Vietnamese doctors visit New Zealand to learn vital new skills. PAGE 12

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President’s Perspective

Ian Civil, FACS President at the Opening Plenary, Plastic Surgery Congress 2011, Gold Coast, July 2011 with (from l-r) Paul Bell (Scientific Convenor), Howard Klein (President NZAPS), Swee Tan (recipient FACS Research Award), Peter Callan (President ASAPS), John Perang (President Plastic Surgery Foundation USA), Phil Haack (President ASAPS).

Making our presence felt

College representatives will be engaged at specialty meetings to gain more insight on complex issues

This year I will be attending most of the Specialty Society Annual Scientific meetings and congresses. Recently I attended the Plastic Surgery Congress at Broadbeach in Queensland. Bringing together the Australian Society of Plastic Surgery, the New Zealand Association of Plastic Surgeons and held with the participation of the Australasian Society for Aesthetic Plastic Surgeons, the Australian Hand Surgery Society and the Australian and New Zealand Society of Ophthalmic Plastic Surgeons – the meeting reflected the complexity of surgical governance and clinical expertise in which surgical care is now delivered.

There was world leading research and in particular I was delighted to acknowledge the outstanding work of Professor Swee Tan whose contribution to understanding the genesis of vascular anomalies has provided significant improvements in treatment and outcomes. The principles are now also being applied within oncological research and other areas.

There were numerous sessions dealing with the commercial realities of the world in which we work. Aesthetic plastic surgery is particularly challenged in regard to the ethics of advertising, marketing and practice profile. Practice managers and other affiliated staff are actively involved to ensure that the appropriate cultural and ethical values can be understood and shared by all. Both ASAPS and NZAPS are to be congratulated on the forthright way in which they are trying to address these issues.

Importantly the educational components were prominent. Not only the scientific sessions where the expected areas of reconstructive, plastic and aesthetic surgery were considered, but also...
to issues of collegial support and the skills to be an effective educator. RACS now provides a number of resources into all Specialty Society meetings such as the SATSET course for supervisors and also training courses for Supervisors. Currently being finalised are courses focusing on support for the trainee in difficulty (KT oT) and also training around these issues in the months ahead.

Also at the meeting was the RACS stand where College staff can explain the various activities available and provide resource material or reports that provide the foundation to our education, professional development and CPD requirements. This information and material is all available on our web site, but there is nothing like the opportunity to discuss it with your College staff to improve your understanding of the detail.

I was involved in a number of discussions around our training programs and our governance structures. RACS has now communicated clearly to the Australian Medical Council about our requirement to have more flexibility in key aspects of our training– like selection. Whilst achieving the principles of good selection practice, we need to build in measures where the specific requirements of our nine specialties can be more fully reflected. This is now being addressed.

Separately I have had a number of discussions about possible models of improving the effectiveness of our governance structures. Having the input of Fellows through our representative methods as well as hearing directly of the concerns from the Specialty Societies and Associations is now a priority. It is really beneficial that senior Office Bearers from RACS now routinely attend the specialty meetings. This will be substantially enhanced by better integration of our leadership and representational governance approach.

More than anything else I took away from the Plastic Surgery Congress an understanding of the challenges faced by the Societies as they relate to their subspecialty groups and at the same time an appreciation of the relationship, expected by members, with the College. What I hope I left behind is encouragement to concurrently participate in subspecialty, specialty and College activities. The costs, commitment and expectations of each group are different, but together they provide a matrix of clinical, educational, and representational activities which can fulfill all of the needs of practicing surgeons and trainees. Participation in any one group alone cannot effectively meet those needs.

I look forward to the ongoing discussions around these issues in the months ahead.

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

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve. We will acknowledge your donations and place your name on the gown if you approve.

If you would like to donate your gown to the College, please contact Katie Fagan on +61 3 9049 1248. Alternatively you could mail the gown to Katie Fagan, c/o Conferences and Events Department, Royal Australasian College of Surgeons, 250-290 Spring St, EAST MELBOURNE, VIC 3002.

The ANZ Journal of Surgery

The College’s scientific journal has undergone significant changes over the past five years

This year marks the 80th anniversary of the ANZ Journal of Surgery, the College’s academic publication and the pre-eminent surgical journal published in Australia, New Zealand and the South-East Asian region.

It also marks the final year of Professor John Halls tenure as editor-in-chief, a five year period that has seen the journal undergo significant change.

In 2011, the acceptance rate for original articles is about 20 per cent, compared with an acceptance rate of 67 per cent in 2007. The product of this commitment to excellence has been a steadily rising citation rate. This is reflected in the journal’s so-called Impact Factor, which is the commonly used measure of a scientific journal’s average number of citations. Often used as a measure of a journals relative importance within its field, the higher a journal’s Impact Factor the more influential it is deemed to be.

In 2010 the ANZ Journal of Surgery’s Impact Factor was L344, up from 998 in 2007. In the same year, downloads of articles reached 176,000.

Dedicated to the promotion of outstanding surgical practice, and research of contemporary and international interest, the journals readership is increasingly international, with 22 per cent of readers from Australasia, 22 per cent from the US, 20 per cent from Europe, 7 per cent from the UK, 5 per cent from China and 2 per cent from Japan. And fully 60 per cent of articles submitted for consideration come from countries other than Australia. Of those from other countries, 15 per cent come from China and 7 per cent from the UK.

There is now a much more efficient flow of manuscripts, with John leading a team of conscientious handling editors and reviewers.

Under John’s leadership, the practice was initiated of issuing a media release in conjunction with the appearance of each issue of the journal. The media release publicises what is deemed the most newsworthy article of the latest issue, and this has resulted in several media interviews with contributing authors.

The journal’s format is also more attractive and user-friendly.

But perhaps John’s most lasting contribution will be the journal website – ANZJSurg.com. It is an astonishingly comprehensive website, with every article that has ever appeared in the journal since its inception now retrievable at the push of a button. As publishing becomes more electronic and less paper based, John has ensured the College’s academic journal is well placed to seize future opportunities.

The Winthrop Professor of Surgery, John has for 25 years been a consistent surgeon on-call for emergencies and trauma at Royal Perth Hospital.

When recently asked what he thought his greatest achievement as editor-in-chief was, John answered “bringing the journal closer to the College”. He is to be thanked and congratulated.

Throughout 2011, a transition phase has seen John working closely with his successor, Professor John Harris, the Foundation Professor of Vascular Surgery at Sydney’s Royal Prince Alfred Hospital and a distinguished

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The editor reserves the right to change material submitted.

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For more than 60 years, the bodies of fallen Australian and Japanese troops, killed in one of the bloodiest battles of the Kokoda Campaign of 1942, lay forgotten and unidentified in some of the most impenetrable terrain on earth.

Slain during the frenzied fighting that led to one of the first Japanese retreats of WWII, the bodies of the lost were reclaimed by the jungle high upon a ridge above the Kokoda track. Believed to be the site of Eora Creek, a fierce engagement that lasted five days and claimed the lives of 79 Australians and at least 69 Japanese soldiers, the lost battlefield lay unknown even to the thousands of trekkers who annually walk the trail below in tribute to the fallen.

Lost even to military historians, the site, which they believed capable of managing the complexities involved in securing, investigating and preserving the site.

One of those was Melbourne breast surgeon Mr Peter Gregory who knew Mr Freeman from previous trekking adventures.

Uncovering

Following that phone call, Mr Gregory, with philanthropist David Moffatt, accompanied Mr Freeman for an initial visit to the site in June last year, again with archaeologists in November and most recently in July.

“Our site mapping has now logged more than 300 weapons pits, unexploded ordnance and medical equipment believed to have come from a Japanese hospital,” Mr Gregory said.

“Now the Department of Defence War Graves Unit is involved along with archaeologists, forensic anthropologists, forensic dentists and the Director of PNG’s National Museum and we have now exhumed the bones of one soldier. The process of determining nationality will now occur.”

“Dozens of bodies, including five Australians, were never recovered and are still listed as missing so a sample from that body has been sent to Adelaide University for DNA analysis.”

“The terrain up there is so rugged, just getting there requires a half-day slog straight up from the Kokoda Track, that the body of a soldier could lie 10 feet away and you would not see it.

“It would not even be possible to get there without the Alola people acting as guides because you could turn around in the dense jungle and get lost in an instant, so we are extremely grateful for their help.”

Mr Gregory said the battlefield was misidentified because “popular belief” assumed the fighting took place on the second highest ridge of the area rather than the highest.

He said archaeologists now estimated that more than 800 Japanese soldiers had been based at the camp, which housed a field hospital, weapons caches and officers quarters.

“It seems that this site was first a care centre or dressing station during the Japanese advance, but then became a major battle site months later during the Japanese withdrawal,” Mr Gregory said.

“The Japanese held the high ridge over the Eora Creek Gorge giving them a significant geographic advantage against the advancing Australians, but they chose to position themselves close to the only water on the ridge, neglecting the highest ground, which ultimately gave the Australians the pivotal advantage in the engagement.”

