Hearing the next generation

Important initiative from the Foundation of Surgery p22
If you’re a doctor in training interested in a research placement, would $25,000 or $50,000 help?

Avant is delighted to announce the launch of the Avant Doctor in Training Research Scholarships Program.

Each year we will award two full-time scholarships to the value of $50,000 each and four part-time scholarships of $25,000 each.

Let us help turn your dream of that elusive research placement into a reality.

As a recipient of grants in the past, I would encourage you to put as much detail as possible into the application, it’s worth the time and effort to get it right.

Dr Gareth Crouch
Cardiothoracic Registrar (SA)
Member, Avant’s Doctor in Training Advisory Council

Applications open at 9am on 13 February 2012 and must be received by 5pm on 31 May 2012.

For more information or to download the application form, please visit www.avant.org.au/scholarship

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President’s Perspective

Anticipation
An exciting few years are ahead of us

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

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

The ASC in 2013 is in Auckland and already arrangements are well in hand for a fantastic event there. By dint of circumstance, the ASC in 2014 is now being planned as a parallel meeting with the College of Anaesthetists. It will be held in Singapore. Martin Richardson, an orthopaedic surgeon from Melbourne will be the coordinator. Although RACS was aiming to be in Melbourne and ANZCA in Sydney, circumstances beyond our control have colluded to enable parallel meetings – the first since 2000.

One to keep free in the diaries! The ASC is the premier surgeon meeting, there is a very broad program in both the plenaries and the scientific sessions that appeals to all specialties and the many outside clinicians and researchers. Nevertheless, our perspective needs to be heard in the corridors of power, be they at jurisdictional level or through the workplace.

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

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

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

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

Also an increasing number of multi-disciplinary groups now involved with the meeting, there is a very broad program in both the plenaries and the scientific sessions that appeals to all specialties within the broader ‘surgical church’.

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

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

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

In the Council strategic planning weekend, held just before Easter, two clear messages were apparent. The first was to emphasise the role of advocacy in College activities. We need to explore every opportunity to promote surgery and surgeons. The politics of health is very complex with no ready solution that will be acceptable to all stake-holders.

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

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

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

Mike Hollands
President

The 2014 ASC will now be in Singapore.

To obtain a registration form, contact Sonia Gagliardi on (61 2) 9828 3928 or email: sonia.gagliardi@sswahs.nsw.gov.au

DSTC is recommended by the Royal Australasian College of Surgeons for all consultant surgeons and final year trainees.

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) bring you courses for 2012.

2012 COURSES:
Sydney (Military Module): 24 July
Sydney: 25-26 July
Auckland: 30-31 July + 1 August
Perth: 24-25 October
Melbourne: 30 Nov, + 1 December

The DSTC course is an invigorating and exciting opportunity to focus on:
• Surgical decision-making in complex scenarios
• Operative technique in critically ill trauma patients
• Hands on practical experience with experienced instructors (both national and international)
• Insight into difficult trauma situations with learned techniques of haemorrhage control and the ability to handle major thoracic, cardiac and abdominal injuries

The DSTC course is recommended by the Royal Australasian College of Surgeons for all consultant surgeons who participate in care of the injured and final year trainees. It is considered essential for surgeons involved in the management of major trauma and those working in remote, regional and rural areas.

This educational activity has been approved by the College’s CPD programme. Fellows who participate can claim one point per hour (maximum 18 points) in Category 4: Maintenance of Clinical Knowledge and Skills towards the 2012 CPD totals.

The Definitive Perioperative Nursing Trauma Care Course (DPTNC) is held in conjunction with many DSTC courses. It is aimed at registered nurses with experience in perioperative nursing and allows them to develop their skills in a similar setting.

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.

DSTC is recommended by the Royal Australasian College of Surgeons for all Consultant Surgeons and final year trainees.

Please register early to ensure a place!

To obtain a registration form, contact Sonia Gagliardi on (61 2) 9828 3928 or email: sonia.gagliardi@sswahs.nsw.gov.au

2012 Definitive Surgical Trauma Care (DSTC) and Definitive Perioperative Trauma Nursing Care Courses
At the last meeting of Council I was honoured to be elected Vice President. I am aware that I assume the responsibility of this position at a time of significant change, both within the College and externally. Working parties are reviewing both the College’s governance arrangements and the way in which our education programs are delivered. It is too soon to say with any certainty what models will emerge from these processes, but they will be different from those currently in place.

