Fiji School of Medicine Trainees performing during Pacific evening

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Mr Harijit Singh recounts his experiences as the 1993-1994 Rowan Nicks Scholarship recipient.

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“Instructing on the course is rewarding, providing a chance to interact with new trainees.”

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BREAST CANCER AUDIT
Surgeons are participating in an innovative auditing process for the treatment of early breast cancer.

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Informed Financial Consent

The CEO and I met recently with the Commonwealth Minister of Health in Sydney. Issues of surgical standards and workforce shortages were deflected repeatedly throughout this meeting to focus on Minister Abbott’s key concern of Informed Financial Consent. As personal experience has significantly influenced his interest in this area, there was no doubt about the earnestness and the intensity of his attention to this issue. Indeed from his perspective, it is a key measure of the professionalism of surgeons that we address the current problems.

Intuitively, he is right and we do need to embrace processes which inform patients of the cost of a surgical event.

Whilst not disputing progress that has been made in a number of working groups coordinated by organisations like the AMA, Minister Abbott regards this as a key issue for surgeons. We obviously perform the greatest diversity of procedural items where the issue of out-of-pocket costs are relevant. It was evident that the Minister was no longer going to tolerate delay on this issue based on professional relationships or doctor-patient privilege. He was adamant that he regarded the surgeon the clinical leader of the operative team and even if other members were independent practitioners, the professional responsibility was clear. In media statements he has even “flown kites” around penalties and discrimination for clinicians who do not comply. We strongly advocated that such draconian measures were inappropriate and would cause further professional abreaction and reaction.

I discussed the model which exists in my own practice. He was accepting of the fact that surgical assistants and anaesthetists do change and that anticipated procedures by necessity can evolve. This is particularly so in emergency cases where acute clinical decisions relegate financial consent to a secondary consideration. When I book a patient for surgery, my Nurse Manager provides a list of fees for the proposed operation and the likely gap. I give an assurance to the patient that for my part, this will be the extent of their out-of-pocket expenses even if further surgery becomes necessary during the episode of surgical care. In most cases, I am aware of my assistants operating costs, so this information is also documented. My rooms then provide the patient with the contact numbers of the Anaesthetist. In addition, because of the different levels of insurance cover of the hospital care, we ask the patient to check with the hospital and their fund to ascertain any further possible charges. I can not obligate my surgical team to charge prescribed fees as this would be in violation of the Trade Practices Act. However, I do believe that patients should be given the opportunity to understand what out-of-pocket expenses the insurance companies expose them to.

Recently, The Anaesthetic Society of Australia proposed the following steps to facilitate Informed Finance Consent by Anaesthetists:

1. The surgeon’s rooms providing contact details of the assigned Anaesthetists to the patient along with the suggestion that the patient contacts the Anaesthetists for detailed financial and other information.
2. The surgeon’s rooms to notify the relevant Anaesthetist or anaesthetic practice of patient details promptly once the patient is booked in for a procedure. In this way, the Anaesthetist can then forward the appropriate financial and other information to the patient prior to their admission to hospital.

I have given an undertaking to support these initiatives at a College level so would be grateful if Fellows would consider such an approach.

I should emphasise that I am not proposing that my own practice should become a College policy, but Tony Abbot as a Minister and a consumer is correct in pushing this issue on behalf of patients. To be successful, he must do this in a collaborative way.

Task Transfer, Distribution, Substitution, Delegation or Obfuscation?

The worldwide trends are now obvious. There is a shortage of doctors substantially contrived by Government policy of the late 1980s and 1990s combined with pressure for early retirement, decreased working hours, more flexibility and part-time work and far more pressure for work-life balance as well as increasing demand for health services driven by the
ageing population and increasing technological opportunities. At the same time as this shortage, subspecialisation in surgery has placed further pressure on the provision of generalist, rural and emergency services. The knowledge that is being utilised in our surgical practice is now more readily available to the public broadly and our patients specifically.

Surgeons rather than bureaucrats need to be driving the concepts based on task delegation rather than task substitution, evidence and standards of care. As a College, we have indicated that we are willing to engage in role evolution but do not support independent practice by less qualified health professionals without there being adequate supervision. Working within a team is something that surgeons have had considerable experience with but we need to hone these models to maximize the use of our surgical expertise.