“Until now we have known about the two other major battles of the Kokoda campaign – at Isurava where Australia now has an ANZAC cemetery and at Brigade Hill where 69 Australians were killed – but the largest battle was at Eora Creek.

“Despite the fact that it has remained shrouded in mystery, it was the most important battle of all because it marked the first time in the war that the Japanese fully retreated.”

Now Mr Freeman, Mr Moffatt and Mr Gregory, in full consultation with the Alola people, have established a trust to raise funds for some community projects and to help develop a heritage site management plan which they hope will be key input into an application for the Kokoda Track to receive a World Heritage listing.

While the strategies and fund raising, of the trust have become the province of philanthropist Mr Moffatt, the welfare of the villagers has become the focus of Mr Gregory who worked in PNG as a volunteer during his early medical training.

Just last month, he spent a week at Alola sitting around the fire with village elders to determine what they wished done to improve their lives as a thank-you for their involvement.

“There are only 75 people in Alola and life is pretty basic, no electricity, no running water except from the stream, grass huts and cooking fires and virtually no health services,” Mr Gregory said.

“Yet while it is important that their village life isn’t disturbed by all this, we want to assist them for giving us this gift through the provision of education and health care.”

Giving Back

Mr Gregory said that upon each visit to the village he conducts a basic clinic in which he stitches wounds, drains abscesses, checks blood pressure, heart and lungs, but that plans were now unfolding to build a health clinic and primary school.

“We have now agreed to fund the secondary education of 10 village children in Port Moresby given that there is no accessible secondary education of 10 village children in Port Moresby given that there is no accessible education of 10 village children in Port Moresby,” he said.

“We then plan to fund the training of two people of the village to undertake a basic medical course to become Health Extension Officers.”

“We have also provided the initial money to build the school and clinic and while we may have to chopper in concrete, the villagers are happy to do the construction and have already begun, so hopefully both facilities will be built by the end of the year.

“At the same time, their own economic well-being should be improved by their ability to charge for their services as porters and guides to the people now visiting the lost battlefield.”

Mr Gregory said he planned to make six-monthly visits to Alola in coming years with the assistance of his wife who is a nurse and midwife.

“In such tropical country as Alola, you are limited in the surgery you can do without appropriately sterile facilities because of the high infection rates,” he said.

“But even so, I can treat fresh injuries or wounds and there is one fellow in the village who has a spear tip still under his skin so I think I’ll treat that upon my return.

“My wife, who hasn’t been there yet, will come with me on future visits which will be a great advantage because she is a very skilled nurse and will probably be of more practical use there given the logistical limitations placed upon surgery.”

With Karen Murphy

Surgeons in the Field

A goodwill gesture has revealed an important landmark in Australian/PNG history
Younger Fellows

Great opportunities for Younger Fellows in 2012

Take advantage of the amazing experiences on offer

Steve Leibman
Chair, Younger Fellows Committee

The College provides some excellent professional development opportunities for Younger Fellows. It's time to start planning for 2012 to ensure you get your application in on time.

Coviden Travelling Fellowship Educational Grant, 2012

Younger Fellows face many challenges when undertaking post Fellowship studies or training. The Younger Fellows Committee in partnership with Coviden offers two Travelling Scholarships annually which can help to offset the cost of studying overseas. You are eligible to apply if you are planning to train overseas within the next 12 months, but returning to Australia to practice. Applications will be accepted from 1 August - 30 September 2011.

Younger Fellows Leadership Exchange: AAS Academic Surgical Congress

Each year our College and the Association for Academic Surgery (AAS) in America exchange delegates as part of a leadership exchange. The purpose is two-fold, firstly to provide professional development for a Younger Fellow; particularly in relationship to leadership and secondly to promote an exchange of ideas and possible solutions for common issues affecting Younger Fellows in both organisations. The exchange also aims to identify opportunities for our Younger Fellows to access International Clinical Fellow positions in the US. The Exchange covers airfares, accommodation, transfers and conference attendance expenses for the RACS representative. Interested Younger Fellows are encouraged to apply from 1 to 30 September 2011. The 7th Academic Surgical Congress will take place from February 14-18, 2012 at the Encore at Wynn, Las Vegas.

Younger Fellows Forum, 6-28 April 2012, Kuala Lumpur

Last but not least, I am pleased to inform all Younger Fellows that the development of the program for 2012 Younger Fellows Forum is well underway. Seema Bagia is convening the Forum which promises to provide a chance to share ideas and experiences will affect your professional and personal lives. The programme will include sessions on topics' and a chance to relax and network with your colleagues. I am sure this unique opportunity for debating ‘hot surgical issues’ and a chance to relax and network with colleagues. I am sure this unique opportunity for debating ‘hot surgical issues’ and a chance to relax and network with your colleagues. I am sure this unique opportunity for debating ‘hot surgical issues’ and a chance to relax and network with your colleagues.
An ongoing bond between New Zealand and Vietnam is assisting in building skills

Across-cultural bond forged during the summit of the Vietnam War between local people and New Zealand medical teams sent in to help provide medical and surgical services in the midst of the violence has, decades later, resulted in a recent visit to New Zealand by two Vietnamese surgeons.

Earlier this year, Orthopaedic surgeons Dr Viet Vu Van and Dr Nhan Phan Tran Dai spent six weeks attending theatre and consultations in cities and towns across the country including Auckland, Nelson and Dunedin.

The visit by the two Vietnamese surgeons accompanied by an interpreter was supported and funded by a Surgeons International Award through the RACS Foundation for Surgery.

The RACS Foundation for Surgery has agreed to fund a planned visit later in 2011 for two Vietnamese surgeons to assist the re-building of health care in Binh and funded by a Surgeons International Award.

According to a report written by the surgeons following the visit, the procedures of most interest included joint replacement surgery, anterior cruciate ligament reconstruction, arthroscopy, fracture and trauma management, particularly involving the use of intra-operative X-ray imaging, and the role of physiotherapy in rehabilitation.

One of the really positive aspects of this visit, not just transferring skills and knowledge but giving the surgeons the opportunity to overcome some of these problems particularly after seeing how our hospitals systems work in terms of patient flow, in-patient and out-patient care, the use of diagnostic tools and post-operative care.

Mr Dunbar will visit the hospital when it is fully operational next year.

He praised the efforts of Mr David Morris in Auckland and Middlemore Hospitals.

The trip came at the request of the Director of the Rehabilitation Centre, Dr Cuong Phan Canh, who visited New Zealand in 2007 and wanted the same experience for members of his surgical team.

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From February to April, the two visiting surgeons were hosted and supervised by Mr John Dunbar in Dunedin, Mr Allan Panting in Nelson, and Mr David Morris in Auckland and Middlemore Hospitals.

The visit was co-ordinated through the New Zealand Viet Nam Health Trust (NZNHT), an organisation established during the 1990s to assist the re-building of health care in Binh Dinh province, Central Vietnam.

Since 1990, the Trust which until recently had been funded predominantly by NZAID, has provided equipment, support and surgical team visits to the regional town of Quy Nhon and Bong Son, where the NZ medical teams had been stationed during the war.

The team visits have covered a range of specialties including paediatrics, medicine, orthopaedics and trauma, obstetrics, cervical cancer screening, urology, general surgery, anaesthesics, nursing programs including infection control, laboratory training and the establishment of a Blood Bank service.

With the Quy Nhon Rehabilitation and Orthopaedic Centre now in the process of being rebuilt, the recent six-week exchange program was designed to give the surgeons exposure not only to complex orthopaedic procedures but also to the organisational structure and professional inter-relationships of modern western health facilities.

The trip came at the request of the Director of the Rehabilitation Centre, Dr Cuong Phan Canh, who visited New Zealand in 2007 and wanted the same experience for members of his surgical team.

He said that until now, surgeons at the Centre had been limited in what they could do by many factors including the lack of adequately sterile operating theatres, the lack of surgical equipment and intra-operative radiology and by the limitations placed upon them and allied health professionals in their ability to gain global exposure.

"There are still some older people in Quy Nhon who hold New Zealanders in high regard for the assistance offered them during the war, particularly because the New Zealand teams treated all victims equally, including members of the Viet Cong," he said.

"I think a number of people in the western countries involved in that conflict feel a degree of guilt about what happened to the people of Vietnam and it is a privilege to be in a position to help them now."
Be involved in revealing new research

The College is reaching out, welcoming medical students and junior doctors to surgery

Richard Hanney
DCAS course Convener

The College took this important initiative further by holding a dedicated program for the medical students on the opening day of the Congress. For a concessional registration of $300, the students were able to explore first hand their interests in a potential surgical career. Two sessions, chaired by Mark Edwards and John Collins, specifically explored the mechanisms and challenges of pursuing a career in surgery. Around 45 students attended this program. Again the feedback indicates that this was a very worthwhile initiative, important to continue and develop further at future Congresses.