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

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

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

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

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

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

Guiding principles

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

> Patient welfare remains paramount.
> There needs to be greater clinician input into the formulation of health policy and into the management of our hospitals.
> Decreasing the size of and streamlining health and hospital bureaucracy should be a major efficiency drive.
> Existing resources can be spent more effectively.
> Government initiated changes should not compromise patient care.

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

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

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

The next few years will undoubtedly be challenging. But, unlike governments which seem not to see past the next election, our advocacy will be aimed at improving the delivery of surgical care in the decades ahead. I look forward to working with you.
The severe shortage of specialists in Western Australia (WA) will only get worse in the coming years, and has been likened to ‘global warming’.

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

West Australian, 11 April.

Obesity getting bigger

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

Adelaide Advertiser, 12 April.

Skin in demand

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

The Age, 9 April.

Appendectomies on the way out

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

Canberra Times, 7 April.

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The Age, 9 April.
Do you need to be registered?

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

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

The MBA has opted not to change the definition of practice and released a statement to guide those uncertain as to whether they need to be registered. For the information of Fellows, those parts of the MBA’s statement pertaining to registration are reproduced below. Fellows who remain uncertain as to the need for registration are advised to visit www.medicalboard.gov.au to contact Us to lodge an online enquiry form or to call 1300 49 495 (within Australia) or +61 3 8708 9001 (overseas callers).

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

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

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

A person in that role to comply with the Board’s registration standards for professional indemnity insurance, continuing professional development and recency of practice and/or

1. they are required to be registered under any law to undertake any specific activity.

Roles for which current practising registration may not be necessary

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

1. An examiner or assessor of medical students or medical graduates, when the student or graduate is not treating patients as part of the assessment, provided that the organisation on whose behalf they are acting believes that current practising registration is not necessary for the scope of activity.

2. A tutor or teacher working in settings that involves simulated patients or settings in which there are no patients present, provided that the organisation on whose behalf they are acting believes that current practising registration is not necessary for the scope of activity.

3. A researcher whose work does not include any human subjects and whose research facility does not require them to be registered.

4. A person who speaks publicly about a health or medical related topic and who will not be giving any individual patient advice.

5. A person serving on a board or committee or accreditation body when their appointment is not dependent on their status as a “registered medical practitioner”.

6. A person who may be using skills and knowledge gained from an approved qualification, but is not using a protected title, nor claiming or holding themselves out to be registered, such as a person in an advisory or policy role.

7. A medical practitioner who is registered overseas and is visiting for any role not involved in providing treatment or opinion about the physical or mental health of any individuals.

8. A person who is directing or supervising or advising other health practitioners about the health care of an individual(s) and/or

9. their employer and/or their employer’s professional indemnity insurer requires a person in that role to be registered and/or

10. their employer and/or their employer’s professional indemnity insurer requires a person in that role to be registered and/or

11. professional peers and the community would expect their employer and/or their employer’s professional indemnity insurer requires a person in that role to be registered and/or

12. professional peers and the community would expect

Information for Fellows

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I had missed my own convocation, but still not enough. The breadth of cultural backgrounds was impressive and this was matched by the efforts of the Chair of the Court of Examiners in ensuring all the names were pronounced correctly. That was not an easy task, but one so important to do well. I looked at the words of the pledge again, “I will be respectful of my colleagues, and readily offer them my assistance and support.” Yes, the diversity of surgeons is really important to support.

“Poison’d Chalice”

Mindy you Shakespeare was not the source of great reassurance – most of the pledges he referred to were drunken toasts over ‘Rhenish’ wine. The Code of the Pirate Brethren also flashed into my mind with Captain Barbossa stating the code is more what ye’d call “guidelines” than actual rules. Geoffrey Rush is so good at Barbossa, but also Shakespeare. The new Fellows were now convocating. It was an impressive sight. There were certainly more female surgeons than in my day, but still not enough. The breadth of cultural backgrounds was impressive and this was matched by the efforts of the Chair of the Court of Examiners in ensuring all the names were pronounced correctly. That was not an easy task, but one so important to do well. I looked at the words of the pledge again, “I will be respectful of my colleagues, and readily offer them my assistance and support.” Yes, the diversity of surgeons is really important to support.