The Clinical Team

The Clinical team needs to be headed by the Senior Clinician and in our case this is the surgeon. Clinical outcomes and responsibilities must be clear to all members of the team and more importantly our patients. Within this surgical team, the sharing of traditional surgical roles does not in any way undermine the surgical authority or the responsibility to our patients. For example, we already delegate work to our Trainees in a supervised environment and the US style Physician Assistant concept is a reality in private practice where Nurse Managers assume similar roles.

The experience in United Kingdom with task delegation and substitution is that names will be important. Let’s acknowledge the background of our professional team. If we utilise the skills of an assistant then we need to be pro-active in declaring this. The names not only require clarity but should make a statement about that person’s role.

What is also becoming evident from the experience in England is that training is more protracted for non-medical staff. Operative surgery is not just a question of performing a list of technical manoeuvres. It requires constant decision making and judgment. Undergraduate medical training provides skills in independent decision making and it is a substantial platform to learn quickly in the post graduate environment. This is often not stated. However if training of a medical graduate consumes additional operative time when compared to an experienced operator, then teaching to the non-medically qualified is likely to have a significantly longer learning curve.

In the debate, we will need to be very clear about task delegation to members of our team that are medically or non-medically trained. The Universities may have tragically decreased the scientific component in some medical degree courses but that degree is still the valid entry into surgical training. We need to be confident of which components of care are undertaken by which member of the team and how independently they can proceed. A highly topical example is the training that is provided to trainees who then enter General Practice. Whilst undertaking limited procedures would be appropriate, as shortages in the surgical workforce worsen, the pressure on General Practitioners to undertake open cavity procedures will increase. This may be without any of the infrastructure or support that is critical. The College will need to have well-reasoned positions for these types of concerns and their possible impact on surgical outcomes.

Satisfying the Workforce Requirements of Screening

The proposed faecal occult blood population screening programme will necessitate an increased number of colonoscopies associated with positive results. This initiative has prompted consideration of training nurses and general practitioners to do these procedures and the Conjoint Committee for Recognition of Training and Endoscope (CCRTE) has been asked to consider a role in accreditation of their training. This is at a time when we are having difficulty providing adequate access to endoscopic training as part of the requirement for training for the FRACS in General Surgery. Nurse Endoscopists already provide endoscopic services in the UK. Is there a need in Australia and New Zealand for this approach and should we collaborate in introducing similar services? Alternatively, should we concentrate on training of surgeons which is our first priority?

This is our Debate

We cannot avoid this debate. As surgeons, we are expected to be able to deal with a wide range of operations from “easy” to “complex” with skill, care and compassion.

In 2006, the skills of the trained surgeon are the result of expansive undergraduate learning and intensive postgraduate training resulting in the accumulation of knowledge, technical skills and most importantly, judgment. So even if we delegate mechanical components of our trade, we must retain the overall decision making in clinical management if the standard of patient care is to be maintained.

However, the population is increasing and ageing and in most specialties, particularly in the public system, access to surgery is compromised. We can delegate some of our tasks as many of us do in private practice already, but we must retain control with the clinical agenda in the interest of standards. To do this, we cannot afford to be dismissive and must engage in the debate. As a group, we are well qualified to take a leadership role in the direction of health care. I urge you to become involved rather than allow the often ill-informed bureaucracy to dominate the health agenda. The erosion of clinical influence has already occurred in the upper levels of power in the United Kingdom. Change is inevitable, but let’s ensure that it is balanced and driven by health outcomes.
Grace’s star shines bright

A Chatswood doctor has been awarded one of Pakistan’s highest honours for her work in reconstructive surgery for leprosy and deformity patients.

It is the third-highest award Pakistan gives to civilians for humanitarian service to their country and roughly equivalent to an Order of Australia.

On 23 March Dr Grace Warren, 77 received the Sitari-e Pakistan (Star of Pakistan) at a ceremony in Canberra as part of Pakistan’s National Day celebrations.

Dr Warren has spent most of her working life teaching, supervising and performing reconstructive surgery in developing Asian countries. She said one of the most rewarding parts of her missionary work was passing on knowledge to foreign and local doctors.

“It’s very rewarding to see the locals picking up the ball and running with it,” Dr Warren said.

She said the best way to transfer surgical skills was to teach surgery techniques over three weeks and then return three months later to help doctors refine their skills.

In the male dominated world of surgery in Australia in the 1950s Dr Warren was forced to learn reconstructive surgery from books. By the 1970s she was running training programmes in leprosy surgery in Asia.

Dr Warren is still active as a medical and surgical consultant in Australia and she now treats diabetic patients who suffer nerve damage that is similar to that experienced by leprosy sufferers.