The total of 83 registrants at this year’s DCAS course was the highest number to date. In addition to engaging interested medical students, the Section of Academic Surgery has sought to engage the prevocational doctors, and 15 attended the 2011 DCAS course. The largest sub-group attending was from the College with a total of 26 Fellows. The presentations from the faculty from Australia, New Zealand, the US and Scotland were inspiring and this was reflected in the evaluations. Most pleasingly all nine surgical specialties have been represented on the DCAS faculty to date.

Plans for the 2012 DCAS course are already underway. It will again be held on the day before the ASC, on Sunday, May 6, in Kuala Lumpur. While the logistics of holding the congress offshore will be a challenge, there is no doubt that the DCAS course will again be well attended, and the organisers are excited about the prospects of drawing in more local participants from Malaysia and surrounding countries.

To that end there will again be complimentary registration for interested medical students, and this opportunity will be promoted by their own Surgical Interest Network (SurgIN). For the first time, however, there will also be a complimentary airfare and accommodation provided for the medical student or pre-vocational doctor that has the most highly ranked presentation at the Surgical Research Society meeting in Adelaide on November 11, 2011. This is in addition to the number of established prizes awarded at the SRB meeting. For further information, contact academic.surgery@surgeons.org

The DCAS course has continued to evolve over the last three years, but remains committed to inspire and facilitate those interested in a career in academic surgery. The faculty line-up for the meeting in Kuala Lumpur is outstanding and the interactive sessions will provide options and practical advice. Concerning to DCAS 2012 in Kuala Lumpur and be inspired. And let us know what you think by contacting the organisers on dicas@surgeons.org

Alfred
Hospital General Surgery Meeting

The Department of General Surgery at The Alfred Hospital, Melbourne, is again running The Alfred General Surgery Meeting on 28 to 29 October, 2011, to be held at The Langham Hotel, Southbank, Melbourne

Jonathan Serpell
Professor/Director of General Surgery, Alfred Hospital

This meeting is a biennial one for General Surgeons and follows the previous meeting held at The Sebel Hotel in 2009 which was an outstanding success.

The meeting theme is “Practical Updates for General Surgeons” and the target audience is therefore General Surgeons with a wide range of interests and SET trainees in General Surgery.

There are five sessions including Updates on Common Problems such as breast infections, common peri-anal problems, assessment of groin pain, management of incidental pancreatic lesions, and investigation of adrenal incidentalomas.

The second session on Emergency Surgery will cover necrotising fasciitis, large bowel obstruction, pelvic fractures-blending and hypotension, acute diverticulitis – when to drain, to laproscope and to observe, and severe chest trauma.

The session on Cancer Updates will include presentations on melanoma, breast cancer, carcinoids, GIST, oesophageal cancer and papillary thyroid cancer. Session four will be Improving Outcomes and Avoiding Problems and will include angiocauters and amplifier agents – when to stop and when to operate, enhanced recovery after surgery bile duct injuries – a medicogical perspective, and safety in surgery.

The final session on Interventional and Surgical Techniques includes presentations on management of the failed lap band, advanced colonoscopic intervention, advances in laparoscopic surgery, stureless thyroidectomy, complicated popic ulcers and severe parotitis including timing of ERCP, necrosectomy and cholecystectomy.

The invited speakers, Chris Pyke, Adrian Polglase, Robert Padbury, Paul Mylks, Gregor Brown, Neil Collier and the local faculty will address these common and important problems which the General Surgeon in everyday practice will wish to deal with.

The meeting has been scheduled to enable attendance at the conference followed by a long weekend in Melbourne to take in the Derby and the Melbourne Cup. The Conference Dinner on the Friday night will be held at The Carousel at Albert Park which is a superb venue in spring. The Conference Dinner is included within the registration and a small section of the Royal Philharmonic Orchestra will provide entertainment.

This General Surgery Meeting on Practical Updates should appeal to General Surgeons in all areas and in all subspecialties and we look forward to seeing you at the meeting.

Richard Hanney
DCAS course Convener

Be involved in revealing new research
The College is reaching out, welcoming medical students and junior doctors to surgery

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Richard Hanney
DCAS course Convener
The surgeon under siege

Is it just me or are all surgeons feeling battered by the winds of change?

Jessica Yin
WA Regional Chair

In the past few years we have had to contend with the dissolution of surgical departments which have been absorbed into clinical units governed by body parts (e.g. cardiothoracic, gastrointestinal), the introduction of the Four Hour Rule (coming to a state near you!), the Surgical Safety checklist, multiple new quality assurance procedures and, in my own public hospital, a new dress code that bans ties, watches and jewellery in any clinical areas. We now face the prospect of targets for bans ties, watches and jewellery in any clinical areas. We now face the prospect of targets for even hospital boards. I could go on.

Recently (and yet again) the College has faced the issue of subspecialty separation. My own subspecialty of Urology also faced this prospect many years ago and decided (wisely, I feel) to remain with the College. It would seem to me that despite all of our differences the one thing that links us all is our common goal of excellent surgical care, no matter what the field. In facing the onslaught of imposed changes, a united front surely works to the advantage of all.

As I write this monumental whinge about the constant barrage of yet another process or check whose objective is to increase safety but whose introduction inevitably increases inefficiency in the system. It is interesting to reflect that often the same checks are absorbed into the private hospital system with little or no change to efficiency.

An oft heard criticism is that the introduction of a new policy is not preceded by robust research to justify the change. This is particularly the case when infection control and its related goals. It is interesting to reflect that the process is very much a fixed feature in every hospital. What started as a small number of interested clinicians has now grown to full scaled departments with a fixed feature in every hospital. What started as a small number of interested clinicians has now grown to full scaled departments with their own toilets!

My long suffering spouse has been a revelation. My long suffering spouse is a good selection of restaurants, secure and child-friendly accommodation and a variety of outdoor sport facilities, which has been a whirlwind of Ministerial meetings, media interaction and constant advocacy.

The appointment carries an attractive remuneration package including accommodation and shared access to vehicles.

Please send expressions of interest or queries for more information to:

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FULL TIME POSITION AVAILABLE NOW

An orthopaedic surgeon is required to assist with the development and delivery of acute orthopaedic surgical services in Timor Leste. Based at the National Referral Hospital in Dili, Hospital Nacional Guterres Valsan (HNGV), this unique and rewarding role is best suited to an orthopaedic surgeon with excellent people skills, a good level of cross-cultural sensitivity, and who is keen to use his/her technical skills to improve the acute orthopaedic services in this young nation. In addition to clinical work, the position offers the opportunity to mentor surgical trainees and doctors from the district hospitals, teach surgical/orthopaedic techniques, provide equipment advice and conduct district outreach visits.

The position is open to qualified orthopaedic surgeons with an Australian, New Zealand or equivalent qualification.

Managed by the Royal Australasian College of Surgeons (RACS), the Australia Timor Leste Program of Assistance for Specialist Services (ATLASS) aims to improve the availability and quality of surgical services to the people of Timor Leste through mentoring and training of Timorese doctors and nurses and assisting with the delivery of health care services.

HNGV is responsible for the provision of a wide range of surgical and non-surgical specialist services and is the only referral hospital in the country. The RACS program currently employs 4 full-time clinicians (general surgeon, anesthetist, orthopaedic surgeon and ophthalmologist) at HNGV and co-ordinates 16 specialist surgical team visits across Timor Leste per year.

For the successful candidate, this is an exciting opportunity to experience life in Timor Leste. The capital Dili offers a good selection of restaurants, secure and child-friendly accommodation and a variety of outdoor sport facilities, making it an ideal and safe location for both individuals and families.

The appointment carries an attractive remuneration package including accommodation and shared access to vehicles.

Please send expressions of interest or queries for more information to:

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Surgical News PAGE 17 August 2011
Mr. Peter F Burke FRACS, was appointed to the Archives Committee by Sir Douglas Miller in 1979. He served on that committee for almost 20 years and was appointed Honorary Principal Curator of the College collections following the tragic death of Mr Peter Jones in 1995. His current appointments to the College include that of Specialty Editor in Surgical History for the ANZ Journal of Surgery.

Lawrence Simpson was awarded the Medal of the Order of Australia in January 2011, for services to medicine as a clinician and educator, a former thoracic surgeon and now Melbourne University administrator, Lawrence was a senior surgeon at several leading Melbourne hospitals and spent many years teaching surgery and medical history.

Simpson regards the period between 1958 and 1967, when he was Medical Director and thoracic surgeon at the Kwanghi Christian Hospital, this facility having been opened in 1959, as the most extensive and important of its kind.

In Zurich, the Ramistrasse is a magnificent boulevard in the university precinct, high above the city of Zurich. Two buildings are of immense interest to students of medical history, the University main building situated at 71 Ramistrasse, has a tower and within that tower the Institute of the History of Medicine and its library and collections are located.

Adjoining this huge building is a magnificent property at number 69: this magnificent property at number 69: this building, which had been the site of the Physics and Physiology building of the University of Zurich in the late 19th century, was extensively renovated between 1987 and 1990 and now is the Museum of the History of Medicine of the University of Zurich.