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

-extract from RACS Pledge.

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

And there we were, all assembled. The Council, the newest Fellows and the older Fellows. We rose and recited the pledge together. I realised that I was feeling something that I had not felt in a long while. It seemed as if the constant “Brownian” activity of my world had paused. It seemed as if the ghosts of the great surgeons who had gone before were peering down upon us, listening to us affirming our commitment to ideals. The Pledge ended with the words, “I accept the responsibility and challenge of being a surgeon.” I looked at the new Fellows. They were smiling, content that they had achieved recognition, a place within the profession. Like myself, the older surgeons looked like they had just reaffirmed their pride in the profession that they belonged to.

As my mind drifted, it began to dawn upon me that there is a place and a role in society for ceremony and tradition. But maybe there is more to it than that. Maybe it is the way to start ‘the revolution’ I spoke so passionately for in my last reminiscences. A pledge based revolution. A realisation that the best place for my loyalty, my efforts was not hospitals or institutions, but to the ideals that form the basis of my profession. I thought of my current Trainer. Would she understand the pledge? A bit too much of Generation Me, I thought. Perhaps I was being unfair. I will need to challenge him and see what I can ‘open up’.

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

Professor U.R. Kidding

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A new gown will make things easier for future presidents.

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

In temperatures of more than 30 degrees and at a time of year when the country regularly suffers 90 per cent humidity, Mr Civil was required by protocol to don the heavy woolen travelling gown over his suit when acting in his official capacity. It was, said Denise, unbearably hot and heavy so she decided to do something about it.

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

Now, after four months of effort, the new robe is complete and has already been given to the College. Made of black silk with gold ribbons and embroidery, it is elegant, light and, of equal importance, represents the College symbolically.

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The new robe designed by Denise is elegant, light and, of equal importance, represents the College symbolically.

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Doctor health

Mr N-destruct-able

Cutting through the hard issues

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

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

Don’t have a GP? Maybe you’ve never been seriously unwell? If you’ve got kids and dependants you’re likely to have applied for life insurance. That’s if your blood pressure is near normal, you don’t do postoperative rounds. Complications ensued, caused almost entirely by a failure to rest and recover like any of N-destruct-able’s own patients would have been advised and Mr Snip’s patients were advised.

The old surgical adage, “sutured wounds do not travel well,” was ignored or forgotten. For the next few days N-destruct-able persisted in operating, supervisors were advised, N-destruct-able rested, slowly recovered and was advised to obtain a regular GP. Those of you who have already learnt that you are as mortal as your patients have probably already got a GP. My advice to those who don’t is: don’t choose your best friend; and don’t choose your wife, husband, father, mother, daughter or son.

Your GP should be someone you respect, and even be a little afraid of. My blood pressure always rises when I know you are as mortal as your patients.

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Your GP should be someone you respect, and even be a little afraid of. My blood pressure always rises when I know you are as mortal as your patients.
As a boy growing up on a farm along the beautiful Bass River in Gippsland, the late plastic surgeon William Wilson felt a great love of country spreading from the farm itself, to the nearby river system and out to Western Port Bay.

Along the way, he also developed an affinity and fascination with the man who mapped that corner of the world and who left echoes of his presence from the farm itself to the nearby river system and out to the nearby river system and out to the nearby river system.

The late Fellow William Wilson had a passion for the George Bass story and his compass. Dr Wilson-Anastasios described the artefact as her father’s pride and joy.

"Dad cherished the sundial and compass, but in his will he made no mention of it or where he wanted it to go," she said. "Yet, although the sundial could be adjusted for latitude differences, the compass was actually weighted incorrectly for use in the southern hemisphere." George Bass, naval surgeon, arrived in New South Wales in 1795 at the age of 24 on the same ship that carried Matthew Flinders.