“What I learnt to do in leprosy in Asia, I am now doing here,” Dr Warren said.

Her award recognises her ongoing work and biannual visits to Pakistan over the past 40 years.

“Now hundreds of Pakistani people can carry out a reasonably normal existence,” Dr Warren said.

“There’s such a stigma that even if someone has a deformity they think they are a beggar and outcast them.”

She said she was pleased that a Muslim country could honour a female Christian who was carrying out medical work in the name of God.
From this official beginning the Meeting proceeded through three-and-a-half days of presentations and hands-on practical demonstrations to its informal beach picnic closure four days later. Even the rain and the humidity that are the norm for Suva in March could not dampen the Meeting’s positive atmosphere.

The New Zealand Agency for International Development (NZAID) and its parent body, New Zealand’s Ministry of Foreign Affairs and Trade have sponsored the last five of these biennial meetings. New Zealand surgeons, and more latterly a number of Australian surgeons, have given of their time to participate in these meetings, and administrative assistance has been provided by the New Zealand Office of this College. On this occasion an oncologist from Palmerston North and an O&G specialist from Auckland also attended and participated in relevant sessions.

At least one surgeon was present from the Cook Islands, Federated States of Micronesia, Marshall Islands, Papua New Guinea, Samoa, Solomon Islands, Tonga and Vanuatu. There was a high attendance by Fiji surgeons and by the surgical trainees from the postgraduate Fiji School of Medicine programmes. The Meeting was preceded by a Registrars’ Training Day and these registrars, particularly those in the Masters programme, contributed significantly to the Meeting. The FSM Masters programme now has its first female trainee who presented a paper that explored issues surrounding her multiple roles of surgical trainee, wife and mother within a Pacific culture.

The Pacific Islands surgeons contributed papers and cases for discussion or participated in panel discussions. One paper by Mr Ifereimi Waqainabete presented his research into the neuropsychological effects of kava. His research subjects were all medical students in Fiji. After persuading us all that kava did indeed have neuropsychological impacts, Waqa and his family then hosted a Pacific night which included a kava ceremony. Some of those present were obviously keen to test the validity of the research for themselves.

The programme included sessions on urogynaecology, breast disease and malignancies, trauma, disaster management, thoracic problems and, of course, the ubiquitous diabetic foot. Maintaining an appropriately trained surgical workforce is even more problematic throughout the Pacific Island nations than it is in New Zealand and Australia. Workforce issues merited a focused session of their own, but also arose within discussions on other issues.

One afternoon was focused on a series of lectures and a hands-on workshop of the “Ponseti Technique” of clubfoot casting. This was run by Dr Haemish Crawford from the Starship Children’s Hospital in Auckland and included two other visiting speakers. The first was Dr Shafique Pirani from the University of British Columbia who explained how he had initiated this technique in Uganda where the incidence of clubfeet seems almost as high as in the South Pacific. Mr Martin Egbert, a businessman from Las Vegas and parent of a child treated by this technique in the USA,
gave an insight into the extensive parent network that exists worldwide for this condition. He explained how the Ponseti Technique has become the standard of care for clubfoot babies in the United States.

Following the lectures and videos a number of young children were presented for evaluation. Some of these children were casted and the technique explained again. This gave some delegates the opportunity to get their “hands wet” as well. This session concluded with the formation of a Pacific Island Ponseti Interest Group that agreed to explore the possibility of setting up a programme in each of the Pacific Islands present, similar to that working so successfully in Uganda.

The Pacific Islands Surgeons Association (PISA) was formed at the previous Meeting in Rarotonga in 2003. The Fiji meeting provided the opportunity for PISA’s General Meeting at which Professor Eddie McCaig (Fiji) was re-elected President, Dr John Hedson (Federated States of Micronesia) Vice President and Dr Teariki Noovao (Cook Islands) Treasurer. Mr Ifereimi Waqainabete (Fiji) is the newly-elected Secretary and has been replaced as Trainee’s Representative by Dr Saia Piukala (a Masters student from Tonga). PISA was also able to collect the required signatures for it to proceed with its application for incorporation in the Cook Islands.