The property has a fascinating history, including the fact that no less than five Nobel Laureates taught and undertook research in this building within a time span of 40 years: among those was Albert Einstein, who obtained his first independent academic position as an Associate Professor at the University of Zurich in 1909.

The medical history collection is vast, comprising thousands of books, brochures, illustrations and other written materials, but it is fully complemented by a varied and fully displayed collection containing objects dating from the earliest times up to the present. These objects give visual and palpable evidence of the knowledge and practices in the individual phases of the development of medicine.

The visitor who tours the permanent display in the museum truly obtains an overview of the history and evolution of medicine. The museum collection offers a wide variety of dramatic displays which superimpose actual instruments/devices on a contemporary illustrated background, bringing the displays “to life”.

Not only the museum, but the library and the archives of the Institute for the History of Medicine are also open to the public.

Just 7km from Zurich is Basel, and here are two destinations well worth a visit from anyone interested in the history of medicine. Of these, the most important, fascinating and memorable is the Pharmacy Museum of Basel, which is located in the old town of Basel and is quite difficult to locate on foot.

This extraordinary building was first mentioned as a bath house in 1296 and was occupied by many illustrious families, until finally in 1924 it became the University of Basel Pharmacy Museum.

The property is also historically important, not only is the current museum totally contemporary, but it is also historical although up until the 18th century, little educational material had been acquired.

The Institute of Anatomy: there is a skeleton estimated to be the oldest anatomical preparation of a skeleton in the world, and it was made by Andreas Vesalius in Basel in 1543. Vesalius is generally considered to be the founder of modern anatomy and he collected, recorded and edited his own observations and revelations concerning his preparations. They form the basis for his great work entitled “De Humani Corporis Fabrica”, reference to this wonderful book was made in the January/February edition of Surgical News.

For the student of anatomy and what surgery is not, a visit to this museum is mandatory.

The brothers Cosmas and Damian, the patron saints of doctors and pharmacists, preside over the entire collection.

Councillor, as Honorary Principal Curator and Victorian Fellow Peter Burke FRACS of the Australian Medical Association recommended those 20 years ago. In those 20 years the medical history collection had been augmented and many new acquisitions had been made.

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Nurse collaborative arrangements

Recent legislation fundamentally alters the potential relationship of doctors with nurses and midwives

1 Background to the Amendment Act

The Amendment Act essentially arose due to Australia’s shortage of medically trained practitioners. The Health Minister, Nicola Roxon, flagged the legislation early in her term, surmising “…there needs to be an increase in the number of doctors to meet the work that does require their high level skills and expertise.” The reforms aim to permit NPs to undertake health assessments, order tests, prescribe specific drugs, and refer to specialists, akin to their role in public hospitals. The UK, Canada and the US have used NPs in this manner for years. The National Health Act (providing they are authorised to practise under it) and the Health Insurance Act 1973 (Cth) (“Health Insurance Act”) and the Health Legislation Amendment (Midwives and Nurse Practitioners) Determination 2010 (Cth) are “authorised.” The requirement for collaborative arrangements with medical practitioners is a key component of this scheme.

2.2 Collaborative Arrangements

are defined as being one of the following:

(a) a NP or midwife engaged by a medical practice or one or more specified medical practitioners;
(b) a patient referred in writing to a NP or midwife by a specified medical practitioner;
(c) a NP or midwife with a written collaborative arrangement with one or more specified medical practitioners (each of which may cover a number of patients); or
(d) a NP or midwife with a collaborative arrangement with one or more specified medical practitioners in regard to a particular patient (which must be documented along with the patient’s consent) while the details concerning the manner of care provided to the patient are agreed in advance.

Collaborative agreements and arrangements represent the greatest shift from the existing state of affairs. We refer to “collaborative partners” and “collaborative partnerships” when referring to the above relationships.

2.2.1 Collaborative Arrangements

Collaborative agreements are written agreements (contracts) between the collaborative partners. Written agreements may cover one or more patients. This may encompass all patients, the medical practitioner’s patients, the NP’s patients, or patients with epilepsy/heart conditions (for example).

2.2.2 Collaborative arrangements

A collaborative arrangement covers just one patient, and requires the NP or midwife to keep comprehensive records as to:

(a) the collaborative partners and patient;
(b) plans for the operation of the collaborative arrangement;
(c) the scope for each collaborative partner; and
(d) the sharing of records, referrals or results.

2.3 Specified Medical Practitioners

For an NP, a specified medical practitioner means all kinds of doctor. For a midwife, a specified medical practitioner means an obstetrician, a medical practitioner providing obstetric services, or a medical practitioner employed or engaged (and so authorised) by a hospital.

2.4 Prescribed and necessary services

NPs and midwives are only able to access those prescribed services (pathology and diagnostics) deemed necessary in the regulations. The services attracting Medicare payments for NPs and midwives are similarly prescribed.

3 Collaborative arrangement benefits

Consequential to the Amendment Act, it was asked (and still will) whether doctors will be swamped by NPs or midwives, each promoting services and requesting participation in a collaborative agreement or arrangement? Well, the answer was and is yes and no. It is also important to recognise collaborative arrangements can be instituted by doctors themselves, as they clearly present several benefits.

3.1 Expanded services and revenue streams

The ability for NPs and midwives to access Medicare benefits (and to direct to others to do the same) can broaden a practice’s revenue streams, without paying a full practitioner’s salary. Some financial incentives are also available for employing a practice nurse, for which guidelines are available.

3.2 Greater patient care

The overall time spent with patients can increase. The delegation of tasks provides an opportunity to increase the range of services offered. Engaging a NP or midwife to provide basic medical services allows medical practitioners the ability to take more of a management role in the treatment of their patients, by spending less time on less complex work and more on the more complex, that which requires their level of skill and expertise. The dual attention also improves the management of chronic diseases, and provides both the medical practitioners and the NP or midwife an increased capacity to adapt to change as necessary. All of which contributes to a greater sense of patient satisfaction.

3.3 Treatment access

More medical professionals usually mean greater access to medical attention. The benefit of impact of NPs in this context can be seen in the Canberra Hospitals’ walk-in clinic. The Clinic saw its 1200th patient in February 2011, equating to over 1,200 patients a month from its opening in May 2009. Staffed by 15 full-time equivalent NPs, patients with minor conditions are seen on demand, without appointments or fees.

These NPs act under the hospitals auspice, outside collaborative arrangements. Consequently they are limited in what they can offer. Collaborative care therefore offers NPs and midwives the opportunity to expand this service into private practice.

3.4 Broader maternal services for midwives

Midwives can become more involved in the management of women at each of the antenatal, birthing and postnatal stages. For obstetric specified medical practitioners and practices, the benefits include:

3.4.1 an expansion in the number and type of maternal services for patients;
3.4.2 more shared care models with midwives in the care of pregnant patients; and
3.4.3 providing continuity of care by offering the collaborative partners at a single location.

References

5. Health Insurance Act 1973 (Cth) s 6;
6. National Health Act 1953 (Cth) s 41;
8. Health Legislation Amendment (Midwives and Nurse Practitioners) Determination 2010 (Cth) Schedule 1
9. Health Insurance Act 1973 (Cth) s 53;
10. National Health Act 1953 (Cth) Schedule 1
12. Health Insurance (Midwife and Nurse Practitioner) Determination 2010 (Cth);
13. Health Insurance Regulations 1975 (Cth) reg 28;
14. National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 7;
15. Health Insurance Regulations 1975 (Cth) s 53;
16. Health Insurance (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 6;
17. Health Insurance Regulations 1975 (Cth) reg 28;
18. National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 6;
19. Health Insurance Regulations 1975 (Cth) reg 28;
20. National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 7;
21. National Health (Collaborative arrangements for nurse practitioners) Determination 2010 (Cth) s 7;
22. Health Insurance (Midwife and Nurse Practitioner) Determination 2010 (Cth) Schedule 1
23. National Health (Listing of Pharmaceutical Benefit) Instrument 2010 (Cth);
The importance of strategic direction

The healthcare marketplace is rapidly changing and each change seems to impact on the revenues and operations of both private medical practices and public hospitals.

Marianne Vonau
Chair, Professional Development

Many in private practice are being forced for maybe the first time to consider where our practice stands in the market place and what to do about its future. With the heightened competition for patients, you can no longer afford a business as usual attitude, but need to decide how to position yourself in the future in order to maintain your net income and grow your practice. Developing a strategic plan helps to begin the process of specific issues within your practice and implementing related solutions.

Those of us practising in hospitals may believe that strategic planning is a bureaucratic and vague process run out of a hospital administrator’s office. There is usually some consultation and then the development of a few lofty commitments. Surgeons may ask, “What has hospital strategic planning got to do with me?” Too often, the answer may be, “Very little.”

However, strategic planning involves some of the most important deliberations that occur in a hospital. Surgeons who are not part of the strategic planning process may find themselves isolated from the conversations and decisions that have direct and important impact on them and their patients. Remember a strategic plan is ultimately a leadership tool and a cornerstone in a hospital. Surgeons who are not part of the “Very little.”