Within five years, Bass and Flinders had explored the coast south of Sydney and circumnavigated Tasmania. Flinders named Bass Strait in honour of his friend’s heroic whaleboat voyage. Dr Wilson-Anastasios said it had been that courage and adventurous spirit that was always the great appeal of George Bass to her father. "I think it was the combination of them both being surgeons and both sharing a hunger for adventure that was at the heart of Dad’s affinity with Bass," she said. “Dad was quite a trail-blazer himself in plastic and reconstructive surgery, with a particular interest in hand surgery, and trained under John Hueston who was the pre-eminent plastic surgeon in Melbourne in the 1970s. “Therefore it always made sense to us that he would have such an interest in a fellow explorer surgeon.” Dr Wilson-Anastasios said that even though Mr Wilson had security concerns regarding the safety of the precious object over the years, he could never let it out of his possession for long. However, she feels sure he would be happy with the family decision. "Dad treasured the object so much that even though he loved sharing it with people, he could never quite bring himself to part with it," she said. "But I think he’d be thrilled to see it on display at Melbourne Museum now – in a cabinet with his name forever associated with the name of George Bass."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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With Karen Murphy

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

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

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

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

Prostate cancer is the second most common cause of cancer death in Australian men with almost 12000 new diagnoses and almost 3000 deaths per year.

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

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

“The unique approach we have taken is to look simultaneously at different levels of biology,” Dr Hong said.

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

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

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

Dr Hong has won considerable support from the RACS for his work, receiving both the Foundation for Surgery ANZ Journal of Surgery Scholarship for 2010 and the Foundation for Surgery Catherine Marie Enright Scholarship for 2011. He has presented his work at conferences in Melbourne, the Gold Coast, Perth, and New Zealand and last year gave a presentation on his research at the European Association of Urology Annual Congress in Austria.

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

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

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

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

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

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

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

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

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

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

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

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

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

With Karen Murphy

Convenor

Factory Visit Program

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

Qantas, Sydney

On Friday, 6 July 2012, we have arranged a whole day visit to Qantas Engineering, Catering and possibly Baggage Handling. This follows a memorable site visit to the Heavy Engineering section of Qantas in Melbourne. At the start of each half day there will be a brief introduction to the workplace, as on previous factory tours. This will be followed by workers discussing their injuries and return-to-work programs. This is followed by an approximately two hour tour of the site during which we see what the workers do, where injuries have occurred and a selection of suitable duties for return-to-work which is facilitated by an approximately two hour tour of the site during which we see what the workers do, where injuries have occurred and a selection of suitable duties for return-to-work. We conclude with the opportunity to further discuss injuries and return-to-work with workers and management. Finally there are group discussions and you have an opportunity to individually reflect on the visit and evaluate the program.

Godfrey Hirst and Ford Motors Carpets, Geelong

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

Advocacy remains core College business

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

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

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

Among the former are the FRACS logo which was formally launched at the Annual Scientific Congress in Adelaide last year and which Fellows can access via the College website. At a time when just about anyone with a medical degree (and a number of podiatrists without one) can call themselves a “surgeon”, the FRACS post nominal stands for clinical excellence and which will be brought to fruition by Professor Michael Grigg who has succeeded me as VP.

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

GAC is following this up with position papers on medical tourism and bowel cancer screening. The former includes development of a checklist for patients considering travelling abroad for surgery.

It raises crucial considerations such as the surgical expertise and the quality of facilities available in a given country, responsibility for post-operative care, and the extent of one’s insurance coverage. It is hoped that this brochure will be made available through government channels to prospective medical tourists.

The position paper on bowel cancer screening advocates strongly for two yearly testing of those aged 50 years and over, something governments in both Australia and New Zealand have been very reluctant to fund. Work on both position papers is nearing completion and has seen GAC consult with relevant specialty societies to ensure their accuracy and persuasiveness.

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

It found that while the current surgeon per population ratio is adequately and safely servicing the Australian population, this population is expected to increase and its average age to rise, resulting in an increasing workload for surgeons. This will be exacerbated by the fact that a large number of surgeons are themselves approaching the age of retirement.

A similar report on the future of the New Zealand surgical workforce through to 2025 is nearing completion.

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

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

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

The team is currently preparing a report that will be provided to the Northern Territory government.

The attempt by cosmetic “surgeons” in Australia to gain recognition as a specialty is another ongoing issue, with the Australian Medical Council still to reach a decision. The College continues to argue that such a specialty would be spurious as Fellows practising as Plastic and Reconstructive specialist surgeons already do all of the work which the cosmetic “surgeons” pretend is theirs alone.