As in other years, those present from Australia and New Zealand were impressed with the day-to-day expertise and dedication of the Pacific surgeons, all of whom are working in conditions and with a range of equipment and diagnostic tools below (and in some countries considerably below) those available to our own surgeons.
The provision of surgical services in regional, rural and remote regions of Australia remains one of the central challenges in health workforce planning. While government health policy has shifted from a concern about oversupply and a focus on maldistribution in rural and remote areas, to a concern about shortages across a wider range of health professions and locations, the inherent challenges of supply in non-metropolitan areas remain unsolved. Many non-metropolitan hospitals continue to experience shortages of surgeons and the proportion of non-metropolitan hospitals with insufficient resources and financial strain is far more significant than in the metropolitan settings. Current policies addressing maldistribution have been unable to overcome the long-term, and systemic problems present within the rural health system.

Together with the supply challenge, there has also been a growth in the demand for surgical services and this will only continue to increase. This is a result of advances in technology, changes in the burden of disease, higher incomes, as well as a growing and ageing population. Targeted training programs and human resource management strategies, as well as improved efficiency in health management to ensure the productive utilisation of surgeons, will all play a role in addressing the ongoing challenge of the provision of surgical services in non-metropolitan areas across Australia.

The following provides a demographic and workforce profile of non-metropolitan surgeons and identifies a range of issues facing regional, rural and remote communities.

Demographic profile of non-metropolitan Fellows

Close to one fifth of the Fellowship practise in non-metropolitan locations within Australia, equating to 634 surgeons in regional, rural and remote communities. Ninety-five per cent of non-metropolitan surgeons are male and 45 per cent are aged 55 years and over (average age is 55.6 years). The average age of non-metropolitan surgeons is significant and highlights the importance of ongoing workforce management within non-metropolitan hospitals. The largest numbers of surgeons practising in non-metropolitan areas are located in NSW (38 per cent or 238 surgeons), QLD (26 per cent or 164 surgeons) and VIC (18 per cent or 113 surgeons). Close to half of all regional, rural and remote surgeons practise as General surgeons (47 per cent or 283 surgeons), with a further quarter practising as Orthopaedic surgeons (25 per cent or 159 surgeons).

Chart 1: Active Non-Metropolitan Fellowship, Age by Gender, Australia, 2005
Working patterns of non-metropolitan surgeons

The proportion of Fellows practising in non-metropolitan Australia working on a full-time basis is 87.2 per cent (553 surgeons). This is slightly above the average for metropolitan surgeons, where 84.9 per cent practise full-time. NSW (17.1 per cent) and WA (15.9 per cent) have the highest ratio of part-time surgeons working in non-metropolitan areas. As surgeons age, it is expected that the ratio of Fellows practising on a part-time basis will increase. This has important implications for workforce supply, including training and supervision arrangements.

<table>
<thead>
<tr>
<th>Region</th>
<th>Metro</th>
<th>Non-Metro</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>2378</td>
<td>557</td>
<td>2935</td>
</tr>
<tr>
<td>Active (Substantial Hours)</td>
<td>240</td>
<td>51</td>
<td>291</td>
</tr>
<tr>
<td>Active (Part-time Hours)</td>
<td>90</td>
<td>19</td>
<td>109</td>
</tr>
<tr>
<td>Temporarily not in practice</td>
<td>59</td>
<td>7</td>
<td>66</td>
</tr>
<tr>
<td>Total</td>
<td>2767</td>
<td>634</td>
<td>3401</td>
</tr>
</tbody>
</table>

Working hours of non-metropolitan surgeons

The average number of clinical service delivery hours (consulting and operating sessions) worked by surgeons in non-metropolitan locations across Australia is 53.5 hours per week. This is 3.2 hours more per week when compared to metropolitan Fellows. The average working hours of surgeons in non-metropolitan regions across Australia are expected to decline significantly over the next five years, shifting from 53.5 clinical service delivery hours per week to 48.2 hours per week by 2010. Issues of sustainability within surgical services will increasingly rest on the capacity to manage an adequate supply of surgeons in regional and remote communities to meet local demand.

Retirement intentions of non-metropolitan surgeons

The retirement of surgeons from non-metropolitan regions impacts extensively on training requirements and capacity. Over a third of non-metropolitan surgeons expect to enter phased retirement from emergency call in the next five years (35 per cent, 221 Fellows), compared with 32 per cent in metropolitan areas. This includes 28 per cent of non-metropolitan Fellows planning to retire completely from operative practice in the next five years (179 surgeons). Twenty-four per cent of metropolitan Fellows expect to cease availability for operative practice.