The workshops provide an opportunity to interactively explore and reflect on relevant issues with your peers through discussion of the theoretical concepts in leadership and management.

Providing Strategic Direction, 9-11 September, Sydney
Planning and communicating direction and strategy is integral to achieving outcomes. In this workshop you can gain the skills and knowledge to produce and implement an organisational strategy. The focus is on how to establish a strategic direction through an effective planning process. You can learn how to conduct an organisational/managerial analysis, sustaining a competitive advantage and developing strategic measurement systems. To maximise your learning, professional reading material is distributed prior to the workshop.

Sustaining Your Business, 18-20 November, Brisbane
This workshop provides the foundation for developing business plans and the various approaches to implementation in order to sustain business growth and performance. The workshop is relevant to individuals who have experience in determining the effective functioning and success of a practice or as clinical managers within health systems.

It also explores financial management; from the preparation and analysis of clinical managers within health systems. You can learn how to conduct an organisational/market analysis, sustaining a competitive advantage and developing strategic measurement systems. You will gain the skills and knowledge to produce and implement an organisational strategy by focusing on how to establish a strategic direction through an effective planning process.

Building Towards Retirement
1 October, Brisbane
Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. The program covers key issues including maintaining health and well being, job opportunities after surgery, superannuation and legal advice, community involvement and building relationships and networks.

Practice Made Perfect: successful principles in practice management
3 October, Brisbane
This whole day workshop focuses on the unique challenges of running a surgical practice. Learn more about the six principles of running a surgical practice. Practice managers, practice staff and Fellows are encouraged to join these workshops for a valuable learning experience.

Writing Medico Legal reports
19 October, Brisbane
This half-day (evening) workshop uses lectures, activities and practical demonstrations to help improve your skills in preparing medical records for use in legal matters and giving evidence as a medical expert witness effectively in court. It is an opportunity to gain understanding of the legal rules covering admissibility of an expert report and how to prepare and set out an expert report to ensure compliance with court rules.

For more information, contact the Professional Development Department at +61 3 9249 1106 and PDactivities@surgeons.org

The workshops are offered by the College and are tailored to the needs of surgeons. They enable you to acquire new skills and knowledge while providing an opportunity for reflection about how you can apply them in today’s dynamic world.

2011 DATES: AUG – NOVEMBER

ACT
• 9 November, Canberra NEW Keeping Trains on Track (KTS1)

NSW
• 26-28 August, Sydney NEW Keeping Trains on Track (KTS1)
• 19 October, Sydney NEW Keeping Trains on Track (KTS1)
• 20-22 October, Sydney Surgical Teachers Course

NT
• 16 September, Darwin NEW Keeping Trains on Track (KTS1)

NZ
• 18 August, Queenstown NEW Keeping Trains on Track (KTS1)
• 1-3 September, Auckland Surgical Teachers Course

QLD
• 15 September, Brisbane NEW Keeping Trains on Track (KTS1)
• 1 October, Brisbane Surgical Teachers Course – Retirement
• 3 October, Brisbane Practice Made Perfect
• 19 October, Brisbane Writing Medico Legal Reports
• 18-20 November, Brisbane Sustaining Your Business

TAS
• 23 September, Hobart NEW Keeping Trains on Track (KTS1)

VIC
• 13 September, Melb NEW Keeping Trains on Track (KTS1)
• 21 October, Wangaratta NEW Keeping Trains on Track (KTS1)
• 12 November, Melbourne Communication Skills for Cancer Clinicians

WA
• 24 August, Perth NEW AMA Impairment Guidelines 5th Edition: OFC Cases
• 21 October, Perth AMA Impairment Guidelines 5th Edition: OFC Cases

Professional Development

Professional Development is important as it supports your life-long learning. The activities offered by the College are tailored to the needs of surgeons. They enable you to acquire new skills and knowledge while providing an opportunity for reflection about how you can apply them in today’s dynamic world.

AMA Impairment Guidelines 5th Edition: OFC Cases
26 August, Perth
The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about a patient’s return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This full day workshop provides surgeons with a forum to review their difficult cases, the problems they encountered and the steps applied to resolve the issues.

Process Communication Model (PCM)
26-28 August, Sydney
Patient care is a team effort and a functioning team is based on effective communication. PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. PCM can also help to detect stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

Providing Strategic Direction
9-11 September, Sydney
In this two and a half day workshop you can learn more about conducting an organisational/managerial analysis, sustaining a competitive advantage and developing strategic measurement systems. You will gain the skills and knowledge to produce and implement an organisational strategy by focusing on how to establish a strategic direction through an effective planning process.

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Surgery is a scientific discipline. The Memorandum of Association (1924) made it clear that the Royal Australasian College of Surgeons aimed to promote surgical research in training.

The College’s mandate to promote surgical research in training has been its primary focus and training has thrived with the attention. The RACS are known throughout the world for their excellence in training and the delivery of research in surgery. These are the two pillars on which surgery stands. The delivery of research in surgery is regarded as a necessity for there has not been the same investment or funding, the increasing sophistication of science, the struggle to identify, train and produce a competent surgical workforce.

There are some far reaching consequences if the research requirements during SET were to be lifted. This would increase the average research competency of most trainees at the ‘practitioner’ and ‘knowledgeable practitioner’ levels, there would be fewer trainees left at the ‘novice’ level, and more trainees likely would choose to reach the ‘expert’ level. In considering the need to lift the research requirements during SET, so that all trainees gain a higher level of research competency, there are three options. The first is that each specialty continues to go their separate ways in defining the research requirements, even though they are essentially trying to achieve the same thing.

The second is to develop a common approach to the research requirements that draws on the best of what has already been developed within the different specialties. The third option, with the support of the Section of Academic Surgery, is a new workshop in the Supervisors and Trainees for SET (SAT SET) series. Over 3 hours it explores how to perform effective management and possess the necessary decision-making skills; feedback and assessment and change and leadership. The American Surgical Association report adds another dimension by saying that “it is inherent in the education of a surgeon that he or she be exposed to a thorough understanding of basic science. It is especially important that the surgeon in training understands the appropriate methods of evaluating published material, clinical research and decision analysis.” Other research competencies could be added. Dreyfus and Dreyfus have defined five levels of competency related to skill acquisition and this is helpful because it promotes a continuum of research competency, rather than a dichotomy, and there is a decision to be made about the level that we expect all of our trainees to reach. If a theoretical distribution of research competency were plotted for our trainees it would likely be skewed to the ‘basic’ level (Figure 1), with most trainees at the ‘novice’ level and none at the ‘experienced practitioner’ level. It is suggested that this is a direct consequence of setting the research requirements at a low level. The curve would be shifted to the right if the research requirements during SET were to be lifted. This would increase the average research competency with most trainees at the ‘practitioner’ and ‘knowledgeable practitioner’ levels, there would be fewer trainees left at the ‘novice’ level, and more trainees likely would choose to reach the ‘expert’ level.

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Shifting the curve
promoting surgical research in training

More emphasis on surgical research in training would inspire another generation and advance our vocation

John A Windsor
Chair, Section of Academic Surgery

The quality of surgical care will suffer for want of the appropriate and timely integration of evidence based advances into surgical care and training. And probably of most importance will be blunted progress in surgical science because of a diminished surgical workforce.

The Section of Academic Surgery has taken on two challenges under the heading of ‘promoting surgical research’. There is the need to both raise the bar and raise the floor. The first challenge is the need to identify what is required for those who choose to commit to a career in academic surgery. They need more intentional, recognised and supported training pathways. A broad review of the current research requirements during SET for each of the specialties is striking for their variation. The requirements in Neurosurgery are for a year of full-time research for all trainees. In contrast, the requirements in General Surgery can be met with a poster presentation at a national meeting.

Overall, the requirements are low, are not based on defined learning objectives, nor are they embedded in a curriculum that defines appropriate training and assessment methodology. Michiangelo once said that “the greater danger for most of us lies not in setting our aim too high and falling short; but in setting our aim too low and hitting the mark.” Aiming too low has been the problem and the ‘minimalistic’ research requirements smack of nihilism, and they bode an understanding of the research competencies (knowledge, skills and attitudes) that are essential in our trainees in the world of modern surgery.

A recent article in the New England Journal of Medicine emphasised the need for scientific literacy in all graduates of medical schools, and it could also be said for surgical trainees in relation to research competencies that “we should expect a higher standard from those who wish to pursue (surgery) in an era in which genomics and informatics will play a role in diagnosis, biomedical sciences and health care. To fulfil expectations we need to foster scholastic rigor, analytical thinking, quantitative assessment and analysis of complex themes in human biology. Our goal should be to help them acquire a different, more molecularly oriented and scientifically sophisticated knowledge base.”

The American Surgical Association report adds another dimension by saying that “it is inherent in the education of a surgeon that he or she be exposed to a thorough understanding of basic science. It is especially important that the surgeon in training understands the appropriate methods of evaluating published material, clinical research and decision analysis.” Other research competencies could be added. Dreyfus and Dreyfus have defined five levels of competency related to skill acquisition and this is helpful because it promotes a continuum of research competency, rather than a dichotomy, and there is a decision to be made about the level that we expect all of our trainees to reach.

