current status), red cells (status over the last 2-3 months) and in nails or hair (months to a year). One billion people worldwide are likely to be selenium deficient, with those living in sub-Saharan Africa, China, Finland and NZ (but not Australia) particularly at risk because of selenium deficient soils, though fish and/or meat in the diet should obviate this risk.

In Se-deficient areas of China, the intake is around 10mcg per day for rural vegetarians. These exhibit low glutathione peroxidase activity which may manifest as Kashin-Beck disease, affecting an estimated 3m people in China; or Keshan cardiomyopathy which is related to the combined influence of Se deficiency, a Codon 198 familial predisposition, and infection with Coxsackie B virus. Se deficiency appears to enhance viral mutations as well as a lack of antioxidant activity conferring greater susceptibility. Other viruses prone to mutate with Se deficiency include Avian Flu, Influenza (H1 N1), HIV, and HCV.

Many studies confirm the role of selenium and SelP as antioxidants and in mitochondrial function within the CNS, highlighting their major role as co-factors and essential elements for cerebral metabolism and neurological health. A major French trial with a cocktail of supplements - 100mcg selenium plus Vitamin C, beta-carotene and zinc for eight years suggested better memory and semantic fluency scores even six years later. However, a systematic review including nine studies failed to show convincing evidence of benefit for selenium in those in whom Alzheimer's disease has developed.

In the cardiovascular system SelP improves oxidation of lipids, reduces cholesterol, have anti-inflammatory actions, and reduces platelet aggregation. However, trials of supplements have not shown a significant reduction in cardiac events or death.

Se sulphide is toxic for the scalp fungus Malassezia so is included in some anti-dandruff shampoos. There has been a SELECT trial, well powered and based in North America, which failed to show benefit of Se supplementation for prostate cancer risk.

And now to John Jakob. Selenium certainly is of proven benefit for semen quality and would be worth taking (200mcg), plus 600mg N-acetyl-cysteine. It is essential for thyroid function, being used as a co-factor in three of the four thyroid hormone deiodinases and possibly reduces levels of autoantibodies in Hashimoto's. So 200mcg should be safe, but I need to ask him how many Brazil nuts he eats first.

# PROGRAMS IN MYANMAR

## The College's Foundation for Surgery has agreed to co-fund annual scholarships


*James Kong with PTC Course Participant Dr Aye Thiri Naing*

The College's Foundation for Surgery has agreed to co-fund annual scholarships to enable Myanmar doctors to travel to Australasia to gain exposure to advanced health and hospital systems.

An initiative of the RACS Global Health Committee, the new scholarship will be modelled on the successful Weary Dunlop Boonpong Fellowship Exchange Program for Thai doctors which the College has successfully co-administered with the Royal College of Surgeons of Thailand for more than 20 years.

The Foundation for Surgery has agreed to provide the bulk of the required funding to support the scholarship program with seed funding also provided by local donors in Myanmar.

The College is now in the process of formalising a Letter of Agreement with the Department of Health Professional Resource Development & Management of the Myanmar Ministry of Health, with the first Scholarship recipients to commence their program in Australia next year.

The new scholarship program builds upon the collaboration between the College and the Myanmar Medical Association to initiate Primary Trauma Care (PTC) training in the wake of Cyclone Nargis, to increase the national health system's capacity to provide effective trauma care to the population.

Since 2009, the PTC Program has trained over 1500 national health providers to deliver basic frontline trauma care, more than 200 doctors have been trained as instructors and 22 senior doctors are being mentored through a Masterclass program, to oversee the longer term sustainability of PTC training in the country. Today the PTC course in Myanmar is self-managed and will soon become a mandatory training component for all medical graduates.

Since 2012, the RACS has also worked alongside Fellows of Australasian College of Emergency Medicine (ACEM) and the Australian and New Zealand College of Anaesthetists (ANZCA) and the Myanmar Ministry of Health to introduce and deliver a sustainable, specialist training program in Emergency Medicine (EM), a specialty and service which did not previously exist as an independent specialty in Myanmar.

In the initial phase of the Emergency Medicine Development Program that ran throughout 2012 and 2013, 18 surgeons were trained as EM specialists and received a Diploma in Emergency Medicine.

A second cohort of eight doctors commenced their EM training in 2014 and successfully completed their program in August this year. A Masters in EM program - similar to the training for all local specialists and led by a local faculty in conjunction with international partners - also began in January this year.