The difference of course is that Plastic Surgeons do so much more as well, repairing lives and enhancing the quality of life of those severely burned, disfigured or injured.

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

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

The Rain

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

I t has been a quiet, sweltering and still afternoon. Humid, hot and overpoweringly oppressive. Sweat beads across my brow and my shirt, soaked, clings to my body. Slick. The thick grass pouts over my feet as I tread through the verdant front paddock. I had mown the lawn just four days ago, but already it has grown long and unkempt. Lush tussocks with long blades of grass envelope my boots. I’ll have to buy more fuel for the mower.

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

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

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

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

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

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

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

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

Bless.

Keith Mutimer

Dr Ina Tinning

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Turning up the volume for Indigenous health

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

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

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

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

Otitis Media treatment

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

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

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

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

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

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

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

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

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

Chanel Thornton, Foundation for Surgery Board member

The College will soon launch new professional development activities relating to the healthcare of Indigenous patients. An online portal to link to activities will soon be available as well as eLearning modules.
Sexual boundaries: Guidelines for Doctors

Be clear on where the line is drawn

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

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

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

The Guidelines affect the liability and obligations of practitioners in two ways. The first is that the National Law provides that

any guidelines released by the Board are admissible in disciplinary proceedings as to what constitutes appropriate professional conduct. The Guidelines provide standards for what constitutes “sexual misconduct”. These standards would be relevant in disciplinary proceedings where a practitioner is alleged to have engaged in ‘unprofessional conduct’ or ‘professional misconduct’ of a sexual nature.

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

What is “sexual misconduct”?

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

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

2. Sexual activity
   This includes sexual activity with a patient currently or formerly under a practitioner’s care or a person closely related to a patient. The fact that such activity is consensual or was initiated by the patient is irrelevant. Sexual activity with a former patient may be sexual misconduct depending on the circumstances, including:
   - The duration of care provided by the practitioner;
   - Whether emotional or psychological treatment was provided;
   - The level of vulnerability of the patient and degree of dependence on the practitioner;
   - The time elapsed since, and the manner in which, the professional relationship was terminated; and
   - The context in which the sexual relationship was established.

3. Sexual harassment or sexualised behaviour
   Sexual harassment or “sexualised behaviour” are quite broadly stated in the Guidelines as including the use of “any words or actions that might reasonably be interpreted as being designed to arouse or gratify sexual desire”. Examples given of specific behaviour include:
   - Making sexual remarks or gestures, touching patients in a sexual way or engaging in sexual behaviour in front of them;
   - Ridicule of a patient’s sexual preferences or orientation;
   - Making comments or requesting details about a patient’s sexual history or preferences not relevant to the clinical issue;
   - Discussing the sexual problems or fantasies of the doctor;
   - Making suggestive comments about a patient’s appearance or body;
   - Making an unsolicited demand or request for a sexual favour, whether directly or by implication; and
   - Inappropriate conduct during examination such as unnecessary disturbing, inadequate draping and intimate examinations without adequate prior explanation.

Why are breaches of sexual boundaries harmful and unethical?

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

What are the warning signs of potential breaches?

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

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

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

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

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

and

- If the practitioner provides the chaperone, ensuring the chaperone is appropriately qualified or trained and of a gender approved of by the patient, parent, carer or guardian.

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

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

\textbf{NOTSS focuses on four categories of non-technical skills:}\n\begin{itemize}
\item Decision making
\item Communication and teamwork
\item Leadership
\end{itemize}

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

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

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

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

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

\textbf{2011 Pilot Courses}\n
In December, 2011, three College representatives went to Edinburgh to participate in a two-day NOTSS Masterclass. The first Australian two-day Masterclass to train a NOTSS faculty was held in Melbourne at the beginning of April, 2012, with 39 participants. We were very fortunate to have one of the Edinburgh faculty, Prof. George Youngson as a presenter. The other faculty members included Bruce Barradough, David Birks and Brendan Flanagan. Three successful one-day courses were piloted in 2011 in Bendigo, Perth and Melbourne with 39 participants including Fellows, Trainees, IMGs and anaesthetists.

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

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

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

- "Outstanding course which should be mandatory for all the surgeons."
- “Very good for raising awareness. I am motivated to pass my knowledge on.”
- "Excellent course, I thoroughly enjoyed it...relevant and will lead to improvements in my clinical practice."