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How the Fellowship examinations are organised

There are many things to consider when organising an examination of the scale today.

Oftentimes we take things for granted – like the smooth running of the Fellowship examinations.

You, as the examination body, must be aware of all aspects of the examination, not only the examination itself but the arrangements that make it happen.

The number of candidates changes each year and affects the arrangements that must be made. The number of candidates for the Fellowship examinations has been affected by the Christchurch earthquakes, which have caused loss to much of the infrastructure in the city. Decisions on venues also have to consider whether they have the capacity to handle the increasingly large number of candidates, particularly for the Australian May examination, which tends to be the largest examination.

Determination of the location of future examinations has been affected by the Christchurch earthquakes, which have caused loss to much of the infrastructure in the city. Decisions on venues also have to consider whether they have the capacity to handle the increasingly large number of candidates, particularly for the Australian May examination, which tends to be the largest examination.

Having said that, the next examination in Adelaide in September will have 62 General Surgery candidates, which is certainly an extraordinarily high number for a single specialty in a smaller city. The current plan for venues over the next few years is outlined in Table 1.

The increase in the number of candidates for the May examination in some specialties has reached the stage where the strain it puts on resources is such that from 2012, candidates applying to sit in May will indicate a preference for venues, but places will be allocated on a first in, first served basis.

The implication of this is that occasionally, if the resources of a venue are exceeded for a specific specialty, a few candidates may have to sit in the other country (most likely in New Zealand either the week before or the week after the Australian exam). In the longer term, if the candidate numbers continue to rise, it is possible that a fourth examination may have to be held.

Table 1.

<table>
<thead>
<tr>
<th>Month</th>
<th>Australia (alternating)</th>
<th>New Zealand (alternating)</th>
<th>September</th>
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<tbody>
<tr>
<td>May</td>
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<td>Auckland</td>
<td>Adelaide</td>
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<td></td>
<td>Brisbane</td>
<td>Wellington</td>
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Table 2.

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<th>Venue</th>
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<th>Sydney</th>
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In early May 2001 in my capacity as coordinator of the College of Surgeons Annual Scientific Congress in Canberra I was sitting in a somewhat cramped little temporary office surrounded by a confusing jumble of papers and files. It was the opening day of the Congress and things were a bit hectic as they usually are at these times.

This was going to be my last Annual Scientific Congress as coordinator and yet in the back of my mind I still wanted to contribute to College affairs one way or another. My future activity was uncertain. Little did I know that in a couple of years I would be back in the job before Campbell Miles took over with all the consummate skill that he has shown over the past few years. Meanwhile matters were soon to take an unexpected turn.

People were coming in and out of the office in a bewildering stream when to my surprise my friend Brian Morgan came in accompanied by Rowan Nicks while I knew of Rowan, as everyone in the College did, as the distinguished benefactor he was. I really did not know him very well. Nor did I know of his history. Our paths had seldom crossed.

Brian and Rowan wanted some help. “Would I check a document Rowan had prepared, perhaps edit it and discuss its contents?”

I may say my first task was to decipher Rowan’s neat illegible handwriting, but on the other hand I said “yes.” How could one say “no” to Rowan? This was the beginning of a wonderful association that I have had for the past 10 years.

After the editing was over I had begun to understand something about Rowan’s scholarly ambitions. Shortly afterwards he asked me to join his committee. Armed with insight, I readily agreed. I was soon to learn it was difficult not to agree with Rowan.

The committee at that time was chaired by Anne Kelby who was soon to become our first female president. My knowledge of the committee was sparse. This was all to change with some measure of speed as Anne, because of her commitment as president elect, relinquished the chair and I was appointed in her place. I had to learn quickly that Rowan’s and my first Rowan Nicks Scholarships demanded a fair deal of dedication and in particular it was imperative that I get to know Rowan, his history and his philosophy. As the distinguished benefactor Miles Little briefed me very thoroughly on this. Miles and Rowan had worked closely together from the initiation of the Scholarships since 1987.

In 2008 Rowan was already 88 years old. He had had a long, intensely interesting and productive life and remarkably he was still deeply involved in many things, particularly in his various scholarships. He still travelled widely. Here was a man who had had a distinguished record in the field of surgery. His Royal Navy War and who had been decorated with the Order of the British Empire.

After the War he had a similarly distinguished career as a cardio-thoracic surgeon first in his native New Zealand and then in the same capacity at the Royal Prince Alfred Hospital in Sydney. Finally, after the death of his beloved wife Mary and his soon retirement from the Royal Prince Alfred Hospital, he, often with his friend Sir Edward (Weary) Dunlop, travelled the world observing, working and helping people in Africa, India and Asia. All these three aspects of his life have been wonderfully described in his autobiography The Dance of Life.

For my part in 2001, I had now entered into Rowan’s life and began to participate in his scholarship activities. It is important to realise that he had ample means inherited from his parents and now in his later years he was fulfilling his ambition to help others and encourage others to help others by means of his scholarships. His philosophy had long been to offer help to young surgeons from developing countries who have shown particular promise and who are destined to be leaders in their own countries. One of his oft repeated mantras was “to teach the teachers to teach others.”

It is appropriate at this time when Rowan has decided to dispense his legacy to describe the various scholarships he has established and which are handsomely endowed by his estate which has been bequeathed almost in equal measure to the various charitable organizations he supported. Surgeons with a subsidiary, but none the less substantial bequest to the Rowan Nicks/Russell Drysdale Fellowship Foundation of which more anon.

In 1990 Dr Godfrey Mugutu, a young general surgeon from Zimbabwe was awarded the first Rowan Nicks International Scholarship. Rowan’s friend Professor, now Emeritus Professor, Miles Little hosted Godfrey at the Westmead Hospital in Sydney in 1990. He was a most successful inaugural scholar and has gone on to be a leader and indeed Professor of Surgery in Zimbabwe.

Since Professor Mugutu’s scholarship there have been many more international scholarships coming from Africa, India and Asia. There have been many successes and they have contributed to the richness of our surgical culture in Australia and particularly in the case of the Rowan Nicks/Russell Drysdale Scholarships.

These countries have a special need for surgeons and they want to establish links with surgeons in developed countries. They do not want a brain drain but some scholarship facilities that already exist.

Retirement in writing only

After retirement from the Royal Prince Alfred Hospital and after the death of his wife Mary, Rowan not only travelled and worked abroad, but also within remote regions of Australia. He witnessed the medical needs of the indigenous community He was touched deeply.

A man not willing to accept the status quo he linked up with the late artist Sir Russell Drysdale’s estate several years ago to offer scholarships in Indigenous Health and Welfare to indigenous and even non-indigenous health workers who were working with indigenous health issues. This scheme has been highly successful. It is based in the Faculty of Medicine of Sydney University with the patronage of the Governor of New South Wales, Her Excellency Professor Marie Bashir, A.C., C.V.O., a former colleague and close friend of Rowan.

As chair of the Rowan Nicks Committee of the College, I am a member of the Rowan Nicks/Russell Drysdale Committee of the Faculty of Medicine of Sydney University. This committee has the good fortune to have Lynne Drysdale, the daughter of Sir Russell as one of its members. She and Rowan have been good friends. It is a truism to say that Rowan was a friend of everyone he encountered.

The sum of these scholarships and fellowships and the resultant annual financial output is not small call on the funds that Rowan has invested and which will be made available from his estate. He was single-mindedly determined that his scholarships and scholarship funds will be available to them and to the future.

Australia and New Zealand each have a host of world class hospitals and surgeons and the need is in the future.

Rowan Nicks and Zariaf Zakaria

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Australia and New Zealand each have a host of world class hospitals and surgeons and the need is in the future.

Rowan Nicks and Zariaf Zakaria

John Masterton

The thanksgiving service in St. James Church in Sydney was wonderfully appropriate and at its conclusion when the clergy and Rowan casket moved out into the sunshine of a beautiful winter’s day in Sydney, the traffic in the city stopped and the bells of the church rang out.

His legacy will be long remembered and generations of young surgeons from around the world will benefit.

Vale Rowan Nicks, a truly great man.

Rowan Nicks

A great life of giving so that they can give


In Memoriam

Rowan Nicks

John Masterton with Kondwani Chalulu from Malawi and Dr Anagha Zope from India, and Rowan Nicks.

Surgical News PAGE 29 August 2011
Dr Deborah Wright feels most fortunate at the research opportunities that have come her way. She said new genomic information and microRNA and the affects of various chemotherapeutic agents would have to be used to develop complex mathematical models to guide surgeons, pathologists and oncologists in designing personalised treatment plans.

"Clinicians already decide whether systemic chemotherapy is indicated based on disease stage – an aggregate of tumour, lymph node and metastasis status – and the individual patient's co-morbidities and functional status and we are mindful of adding to that knowledge built up over decades," she said.