Attracting surgeons to non-metropolitan practice

Based on the College’s groupings of metropolitan and non-metropolitan areas across Australia it was found that 15.8 per cent of Specialist Surgical Training posts were located in non-metropolitan regions. This proportion is lower than the current proportion of College Fellows that practise in non-metropolitan regions (18.6 per cent). In terms of future planning, exposure by a greater concentration of Specialist Surgical Trainees to non-metropolitan practice may be highly beneficial to attract young surgeons to regional and remote communities.
Rowan Nicks Scholar

I had the high honour of being a Rowan Nick’s scholar (1993-94) under the tutelage of Professor Russell W. Strong at the Princess Alexandra Hospital in Brisbane, Australia.

Having obtained the Fellowship of the Royal College of Surgeons of Edinburgh in 1991 after completing my surgical training, the Rowan Nicks scholarship helped me pursue higher surgical training in hepatobiliary surgery. Interest in this field developed out of sheer frustration and helplessness of seeing many trauma casualties succumb to the injuries of the liver. The ‘motorbikes’ and ‘Saturday nights’ primed with the bursting hormones of youth constituted a lethal combination for disaster on the roads.

The scholarship enabled me to leave my full-time job of a specialist surgeon at the Kuala Lumpur General Hospital, and focus my vision on hepatobiliary and liver transplant surgery. This changed my work as well as my life, and I am indeed very grateful to have had this opportunity. This endeavour inspired me through a journey of the fine art and science of surgery, widening my horizon and enhancing my quest to improve and enhance the level of hepatobiliary surgery in Malaysia.

Rowan Nicks’ noble vision for the developing world, created such opportunities for surgeons from emerging countries to connect with their peers and learn from master surgeons. This interaction and outreach resulted in an enhanced level of communication between myself and the Department of HPB Surgery, Princess Alexandra Hospital, Brisbane, thus allowing me to further improve the standard of clinical care in hepatobiliary surgery for the benefit of my local community.

Upon my return I took up my post of a specialist surgeon in the Department of Surgery, Kuala Lumpur General Hospital. It was here that I started performing hepatobiliary surgery in addition to the general surgical work. There was significant ignorance regarding hepatobiliary surgery and liver transplantation. Due to resource limitations such complex surgeries were perceived to be expensive and hence beyond the reach of majority. It was a slow process of creating awareness and educating the healthcare professionals that many cases with complex hepatobiliary and pancreatic problems that were deemed hopeless were in fact treatable and salvageable. Hence over time more and more referrals were received.

In 1995, together with some professional colleagues, I was involved in the setting-up of the Malaysian Society of Transplantation with the sole purpose of creating awareness of organ donation and transplantation in the country. The annual scientific meetings were used to disseminate information on transplantation to healthcare professionals while the help of the media was sought to create awareness on organ donation. Unfortunately after nearly 10 years of various campaigns our cadaveric organ donation rate is embarrassingly low with hardly three to four donors a year.

Similarly in 1997, I was involved in the setting-up of the Malaysian Liver Foundation, a non-profit organization set-up to create awareness on liver problems which were common in the country.

My stint in Australia provided me with valuable experience, for which I am ever so grateful to Rowan Nicks for having created the means; to Professor David Thiele for having found me an illustrious mentor and to Professor Russell W Strong for having accepted me as his trainee.
I believe this scholarship and the guidance and support of Professor Strong gave me the much needed head start to plan and develop the Department of Hepato-Pancreato-Biliary Surgery at the Selayang Hospital in Kuala Lumpur. Hence the first comprehensive, integrated multidisciplinary, tertiary HPB service in Malaysia became a reality in 2000 at the Selayang Hospital.

The Selayang Hospital which is a 960-bed tertiary care facility is located 15 kilometres north of the capital city, Kuala Lumpur. It was planned as a pilot project under the Government’s Information System Strategic Plan developed in 1994 to improve efficiency in the public hospital services using information technology (IT).

The high expectations of the community for better healthcare and the greater sophistication in management techniques led to the development of HPB Surgery. The complexity of the surgery and the associated morbidity & mortality necessitated surgeons to acquire greater skills and knowledge in this highly challenging subspecialty. It has now become evident that the outcome of complex surgical procedures is certainly better in high-volume specialised tertiary care centres with the appropriate expertise and infrastructure.

The Department of HPB Surgery at Selayang Hospital is currently the centre of excellence for the management of complex hepatopancreato-biliary problems in Malaysia. It is staffed by two full-time HPB Surgeons (myself and Mr Krishnan who was also trained by Prof. Strong). Prior to its existence, much of the HPB surgery was undertaken by general surgeons throughout the country while the more complex cases were referred to senior surgeons at the Department of Surgery, Hospital Kuala Lumpur.