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

Another train-the-trainer workshop will be organised for 2012. If you are interested in finding out more about NOTSS, please visit www.surgeons.org email pdactivities@surgeons.org or call +61 3 9249 1036.

Francis Lannigan
Chair, NOTSS Working Party

\textbf{Supervisors and Trainees for SET (SAT SET) Course}\n
29 May, Brisbane; 14 June, Perth

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

\textbf{Management of Acute Neurotrauma}\n
2 June, Brisbane; 18 August, Townsville, 31 October, Adelaide

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

Keeping Trainees on Track (KToT)\n
5 June, Adelaide

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

\textbf{Strategy and Risk for Surgeons NEW}\n
8 June, Brisbane

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

Contact the Professional Development Department on +61 3 9249 1106, by email PDActivities@surgeons.org or visit www.surgeons.org.
- Select Fellows then click on Professional Development.
Surgical supervisors discuss the progress and performance of their Trainees on a regular basis. The information shared, and the language used to describe it, is rarely written down, and certainly no agreed framework exists. Despite this, surgeons do know how to communicate roughly what stage a Trainee has reached. Such conversations are usually lacking in an agreed framework for assessment of progress, or in agreed descriptors that have clear meaning and are highly relevant to where a Trainee is at.

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

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

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

In 2011, a working party of senior Fellows and College staff was established to develop a structure and sequence of standards. The standards were based on the agreed nine RACS competencies each with three patterns of behaviour that have been defined in the RACS Guide to Surgical Competence and Performance http://www.surgeons.org/media/348281/pos_2011-06_23_surgical_competence_and_performance_guide__2nd_edition_.pdf. A major aim was for the descriptors of competency acquisition to maintain alignment with how the College recommends the performance of practicing surgeons should be assessed.

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

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

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

- Competent – Defined scope of practice – Recognise own limitations.
- Recognise conditions for which surgery may be necessary; 
- Defined scope of practice – Recognise own limitations.
- Adapts their skills in the context of each patient – each procedure and recognises the need for new skills.
- Can safely and effectively carry out significant parts of more complex procedures under close supervision.
- Can anticipate and effectively deal with potential complications in the most common procedures.
- Adapts their skills in the context of each patient-each procedure and continues to learn new skills.
- Can safely and effectively carry out most common procedures or individual components of major procedures with supervisor in theatre.
- Can anticipate and effectively deal with potential complications in any of the procedures they carry out.
- Consistently demonstrates sound surgical skills.
- Has a professional development plan for continuing enhancement of skills.
- Can effectively teach others to perform surgical skills and carry out procedures.
- Has appropriate processes for learning or introducing a new technique, e.g. visiting a surgical expert or mentor.

The image below illustrates the major patterns of behaviour for the three major patterns of behaviour. The behaviour markers for one example competence. The three major patterns of behaviour being:

- Demonstrates understanding of the importance of gentle handling of soft tissue and of wound care.
- Aware of how to use surgical instruments and use of local anaesthetic.
- Learns new skills quickly.
- Seeks opportunities to learn new skills.
- Can safely and effectively carry out most common procedures or individual components of major procedures with supervisor in theatre.
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The defined behavioural markers are not intended to be a comprehensive analysis of Trainees’ performance and behaviour, nor are the identified behaviours expected to be observable in every work-based situation. Rather they have been selected because they represent observable behaviours which are sufficiently important to be considered as key indicators of each Trainee’s progression towards being judged as a competent and safe practitioner.

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

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


**Technical Expertise**

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

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

In December, 1824, John Irvine Hunter, Challis Professor of Anatomy at the University of Sydney, died in London at the age of 26. Eulogised by AE Mills as ‘the University’s most gifted son,’ Hunter had been created for Hunter almost as soon as he graduated in 1920 and Miller found that: ‘His lectures were almost electrifying as he poured forth his words with such enthusiasm that he actually used to froth at the mouth. To him anatomy was an exhilarating, exciting exercise of discovery…’

When Wilson [James Thomas Wilson, first Challis Professor of Anatomy], left for Cambridge Johnnie Hunter was appointed to the chair at the age of 24. Full of energy, ideas and enthusiasm, this life of great promise was to be short.”