Since the graduation of the first cohort, for the first time, the major hospitals in the three key cities in Myanmar – Yangon, Mandalay and Naypyidaw - now have Emergency Departments led by accredited specialists. These doctors with EM specialist training are expected to be the teachers of emergency medicine and they will help improve the quality of front line healthcare.

The Director of the RACS' Myanmar Program, Dr James Kong, said that with the collaboration over recent years, the College had developed strong relationships with the Myanmar medical leaders. Following discussions with them and hearing of their desire to enable the next generation of Myanmar medical leaders to obtain modern healthcare delivery experience and technical skills from the international community, the College agreed to set up a scholarship program to enable young, promising Myanmar surgeons to obtain exposure in the Australian system and gain clinical experience and the leadership skills needed to advance the development of modern healthcare in the new Myanmar.

"None of the success achieved so far through the College's Myanmar Program would have been possible without the commitment to build capacity from the College's initial foray in 2009, rather than provide humanitarian aid," Dr Kong said.

"Providing PTC train-the-trainer courses and Master classes allowed the senior doctors in Myanmar to take ownership of their own training. This approach created the goodwill necessary for all of us from different countries and medical specialties to come to work together there.

*James Kong teaching the emergency life support course to Myanmar doctors*

"The partnership between the RACS, ACEM and ANZCA and other international colleagues from Hong Kong, Thailand, Malaysia, and Singapore has also been crucial.

"That international collaboration enabled us to formulate and execute EM training in Myanmar within three months of the initial request with a shoe-string budget; an astonishing achievement!

"We always knew that having international physicians and surgeons flying in and out of Myanmar teaching was unsustainable long term. To be successful we aimed to train a large enough initial cohort of EM doctors to establish the specialty and drive its development into the future.

"I believe that this objective has been met.

"Nevertheless, the provision of effective, quality trauma and emergency care for the injured remains an enormous challenge.

"Myanmar is about the size of NSW with an estimated population of 65 million, so three major hospitals with emergency departments will not have a significant effect in a country where the vast bulk of the population live outside the cities."

**Recent data from World Bank on physician numbers in Myanmar and Australia**

| | Myanmar | Australia |
|---|---|---|
| Physicians | 17791 | 47875 |
| Physicians per capita (per 1,000 persons) | 0.39 | 2.47 |
| Population (million) | 53.26 | 23.13 |
| Rural : Urban | 66.1:33.9 | 10.0:89.1 |

The new scholarship program also builds on assistance provided to Myanmar Surgeons through the College's Rowan Nicks Scholarship and the Surgeons International Award Program.

During the initial roll-out of the EM training program, the College funded three Myanmar specialists to visit emergency departments and trauma centres in Melbourne, Sydney and Hobart.

Since 2005, the College has supported three Cardiac Surgeons and a Plastic and Reconstructive Surgeon from Yangon General Hospital to undertake advanced surgical and leadership training in Australian hospitals.

Two of those Cardiac surgeons, Prof Khin Maung Lwin and Prof Win Win Kyaw returned to Myanmar to take up active leadership roles as Director and Deputy Director of Cardiac Surgery at Yangon General Hospital. With the ongoing support and mentorship of her Australian supervisor, Mr Bruce French, Prof Win Win Kyaw planned the design and led the opening of the first open heart surgery unit in Myanmar in 2012.

The third Cardiac Surgeon and Plastic Surgeon are currently undertaking placements in Melbourne and will return to Yangon next year.

The new scholarships will be awarded annually to one or more qualified health professionals nominated by the Myanmar surgical and orthopaedic societies and Ministry of Health.

Recipients will undertake an attachment in an Australian/New Zealand hospital(s) for a period of three to four months. Administration of the program will be co-ordinated by the RACS' Global Health Department in collaboration with the Myanmar partners.

Dr Kong said the main objective of the scholarships was to give Myanmar doctors exposure to modern hospital systems.

"While some surgeons may use the scholarship to gain advanced surgical training, most Myanmar doctors already have good technical skills," he said. "However, the need to develop and enhance Myanmar healthcare delivery through better systems, processes and management is crucial!

"With the knowledge gained, they can return to mentor their colleagues and teach their juniors. This is another aspect of capacity building and I believe the potential impact of this scholarship program on the future of healthcare in Myanmar is substantial and will hopefully result in improved access to quality care for the people of Myanmar."

The Myanmar Program continues to support skills development through the provision of the Australian and New Zealand Surgical Skills Education and Training (ASSET) Course, the Advanced Trauma Life Support (ATLS) Course and further PTC Master Classes.