The HPB Service at Selayang Hospital is a multidisciplinary programme providing a seamless integrated clinical care for patients with hepatobiliary problems. HPB surgical services include liver resections for hepatic and biliary malignancies and bile duct reconstruction. Pancreatic resections including pancreatic-duodenectomies for tumours and pancreatic duct drainage procedures are also routinely undertaken. Each year about 100 liver resections, 50 pancreaticoduodenectomies and various other major HPB surgical procedures including 300 ERCP procedures are undertaken by the unit.

Liver transplantation commenced in April 2002. The extremely poor cadaveric donor rate has limited the fully-fledged development of a cadaveric transplant programme. Hence the development of the living related liver transplant programme, which is also affected by the high incidence of fatty livers and hepatitis B carriers in the community.

The HPB service also undertakes surgical and non-surgical procedures for the management of portal hypertension and variceal bleeding. Other non-surgical procedures include intrahepatic arterial chemotherapy and radio-frequency ablation of hepatocellular carcinoma.

The key to successful development of any subspecialty is the availability of adequate and appropriate staffing, resources / facilities, backed-up by various other specialty disciplines. HPB surgeries including liver transplantation, are complex operations, which require extensive facilities, resources and collaborative involvement of a multidisciplinary team of trained healthcare personnel.

While the department provides a leadership role in the management of complex hepatic, pancreatic and biliary disorders, the bulk of its work is devoted to high quality treatment of common clinical conditions like hepatocellular carcinoma, traumatic injuries of the liver, pancreas and biliary system, hepatolithiasis, pancreatic tumours and chronic pancreatitis.

The department needs further consolidation and expansion so as to be able to meet the increasing expectations and demands of the community. The workload has increased exponentially since its set-up in 2000 while the resources remain unchanged, thus exerting tremendous strain on the existing resources.

This vision of developing an integrated, multidisciplinary HPB service in Malaysia may not have been possible if not for the contributions of the Royal Australasian College of Surgeons which awarded me the Rowan Nicks Scholarship (1993-94), and the Ministry of Health Malaysia, which provided the means to set-up the Department of HPB Surgery and to these bodies, I am indeed grateful and wish to express my gratitude.
Volunteering as a Clinical Instructor for the PROSPECT project

The College is looking for volunteers for the PROSPECT (Providing Remote On Site Supervision Procedural Education and Clinical Training) Programme.

Since 2003 the College, with funding assistance from the Commonwealth, has been providing much-needed training and supervision to medical personnel in remote locations in the Northern Territory. Through the PROSPECT project, the RACS supports ‘clinical instructors’ in visits of up to four weeks duration across hospitals in both Gove and Katherine.

Clinical instructors have included orthopaedic, paediatric and general surgeons, obstetricians and gynaecologists, physicians and anaesthetists. These are often semi-retired specialists who appreciate that their experience and love of teaching can be of great value in remote hospitals where ‘live-in’ consultants do not exist.

Clinical instructors focus their training on hospital medical officers, although a wide range of staff typically find their visits useful, including nurses, medical students, local GPs and physiotherapists.

A large proportion of patients in Gove and Katherine are Indigenous and often present with advanced morbidity. Major trauma and other life threatening emergencies need stabilisation before aerial evacuation to Darwin. Minor procedures, including some under general anaesthesia, are frequent and such cases are a prime focus of the training program. Many women present in labour with co-morbid chronic illness, often having had no antenatal care.

In the absence of the PROSPECT program, local doctors carry out this demanding work with no supervision and little scope for consultation. Clinical teaching, supervision and advice provided by the clinical instructors is warmly welcomed throughout the hospitals.

The hospitals in Gove and Katherine are of approximately 80 beds and well equipped. Accommodation for clinical instructors is available within the hospital grounds. While not luxurious, these rooms are quite comfortable and adequate with a fully equipped kitchen/living room, separate bedroom, television and air-conditioning.

A typical day for a clinical instructor begins with a 45 minute tutorial following a ‘hand-over’ meeting at 8am with another lunchtime or afternoon tutorial of similar length. Between these times, the clinical instructor provides consultation and advice on new admissions and problem cases in A&E, and coaching/assistance in the operating theatre or delivery suite, as required.