While a student at Sydney University, Hunter came in contact with Norman Dawson Boyle, later a Foundation Fellow.
of the College and the pair collaborated in research, which was to seal Hunter's fame and perhaps even his fate. They investigated the regeneration of nerves and muscles, muscle activity, reflex action in the spinal cord and the sympathetic innervation of muscles and muscle tone.

Royle was an unusual character, an orthopaedist who had kept himself aloof as a student by teaching physical education. He became interested in how muscles work and are controlled. Influenced by the Dutch histologist Jan Boeke, this led him to investigate how spastic paralysis could be alleviated. Initially he performed ramisection on goats, then moved on to cadavers and performed experimental surgery on patients returning from World War I. A creative researcher, he trained himself in the spinal cord and the sympathetic innervation of muscles and muscle tone.

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

Sympathetic fibres

Lecturing and demonstrating at American and Canadian clinical schools before his return to Australia, Hunter showed a particular interest in Henry Head's work on aphasia and according to Professor Ellsworth Smith, Hunter 'did a great deal in making Head's work understood. The most important collaboration between Royle and Hunter began when Hunter returned to Australia in 1922. While in London, Hunter had seen some of Professor Kulchinsky's histological samples which indicated that the sympathetic fibres to striated muscles did not go to the same muscle fibres as the medullated nerves. This combined with experimental work helped inform Royle and Hunter's hypothesis of double innervation of muscle – 'the idea that the sympathetic nervous system controls 'plastic' (postural) tone' and that spastic paralysis could be alleviated by sectioning the sympathetic nerves.

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

The theory of double innervation of muscle was refuted within a few years of Hunter's deaths, but remained an active area of research. Albert Coates, for example also made a detailed study of the sympathetic innervation of skeletal muscle tissue and his work (with OW Tiers) was published in the Australian Journal of Experimental Biology and Medical Science in 1928. Douglas Miller effectively sums up their contribution to medical science: “Though their work was discounted he and Royle had opened up great interest in the previously ignored sympathetic system and much good came of it.”

And Elliott Smith who worked closely with Hunter during his first trip to England bewails the loss of such a young and brilliant mind and provides this panegyric: “It is impossible to convey to those who have not come under the spell of his personality any adequate conception of the magnitude of the loss anatomy and in fact medical science in its widest sense have sustained in the death of John Hunter. The great name he bore would have overwhelmed a smaller man, but it is no exaggeration to claim that he has added fresh lustre to it.”

Written by Elizabeth Milford, College Archivist.
Quality and Safety of Health Care

How does NZ fare?

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

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How I came across Last

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

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

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

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

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

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

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

In London

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

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

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

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

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

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

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

Free parking

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

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

As the publishers Elsevier told me last week, the 9th edition of Last’s Anatomy – Regional and Applied is the one distributed on the Australian scene full of anatomical pearls so characteristic, whereas the 11th Edition (European) authored by Chummins S Simntambly have these all but deleted. To recapitulate a few – the last of Last, we hope not (as said by Ed Morrison):
1. Hilton’s Law – the motor branches of muscle nearby also supply the joint.
2. Flexor skin is more sensitive than extensor skin.
3. Flexor muscles are quicker acting and more precise with finer fibres which in animals are more tender to eat.
4. The mandible at birth is in two parts – so Galen was right after all.
5. The size of the breast goes from the second to the sixth rib and with age and pendulous descent, the circulation of the nipple from the intercostal perforators must go from medial to lateral and therefore any breast reconstruction should be so designed.
6. Flexor hallucis longus is defined as to lateral and therefore any breast reconstruction should be so designed.
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A Personal Perspective
Moving on to the next stage…

I write this as one of my final duties as chair of the Younger Fellows Committee. Traditionally, such an article would cover my experiences and accomplishments on the committee; however, while considering what to write, it occurred to me that despite an extra year as chairman beyond the usual 10 years, I am no longer a ‘Younger Fellow’! I have nothing left to associate with being young! I am the other side of 40 and have nothing left to associate with being years, I am no longer a Younger Fellow! I year as chairman beyond the usual 10 term, so in some way we are all almost always younger, even if not by College classification. The end of College youth is in fact a great time in surgical practice. We have 10 years of experience, and would now feel competent and confident in our chosen field of surgery, but not so arrogant that we don’t feel we still have many things to learn, both as surgeons and as people. I find now the thrill of talking to my patients not only about their illness, but about their lives. So many of them have fascinating stories to tell and it really is possible to learn something new from almost every consult. For most of us, health permitting, we have another 20-25 years in practice, enough time to reap the rewards from the profession we love, or still enough to recognise a desire for a change in direction and work towards it.