# SOUTH AUSTRALIAN AUDIT OF SURGICAL MORTALITY

SAASM is celebrating its ten year milestone

**GLENN MCCULLOCH**
Clinical Director, SAAPM

*With the SAAPM celebrating its 10-year milestone this year, it is valuable to reflect on how the audit has evolved and what it has achieved.*

## Over 5,000 surgical deaths audited

From commencement of the audit in 2005 to the end of July 2015, 5,544 cases of surgical death had been reported to the audit and of these, 94% (5,221) cases have completed the full audit process.

## Assessor feedback provided to treating surgeons

While the reports and educational activities provided by the SAAPM are often highlighted, the value of the feedback component of the audit should not be underestimated. As part of the audit process, an assessor (a consultant from the same specialty but a different hospital) reviews the details of each case.

If it is determined that any aspect of patient care falls below best practice, the feedback mechanism allows for the treating surgeon to be provided with recommendations on improving the quality of patient care. In cases in which no deficiency of care are identified (the majority of cases), feedback confirming that the death was unavoidable and management was appropriate may serve as valuable reassurance.

To our knowledge, Australia is one of the very few countries in which surgical deaths are audited and peer reviewed in such a comprehensive and standardised way. Assessors' feedback has been provided to the treating surgeon in all fully audited cases. In 4% (205) of these cases, a second-line assessment was deemed necessary and a detailed report, based on a comprehensive review of case notes, was provided. In a recent survey, 95% of respondents who received feedback from either a first- or second-line assessor said that this report was useful.

Many surgeons commented that the constructive feedback provided by assessors had influenced their practice, for example:

*"I find these to be very informative. They form the basis for change in the way I practise medicine"*

Referring to cases in which no clinical management issues were identified by assessors, one respondent commented that it was valuable to receive "reassurance that the patient died despite our best efforts".

## Development of the audit process and systems

The Australian and New Zealand Audits of Surgical Mortality (ANZASM) developed a customised database, the Bi-national Audit System (BAS) to securely store all of the data associated with each case and facilitate analysis. BAS also allows the project staff to see, at a glance, how cases are progressing through the process and identify any bottlenecks, that is, stages in which the process is being delayed, which greatly enhances efficiency.

Another notable initiative was the introduction of the 'Fellows Interface' in 2011, a web-based system which allows reporting surgeons and first-line assessors to complete forms online. This system incorporates security which only allows data to be accessed by the reporting surgeon and the SAAPM staff (assessors are only able to access the de-identified surgical case forms).

As a result of ongoing promotion by the SAAPM, use of the Fellows Interface has increased considerably in the last year; 92% of first-line assessors and 64% of treating surgeons now submit online. Efforts to increase the level of online submission continue. To improve the efficiency of the process, and accessibility and ease of use for surgeons, a number of system enhancements are underway, with the most recent being the ability to self-generate a notification of death and carry on to complete the surgical case form online.

## Current participation

**100%** of hospitals where surgery is performed

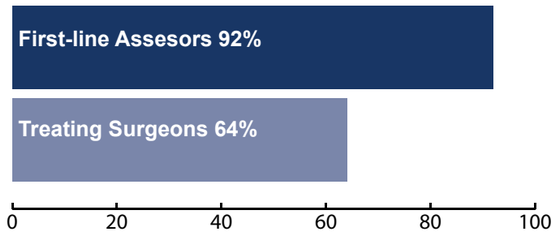
**98%** of RACS Fellows

**93%** return rate for surgical case forms.



AUDITS OF SURGICAL MORTALITY

*Fellows Interface usage (SAAPM, July 2015)*

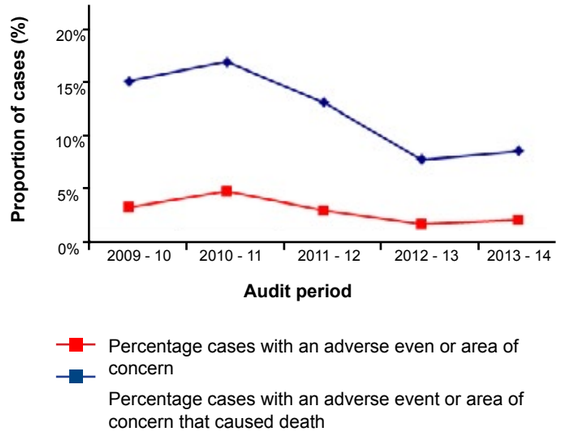



## FINDINGS

## Reduction in cases with serious clinical management issues (= preventable deaths)

An aspect of the data that is always of particular interest as an indicator of the quality of care is the proportion of cases with serious clinical management issues (adverse events or areas of concern). As shown in the chart below, the proportion of cases with identified deficiencies of care in 2013/14 was half the level recorded in 2010/11, having decreased from 16% to 8% of cases. This is a very encouraging trend that will be monitored closely over coming years.