There is sufficient spare time, especially at weekends, to enjoy the environment at Katherine and Gove, two uniquely beautiful parts of remote Australia. Some of the clinical instructors have been accompanied by their spouses or have arranged for family to meet them in Darwin for a holiday once the teaching commitment was completed.

The PROSPECT project is organised and co-ordinated from College Head Office in Melbourne. It is funded by the Commonwealth Department of Health and Ageing. Airfares and accommodation are fully funded and there is an allowance to cover purchase of food and meals, and some out-of-pocket expenses.

The College Project Co-ordinator helps to arrange registration in the Northern Territory and provides a range of useful background information. Instruction is also provided about the reporting and evaluation process that the funding body requires. Northern Territory Health provides indemnity cover as the clinical instructors are classified as Hospital Medical Officers. Clinical Instructors can gain CPD points.

Peter Macneil FRACS

Would you like to visit Gove or Katherine as a RACS clinical instructor? Further information is available by contacting Stephanie Gebert, Projects Coordinator at the College on +61 3 9249 1284 or by email on stephanie.gebert@surgeons.org
Dr Skandarajah, who is now in the process of specialising as a General Surgeon with a future interest in oncology, conducted her research through the Royal Melbourne Hospital’s Department of Surgery and the prestigious Ludwig Institute of Cancer Research.

The Scholarship provided her with a one-year stipend plus departmental costs.

Under the supervision of Associate Professor Joe J. Tjandra and Professor Richard Simpson, Dr Skandarajah’s research looked at the use of proteomics to profile blood as a means of discovering biomarkers which may facilitate the early detection of colorectal cancer.

She said finding a way to detect changes in certain proteins in the blood was now seen to be the next advance from genetic screening.

“Colorectal cancer is the most common cancer in Australia with five per cent of the population developing the disease in their lifetime,” she said.

“It can be cured if diagnosed at an early stage however most cancers present at an intermediate stage.

“(Therefore) early diagnosis of colorectal cancer by way of a simple blood test evaluating tumour markers would be ideal.

“Colorectal cancer results from perturbations in the normal signaling and/or transcriptional regulatory networks of the colonic cells and these perturbations manifest themselves by altering the protein expression patterns of the tumour cells.

“We hypothesised that with increasing tumour load this will eventually alter the quantitative relationship of organ specific proteins in the tumour microenvironment constituting a blood fingerprint.”

Dr Skandarajah said her initial research compared the blood of ten cancer patients and ten patients without cancer to look for those tumour markers.

Thirty proteins were found to have a different expression between the two groups; with their role as possible biomarkers then explored.

“Understanding and capturing the body’s dynamic response to disease is clearly the best marker of a disease state but developing the science to allow for that is the challenge,” she said.

“In my first year I thought I was using an established proteomic technique to investigate blood but plasma proteomics is still in its infancy.

“I spent a considerable time optimising the technology to apply to blood using two-dimensional gel electrophoresis coupled with tandem mass spectrometry.”

Dr Skandarajah said scientists in different fields of cancer research were also working on finding fingerprints of different diseases in blood and urine but that the regular use of proteomics as a clinical tool was still some years away.

She said she appreciated the RACS scholarship funding.

“This research is very labour intensive and very expensive and the RACS Scholarship was enormously helpful.”

Dr Skandarajah is in the process of submitting some of her findings, which also formed the basis of her thesis, to international journals specialising in the science of electrophoresis and proteomics.
More on Find a Surgeon

There are now 1,300 Fellows registered on the College website Find a Surgeon directory.

The Directory is on the front page of the surgeons.org website. It lists active Fellows who have opted to be included, and is searchable by name, region and specialty. Similar directories are available on most of the specialty society pages but the College directory includes surgeons in all specialties.

The Directory is popular with members of the public searching for a specialist in their region. It’s becoming almost standard practice for potential patients to prepare themselves for surgery by looking up information on the internet. This includes visiting the College website for information about properly accredited surgeons. In the short time since the Directory was launched in February, there have been over 5,000 hits on Find a surgeon.

Find a Surgeon represents a fantastic opportunity for Fellows to promote their practices. Those Fellows who have business websites can include the URL with their contact details and this is another way to increase their profile.

More informally, the Directory provides a convenient way for Fellows to look up contacts for scientific or networking purposes.

The option to be included in the Directory is part of the first login to the revamped College website. This option can always be revisited. If you are an active Fellow of the College and you would like to add you name and business contact details to Find a Surgeon, you can do so after logging in to the College website.