"We are working instead to develop a multi-modality model which will combine the clinical and pathological data traditionally used to make treatment decisions with molecular tumour data – that is information about the expression pattern of large numbers of genes within the tumour – to achieve more accurate prognosis and prediction of treatment benefit for individual patients.

"Clinicians could then input details of a patient's gender, age and tumour stage along with molecular features and histological features and the computer could then spit out information about the likely responses to various treatment options."

Dr Wright, whose work is now being funded by the Health Research Council of New Zealand, said such a computerised treatment guide was still some years off with large patient data sets required.

Also as part of her research, Dr Wright conducted a national online survey of cancer clinicians to determine the uptake and influence of computerised prognostic models and existing molecular tests on the care of patients in New Zealand.

She said that while there are molecular modelling tests available in New Zealand and Australia for malignancies such as breast cancer, the research team had been keen to learn how many clinicians used them to guide their decisions.

"The survey we conducted asked for feedback from a range of clinicians including surgeons, pathologists and haematologists and we found that such tools influence the care of many patients with cancer in New Zealand," she said.

We were also very interested to learn that 90 per cent of clinicians predict that their frequency of use and impact on clinical decision-making will increase markedly over the next 10 years.

"All of this means that if we design a prognostic model that more accurately allows clinicians to target treatment to particular patients we should see increased patient survival and decreased patient morbidity," Dr Wright said.

Dr Wright is undertaking her PhD under the supervision of Mr Arndt Merrie, Colorectal Surgeon at Auckland City Hospital and Associate Professor Craig Potter of the University of Auckland.

"I had the great opportunity to undertake a science degree in Cell and Molecular Pathology at the University of Birmingham, at the same time as I was doing my medical degree, which both introduced me to research and sparked my interest in molecular biology," she said.

“When I was offered the chance to work with this amazing team as part of a wonderful research project in a world-class laboratory, I felt most fortunate.

‘Then receiving the financial and professional support of the College was very meaningful to me in that you can sometimes feel overwhelmed by the scope of the research so to know that senior, knowledgeable people believe that not only is the research of value, but that you can do it is very affirming.’

With Karen Murphy
The Milton Shield

A treasure from our past will now be on display once again.

“The Milton Shield”

Mike Hollands
Treasurer

One of the College’s more unusual treasures has not been seen for some time now. It used to hang in the foyer of the Great Hall, but when the old east wing was demolished to make way for the Skills Centre, no place could be found to exhibit it properly.

So in recent years it has been retained in storage.

The Milton Shield was given to the College in 1868 by Conrad Blakemore, whose family had owned it for almost 100 years. There are three known examples of this Shield in Australia: one is in the Powerhouse Museum in Sydney, one belongs to the National Trust, and is on display at Rippon Lea; and one belongs to the College.

The original is made of silver and damascened iron, and measures 880mm in height by 660mm in width. The scenes are modelled in low relief in a technique known as repoussé, where the forms are created by beating out the metal from behind.

Electrotype reproductions were exact replicas of metal objects. The process was invented to produce sets of pages from text made up in movable type, in order to cut down setting and printing time. But it was quickly applied to other objects, especially old coins. Once a mould had been made of an original object, it could be reproduced in alloy thousands of times.

Leonard Morel-Ladeuil (c1820-1888) was one of the foremost metalsmiths of his time. He was apprenticed to Morel, a manufacturer of bronzes, where he learned the techniques of chasing and finishing, and then to the silversmith Antoine Vechte, from whom he learned the art of repoussé.

He found favour with the emperor Napoleon III, but this aroused the jealousy of the French guilds of goldsmiths and silversmiths, who made it difficult for him to earn a living.

In 1859 however, Elkington & Co. offered him a position, and he migrated to England. At first contracted for only three years, in the end he remained with Elkingtons for 23 years, in Birmingham and then in London. After retiring from working life he returned to France and settled in Boulogne, where he died of a heart attack. He was buried with much ceremony in his home town of Clermont-Ferrand.

The firm of Elkington & Co was founded in 1840 by George Richards Elkington (1801-1866) and his cousin Henry Elkington. It grew out of an old-established silversmithing business, and its great success lay in the process of electroplating. G.R. Elkington perfected and patented the process of depositing a layer of silver over a copper base using solutions of potassium cyanide. This process had been shown to him by John Wright (1808-1844), a Birmingham surgeon whose pastime was electrical experimentation.

It quickly superseded the traditional method of plating by hand, which was practised largely in Sheffield. Elkingtons produced a large range of household silverware, which the electroplating process had made affordable to the increasingly affluent middle classes. But they also produced electrotype reproductions of significant objects of artistic merit, such as the Milton Shield.

Conrad George Howell Blakemore MB ChM DOMS FRCSEd FRACS (1899-1976) was an eminent Sydney ophthalmic surgeon. After attending The King’s School and entering the Sydney University Medical School, he enlisted on 26 July 1917, as a sapper in the Engineering Field Companies. On his return to Australia in 1919, he continued his medical degree, graduating MB ChM in 1926. In the same year he married Una Litchfield. Their son Michael, later to become an eminent theatre director in the UK, was born in 1928.

Conrad’s postgraduate work included House Surgeon at the Sydney Hospital and the Royal Westminster Ophthalmic Hospital, and Clinical Assistant at Moorfields Eye Hospital and the Edinburgh Royal Infirmary. He gained his FRACS by election on 29 September, 1930. He became Honorary Ophthalmic Surgeon at the Sydney Hospital, and was a member of the Court of Examiners. During World War II he served as Senior Consultant Ophthalmic Surgeon to the RAAF, with the rank of Group Captain.

The name of the Shield derives from the scenes on it, illustrating episodes from Paradise Lost by John Milton (1608-1674). The Shield is oval in shape, and is divided into several fields, each of which shows a different scene.

The central area is circular, and depicts the archangel Raphael telling the story of the war in Heaven to Adam and Eve in the Garden of Eden. Immediately below this is the figure of the archangel Michael trampling on the defeated Satan. At the bottom of the shield are two figures representing Sin and Death. On either side of the central circle is a kidney-shaped field, the one on the left showing the army of the rebel angels assaulting Heaven, and on the right the fall of the rebel angels. At the top of the Shield are figures of cherubim and seraphim.

The entire surface is covered in floral and animal decoration, and patterns. A cable moulding runs around the outer edge. The College’s Shield is set in a heavy timber oval frame bordered with red velvet and glazed. It has a hinged foot at the back, an indication that it was intended to stand ostentatiously on a very large and elaborate Victorian-era sideboard.

The Shield will in time be put back on display in the Museum.

With Geoff Down, College Curator

“Following the sensation it caused in Paris, where it won the artist a gold medal, the British Government bought the original for the (then) enormous sum of £2000. It is now in the Victoria & Albert Museum in London.”

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With Geoff Down, College Curator

“Following the sensation it caused in Paris, where it won the artist a gold medal, the British Government bought the original for the (then) enormous sum of £2000. It is now in the Victoria & Albert Museum in London.”
Mr Ian Carlisle FRACS  
Award of the International Medal

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he International Medal is awarded for outstanding service overseas over a sustained period.

Ian Carlisle attended Brisbane Boys’ College before studying Dentistry at the University of Queensland. During his undergraduate years (1962-1966), he was a member of the University Rowing VIII. He practised as a dentist in London before returning to Australia to study medicine at the University of Melbourne, graduating in 1973. Following internship, Ian trained first in General and then in Plastic Surgery. He gained experience overseas in Toronto and Harvard before establishing his career in Plastic and Maxillo-Facial surgery in Melbourne. He worked for over 25 years at The Alfred Hospital and Cabrini Hospital.

Mr Carlisle has been actively involved with Interplast since its inception in 1983. He was the Chairman of its Surgical Committee (1995 to 2009) and has been a member of the Board since 2000. His international involvement has been in South East Asia and particularly in Indonesia. He has made 27 visits to Indonesia since 1986, providing specialist services and promoting education and training in plastic surgery.

Ian was also involved in the re-organisation of Burns and Reconstructive services in Bali following the catastrophic bombing in 2002. Ian Carlisle continues to promote the international work of this College and he continues to represent Interplast as an active member of the International Committee.

Mr Ian Carlisle is a most worthy recipient of the College’s International medal.

Citation kindly provided by David Watters

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Trauma: Lessons from the leading edge – 2011 GSA Annual Scientific Meeting

The upcoming Annual Scientific Meeting for the General Surgeons has so much to offer.

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The Scientific Program comprises a number of educational sessions with a highly practical focus, specifically targeted at the General Surgeon and Trainee. Contributing to the success of the program are nationally and internationally recognised guest speakers who are all leading specialists in trauma, including keynote speakers Dr Chui Ming Tiek, a pioneer of Trauma Surgery in Singapore; and Dr Chris Giannou from Greece, war surgeon and former Head Surgeon for the International Committee of the Red Cross.