*Cases with a serious clinical management issue by audit period (2009/10 to 2013/14)*




## High level of consultant involvement

Another positive finding is the high level of consultant involvement in operations that is, the proportion of operations in which the consultant decided to proceed to surgery, operated, or was in theatre. In South Australia during 2013/14, the consultant was responsible for decision-making in the majority of operative cases (91%), which is higher than the national figure for the same period (87%). The consultant operated in 65% of reported operations.

## EDUCATIONAL OUTCOMES AND ACHIEVEMENTS

SAAPM has been involved in increasing the awareness of issues related to surgery by monitoring trends in surgical mortality data and in changing surgical practice to achieve better patient outcomes.

## Individual Surgeons Report

Each year, the SAAPM produces an individual report for each surgeon who had a surgical death audited in that year. The report presents comparative data (all surgeons and by specialty) relating to return of forms, number of deaths and clinical incidents. Information is also provided on the surgeon's own cases, including details of each case (excluding identifying information such as name/URN) and a description of any clinical issues identified by the assessor. These Individual Surgeons Reports were first produced in 2011 and feedback has been very positive. A survey found that, of those surgeons who had received this report, 89% felt that it was useful, educative or both.

## Publications

The audits (both the ANZASM and regional audits) have published a number of articles in peer-reviewed journals. The SAAPM is currently working on an article analysing serious deficiencies of care in neurosurgery, based on 191 serious deficiencies reported nationally since 2009.

## Case Note Review Booklets

Compiled by the ANZASM, these booklets describe selected cases drawn from the national pool of cases and from a range of specialties, with a focus on clinical lessons. Feedback from surgeons on the value of this publication has been positive; a survey of surgeons conducted by the SAAPM found that 93% of respondents read the reports and 98% of the readers found them to be useful and educative.

## Seminars

The SAAPM held a seminar on 23 July 2015 in association with SA Health on the topic of 'The decision to operate – or not'. Speakers included surgeons and other clinicians from various specialties who discussed their experiences and the use of risk assessment tools. The seminar was well attended by a range of health professionals, including surgeons, surgical trainees, anaesthetists and nurses.

The SAAPM also conducted a workshop in February 2012 entitled 'Recognising the Deteriorating Patient'. The workshop was well attended, with an audience comprising surgeons, surgical trainees and nurses. Presentations included 'Identifying the high risk surgical patient', 'Mistakes an intensive care unit consultant has to handle', 'The deteriorating patient' and 'Postoperative pitfalls', delivered by a variety of clinicians including nurses, surgeons and intensive care specialists. In a post-workshop evaluation, the majority of attendees (87%) felt that they were better able to pick up the signs of a deteriorating patient after attending the workshop and 92% indicated that they would be interested in attending a similar event in the future.

## ANZASM National Case Note Review App

Due to the substantial dataset now available, the ANZASM second-line case note reviews have been incorporated into an App format accessible by smart phones and similar compatible devices. The ANZASM is in a good position to utilise the extensive information learned to promote safer health care practices. The App has been based on the success of the Case Note Review Booklets and e-magazines which contain a more in-depth investigation of key surgical issues and lessons that can be learnt from these. The App will increase the quantity and quality of information available on issues that relate to clinical governance and patient care across the country, in a more accessible format. The ANZASM National Case Note Review App is free and allows users to search for cases (by specialty, key word or by the National Safety and Quality Hospital Standards, where applicable); view the latest cases and videos uploaded on a monthly basis and to provide feedback.


## In summary - what have we achieved?

Throughout the first ten years of the SAAPM, the audit process has been continually developed and improved. The type of data collected has been refined in consultation with stakeholders. The audits now have a sophisticated, tailored database that stores all of the data associated with each case, from recording of notifications of death to data analysis, as well as an interface that allows surgeons to enter data electronically. For both the surgical community and the health administration authorities, peer review of surgical deaths is vitally important to inform, educate and improve the care of patients. Findings have been disseminated through reports and articles, and the education role has included individual reporting to the treating consultant surgeon, workshops, Case Note Review Booklets and online tools.