In College terminology, we have a name for younger surgeons and one for those with far more years under their belts, but no term for the group in the middle, the majority of the Fellowship. Perhaps we should be called the “comfortable fellows?” At the same time, we all see patients occasionally with terrible prognoses, more and more (as we grow older) younger than ourselves. These patients remind me how precious life is, and put our own problems in perspective. They remind me to make the most of every day we have because the truth really is that we don’t know what tomorrow will bring. We can’t stop the rain but we do help to protect you.

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

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

Steve Leibman
Chair, Younger Fellows Committee
Hearing a community

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

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

One way to alleviate this burden is to provide alternatives to traditional hospital based outpatient clinics. Moving on an outpatient service to the community can be one such viable option. Community based outreach clinics offer the additional benefit that they make health care accessible to groups marginalised from the mainstream health care system. Aboriginal and Torres Strait Islander (ATSI) people face many barriers to health care access. The need to overcome these barriers is essential in the provision of health care from an otolaryngology head and neck surgery view. The need for a separate and specialised focus on Aboriginal and Torres Strait Islander health is not universally acknowledged within mainstream health care services.

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

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

Active participation

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

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

Kelvin Kong
Chair, RACS Indigenous Health Committee

Newcastle, Lake Macquarie and Hunter Valley regions. Close to 85 per cent of Awabakal staff are Indigenous. Recently Awabakal AMS, supported by several fellows working at the Royal Newcastle Centre and John Hunter Hospital, established a specialist urban outreach clinic for Ear Nose and Throat (ENT) services, as an extension to the surgical ENT services provided by hospitals in the Hunter New England Local Health Network (HNELHN). Dr Rob Eisenberg, Associate Professor Kelvin Kong, Dr Toby Corlette and Dr Monique Parkin, participate in community based clinics across the Hunter New England region, under the guidance and clinical lead of Awabakal’s Aboriginal Ear Health Worker, Marketa Douglas (pictured).

It is well documented that Aboriginal and Torres Strait Islander people report higher rates of hearing loss than their non-Indigenous counterparts, and that Aboriginal children suffer from re-occurring middle ear infection (Otitis Media) more frequently than non-Aboriginal children. Otitis Media, if not treated adequately, can cause significant hearing loss. In children this can lead to linguistic, social and learning difficulties and behavioural problems in school, which reduce educational achievement with lifelong consequences for employment, income and social success.

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

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

Best outcomes

Imperative to the success of this model is the role of the Aboriginal Ear Health Worker and their liaison with the patient and health care providers to ensure the best outcomes for patients. As a case study, Aboriginal Ear Health Worker Marketa Douglas is a critical part of the solution and is extremely committed to the ENT needs of the local community. In 12 months of operation, the clinic has seen more than 130 patients, followed through on operative candidates (including two cochlear implants), and incorporated an audiology service to enable early detection of ear disease and hearing loss. Sustainability of the service has been achieved without burdening existing staff, resources and services. Central to the clinic’s operation is regular assessment, review and feedback to the community, and the inclusion of the community in formulating strategies for improvement.

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

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

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Kelvin Kong
Chair, RACS Indigenous Health Committee
CONGRATULATIONS on your achievements

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

Alan Kline

Presented by Martin Jones

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

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

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

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

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

It must be remembered that this young upstart had arrived in a town where there was one part-time surgeon plying his trade and stories. Many held him in good stead.

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

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

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

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

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

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

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

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

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

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

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

His contributions were recognised by the Commonwealth with the award of the Member of the Order of Australia in 2004. Graham has been an avid supporter of the Operation Open Heart Project of the Sydney Adventist Hospital. This project brings cardiac surgical services to developing nations where no such services exist. He has been on at least 20 such trips. This has led to the development of a fledgling cardiac surgical unit in Port Moresby. The PNG Government has recognised this contribution by awarding him the Order of Logothi.

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

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