Incorporated again into this year’s program is the well-received Trainees’ Day taking place on Friday, 16 September, with the theme of Trauma Surgery. Dr Damian McMahon, Director of the Shock and Trauma Service at the Canberra Hospital, has put together an innovative and up-to-the-minute program comprising case presentations and informative lectures. Prior to this will be the Trainees’ Dinner, held on Thursday, 15 September, at one of Darwin’s award winning restaurants – Char. Dinner, held on Thursday, 15 September, at one of Darwin’s award winning restaurants – Char.

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So why not bring your family along to experience the best that Darwin has to offer? Please visit www.gsa.asn.au for more information. 

For further information, email gsa.australia@surgeons.org or go to the web http://www.generalsurgeonsaustralia.com.au or call +61 3 5248 1199.
Surgical News PAGE 36 Vol. 12 No. 7, 2011

Victorian Audit of Surgical Mortality – 2010 Annual Report Release


Operative profile

In a small percentage of patients (12.9 per cent, 145 patients) no operative intervention occurred. This was an active decision not to proceed and usually occurred in patients admitted as an emergency for an irreversible clinical problem. A total of 1,453 separate episodes of surgery occurred in 901 patients. The most frequent operative procedures described were for trauma or acute abdominal pathology. This reflects the high percentage of patients admitted as emergencies in this series. A consultant performed the surgery in 54 per cent of instances and made the decision to proceed to surgery in 68 per cent.

There was an unplanned return to the operating room in 132 (14.7 per cent) of the 901 patients. Unexpectedly the rate of unplanned return to the operating room was significantly higher in patients admitted electively. This has occurred despite a higher percentage of elective cases being operated on by a consultant surgeon. There is no obvious explanation for this trend. This will be monitored over time.

Unplanned return to the operating room is often, but not always, necessitated by a complication of the initial procedure and is associated with increased risk of death. Consultant involvement in such cases is highly desirable. Direct consultant involvement in such cases has risen from around 30 per cent in 2007/08 to 80 per cent in 2009/10. This recognition of the need for direct consultant involvement is to be commended.

Inter-hospital transfers

Twenty-two per cent of cases required inter-hospital transfer. Issues of patient care related to transfer were common in a third of these cases. The most common criticism was that transfer occurred inappropriately late in the course of the patient’s illness.

Peer-review outcomes

Assessors involved in the audit process review and appraise the appropriateness of the clinical care provided to each case reported to VASM.

Second-line assessments (SLA): The frequency of need for SLA could be seen as an indirect measure of quality of care. Second-line assessments are requested for cases in which the clinical care needs to be looked at more closely or the treating surgeon did not provide sufficient information to reach a conclusion. Such assessments were required in 14.5 per cent of audited cases. This rate is similar to other states. Importantly the rate has decreased from 16 per cent in 2007/08 to 6.6 per cent in 2009/10.

It is disappointing that SLA was most commonly required because the clinical information provided by the treating surgeon was inadequate.

The need for SLA was similar among surgical specialties, and metropolitan and rural hospitals.

Clinical management issues: Assessors use a standard spectrum of criticism to convey their perceptions of appropriateness of care. These are described in detail in section 2.13 of the annual report.

In 88 per cent of audited deaths, no, or only minor, issues of patient care, were perceived. However, in 12 per cent of cases more major issues of care were identified (areas of concern and adverse events).

Over the audit period (2007 to 2010) there has been a significant decrease in the frequency with which assessors are identifying clinical management issues. The incidence of more major criticisms of clinical care is similar among the surgical specialties. It is of some interest that in cases in which there was no operative procedure there was a significantly higher rate of areas of concern or adverse events. The available data does not tell us the reason.

It is important to remember that criticism of clinical care is not always attributable to the surgical team. A third of the issues identified were attributed to other specialty areas.

Perceived impact of identified issues on clinical outcome: There was a perception that the clinical management might have been better in 399 of the 1,113 audited deaths (35 per cent). In only 47 of these 395 patients (4 per cent of audited series) the clinical management was deemed likely to have contributed to the adverse outcome. The perceived relationship of clinical management to outcome was less clear in the remaining cases.

Frequency of specific issues of clinical management: The most common clinical issue among the 496 specific issues identified was delay in delivery of definitive care. This occurred at multiple levels in the care pathway. The underlying problem is usually delay in establishing the true diagnosis leading to late referral and delay in implementing definitive treatment. A similar pattern has been reported by the Western Australian Audit of Surgical Mortality (WASAAM) and the South Australian Audit of Peri-operative Mortality (SAAPM). The recent Case Note Review Booklet published by VASM features clinical cases that exemplify this problem. Patients with the clinical risk profile demonstrated in this audited series tolerate delay in treatment very poorly.

Demographic and risk profile

Review of the demographic and risk profiles confirms the majority of surgical deaths have occurred in elderly patients with underlying health problems, admitted as an emergency with an acute life-threatening condition often requiring surgery. The actual cause of death was often linked to their pre-existing health problems, admitted as an emergency with an acute life-threatening condition often requiring surgery. The actual cause of death was often linked to their pre-existing health problems. The number of deaths attributed to surgery is therefore a very small percentage.

Risk management

Risk management strategies for this generally elderly, sicker group of patients are especially important. The audit looks at three parameters: Venous Thromboembolism (VTE) prophylaxis, use of critical care facilities and fluid balance management. VTE prophylaxis: Prophylaxis was provided in over two-thirds of audited deaths. A conscious decision to withhold prophylaxis due to clinical contraindication was the reason given for non-provision. Inappropriate omission of prophylaxis was rare, only occurring in 17 per cent of cases.

Use of critical care facilities: Close to half the patients in this audited series received critical care support during the course of their hospital stay. Assessors felt critical care support might have benefited a higher percentage of patients. The reasons why support was not provided are a recent addition to the clinical management issues section 2.11 of the annual report. The full report is available on www.surgeons.org/VASM.

In Memoriam

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

>Allan Campbell, SA General surgeon
>Donald Todd, QLD General surgeon
>Hugh Dudley, UK General surgeon
>Peter Barnes, WA Otolaryngologist

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.go to the Fellows page and click on In Memoriam.

The full report is available on the College website at http://www.surgeons.org/VASM.
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Marianne Vonau
Chair, Professional Development Committee

The following quotes are what surgeons have said after attending a Process Communication Model course.

“I just wanted you to know that I have already received very positive feedback from one of the nurses at work about my being a lot more effective in my interactions with patients. I am not at all conscious of this change, but apparently it is very noticeable.”

“I keep on thinking about the seminar a lot, if not most of the time. I am confident that what I learnt will impact positively on patient safety and team building, although it’s early days. What I can tell for sure is that I feel empowered and happy to a degree way beyond my expectations. Million thank you!”

“PCM has opened my eyes to this mysterious line of communication signals, giving me power beyond belief. It’s like I have learnt a new language and can now talk to people so they understand!”

“We are already seeing improvements in our operating theatres with this method. This year we have experienced our best gestation rates in 20 years.”

“In 1971, Dr Tahl Kahler observed a process by which people interacted with one another in a ‘cult of patient safety’ by applying the concepts of PCM. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful. These needs are different for each of the six different personality types, each person represents a combination of these types, but usually one is dominant. If these needs are met positively, individuals are happier, healthier and more productive. If the needs are not met positively, individuals exhibit signs of distress and do things consciously or subconsciously to get their needs met negatively. In summary, PCM:

• Provides the tools to help identify personality types
• Assesses character strengths
• Reflects preferred management styles and choice of best communication channels
• Identifies an individual’s psychological and motivational needs
• Predicts potential management/interaction success or failure patterns under stress
• Provides intervention points for failure patterns
• Offers ways of reinforcing positive, productive behaviours
• Provides the tools to make interaction between individuals more effective

The College piloted and evaluated the PCM course in 2010 with 24 participants. 15 Fellows and nine Trainees. The aim of the evaluation was to assess the potential impact, value and utility of PCM as a training curriculum for surgeons. Participants were asked to complete the same survey on three occasions: at the start and end of the course and again 3-4 weeks post completion of the course.

The participant responses were collated and analysed by Next Element LLC, a US-based company specialising in evidence-based skills development. The results of the post course outcomes confirm the positive impact that PCM training had in the short term:

• The pre-course self-assessment of participant social-emotional skills (self-efﬁcacy, openness, resilience, persistence) showed, in comparison with reference data:
  (i) Values at the lower end of a normal distribution in the areas of ‘home’ and ‘in private practice’.
  (ii) Signiﬁcantly low values in the area of ‘Working with admin staff in public height’.

• The magnitude of change (‘effect sizes’) achieved across all areas by the PCM training was seen by Next Element, in comparison with reference data, as ‘dramatic’ and beyond expectations.

• The most signiﬁcant change was in the surgeons’ assessment of their ability to more effectively deal with admins and management reps of their hospital in the future.

• The ratings for the item ‘My ability to help manage complaints, lawsuits, mistakes and other unintended outcomes’ went up slightly between the immediate post evaluation and the follow-up evaluation a few weeks later.

I have been so impressed with the evaluation results that I am attending a PCM workshop. See you there!”

For more information, contact the Professional Development Department at +61 3 9249 1106 and PDactivities@surgeons.org or visit www.surgeons.org
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