The audits will maintain a continuous improvement approach to maximise efficiency and best meet the needs of surgeons and other stakeholders. At the same time, now that the systems and processes have reached the current level of maturity and high levels of participation and support have been achieved, more attention can be focused on how best to utilise the valuable information gained, in collaboration with stakeholders.

# CLAIMS AGAINST DOCTORS

## Recent Developments

**MICHAEL GORTON AM**
Partner, Russell Kennedy

Like all professionals, doctors are interested in information which may suggest when they are likely to be sued!

Recent information and research provides some interesting insights into medico-legal actions in Australia.

### Surgical Checklist

The WHO and RACS approved Surgical Checklist is a simple quick method of checking a patient and the proposed surgery before surgery is commenced, to eliminate wrong side and wrong site injury and medico-legal claims. Despite the significant publicity given to the "Surgical Checklist" and its methodology, there remain gaps in usage and application. Anecdotally, some hospitals report a less than 100% application of the Surgical Checklist and a number of wrong site/wrong side claims continue to occur.

A review by the Department of Veteran's Affairs "Prevention of Wrong Site Surgery, Retained Surgical Items and Surgical Fires: A Systematic Review", September 2013, still identifies significant risk for wrong site surgery, notwithstanding the application of the Surgical Checklist.

The failure to undertake the Surgical Checklist, which would demonstrably avoided the wrong site/wrong side error, would be grounds for a negligence claim against the surgeon who failed to apply the Checklist.

The Surgical Checklist protocol is cost free and can be relatively rapid. The courts would have a dim view of a surgeon who deliberately chose to ignore the protocol.

### Sex differences in Medico-legal actions

A recent study (Unwin et al, BMC Medicine (2015) 13:172), identified gender differences in claims profiles. The study confirmed an earlier Australian study (Bismark) which recognised the preponderance of claims against male doctors. Male doctors had a two and a half times chance of being subject to a medico-legal action than female doctors. The review had access to information regarding medico-legal claims, regulatory complaints and disciplinary action by medical regulators. The data included information from North America, Europe and Australia and, in all three regions, male doctors were significantly more likely to have experienced a medico-legal action.

The study is of interest, although its application in terms of prevention is not clear. Perhaps the message is simply – males beware!

### Unfounded fears of medical Board action

Information released from the Medical Council of NSW indicated that only a very small number of complaints ended up at the Tribunal in that State. This is reflected in the national data issued by AHPRA and the Medical Board of Australia on an annual basis.

In NSW, of the 1697 doctors with complaints against them before the Medical Council, only 22 of them faced the Tribunal in 2013/14.

Complaints to a medical regulator can increase anxiety and stress for doctors involved. A claim which impugns the integrity or professionalism of a doctor would always have some effect. Other recent commentary has indicated the profound effect of substantial claims, which, in some cases reviewed by the General Medical Council in the UK, may have contributed in some way to the suicide of the doctors. AHPRA data across Australia indicates that of the number of complaints lodged against medical practitioners in Australia, a significant proportion result in no further action being taken.

The President of the Medical Council of NSW, Dr Greg Kesby, was quoted as stating that the figures indicated that the system was doing its job of protecting the public, while treating doctors fairly. He acknowledged that "it is understandable that doctors may fear regulatory authorities", but suggests that fear is unfounded.

"It is only the most egregious departures from appropriate standards of professional judgement or behaviour that will result in deregistration and in those circumstances, both the public and profession benefit from that."

### GP discharge letters create risk?

A recent study in the Medical Journal of Australia (MJA 203(3) 3 August 2015) highlighted that there is a poor understanding by GPs of abbreviations used by specialists and issued by hospitals as part of the discharge of patients.

A retrospective audit of discharge correspondence in a Sydney hospital identified whether abbreviations used were well understood.

In the study, a significant percentage of those reviewing the correspondence incorrectly interpreted the abbreviations used. In some cases, for some abbreviations, they were incorrectly interpreted by 47% of the cohort.

Whilst the study is limited to one particular hospital in one particular region, it clearly has implications for the substantial medico-legal risks involved in the use of abbreviations which are not universal, or not particularly well understood.

The study suggests some solutions, including creating a list of approved medical abbreviations, or the use of computer software programs to auto-complete relevant abbreviations.

The study highlights that the use of shortcuts in official medical correspondence can have adverse implications.

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