Once you have logged in, go to the link under your name in the login box called “Update personal information”, scroll down to Web options then click Yes to “Include in Find a Surgeon”.

If you have any queries about getting your name listed, please don’t hesitate to contact the Library and Website Manager on (61 3) 9249 1272. Feedback is welcome.
Trainees e-group

All current surgical trainees are members of the Royal Australasian College of Surgeons Trainees’ Association (RACSTA) and one of the benefits of the Association is that all members are now automatically subscribed to the Trainees’ Association e-group.

An e-group is a ‘virtual meeting place’ on the College website, accessible to all members of the group. The RACSTA e-group has much to offer:

- **News** – items of interest to the Association
- **Discussion forums** – including Buy and Sell, Examinations and Fees forums. Additional forums will be added in the near future. Members can add new topics within these forums or add to existing discussions by posting a reply.
- **Document archive** – despite the name, this also contains current documents of interest which will include invitations, meeting reports and agendas. The News and Document Archive allow the Trainees’ Committee to send members documents of interest without filling up the inbox! Check these areas regularly for new items.

The e-group can be accessed at any time, day or night, from anywhere in the world that has an internet connection. Using an e-group will keep members in touch with other College trainees and keep members up to date with the developments of their Association and its Committee.

RACSTA members are already subscribed to the e-group so to start using it, follow these instructions:

1. Log into the College website
2. Click e-groups on the right-hand side under your name
3. Select the Trainees’ Association e-group
4. You will be able to see and select news items, document archive or discussion forums from here.

You will need a recent version (v5 or later) of Adobe Acrobat Reader plus access to the internet.

Library/Website booth at the ASC

For information about new electronic resources, as well as tips and training on using the College’s recently expanded Online Library, visit the Library/Website booth at the ASC. Library staff will be happy to answer reference enquiries, run literature searches for you and introduce you to the world of knowledge at your fingertips.

Does the College have your current email address?

Email is fast becoming a preferred means of communications for many people and organisations. It’s fast and convenient, so why not? If your email address has changed in the last twelve months, you may not have thought to notify the College. You can check that your email address is up to date as far as College records go by clicking on the “Update personal information” under your name after you have logged in.
IA is a non-profit company founded in 1983 as a partnership between the Royal Australasian College of Surgeons and Rotary District 980 to provide voluntary medical teams who carry out plastic and reconstructive surgery in developing countries in Asia, the Pacific & in Tanzania. More than 15,000 patients have received treatment, and education and training for local doctors and nurses is an important part of our work.

IA is an AusAID accredited NGO and complies with the ACFID Code of Conduct. Donations are tax deductible.

IA seeks expressions of interest from suitably qualified and experienced persons from throughout Australia for several Board vacancies. Those interested must have commitment, expertise and skills to make a significant and active contribution to the organisation. The skills and expertise currently sought include fundraising/public relations, medical/nursing, AusAID/development and corporate executives with senior level industry experience.

The Board of Directors is responsible for setting the strategic directions of the voluntary services and is accountable for ensuring that the services:

- Are efficiently managed;
- Provide high quality care and service delivery;
- Meet the needs for the development of plastic and reconstructive surgery of the developing countries where our teams provide assistance;
- Meet financial and non-financial performance targets;

Membership of the Board comprises office bearers (5) and up to a maximum of a further 10 other directors.

IA Policy provides for non office bearers to be appointed for a 3 year term with an option for a further term of 3 years.

Interplast Australia employs five full-time personnel and the office is situated at the Royal Australasian College of Surgeons, Melbourne where the Board Meetings are also held.

Expressions of interest enclosing your CV and a statement detailing relevant skills, qualifications or experience should be sent to:

General Manager
Interplast Australia
Royal Australasian College of Surgeons
Spring Street, Melbourne 3000

Further information can be obtained from:

Marion Wright, General Manager
Telephone: +61 3 9249 1231
Email: interplast@surgeons.org
Web: www.interplast.com.au

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Definitive Surgical Trauma Care Course

The Definitive Surgical Trauma Care (DSTC) course is a widely acclaimed two-day trauma course that provides surgeons and advanced trainees with hands-on practical experience that focuses on surgical operative technique in critically ill trauma patients.

Working with experts in the field, you will gain insight into difficult trauma situations with vascular isolation and the ability to handle major thoracic, cardiac and abdominal injuries.

A Military module is available which is a one-day course in skills needed for resource-depleted environments. It includes lectures and hands-on skills sessions.

The DSTC course is highly recommended by the College Trauma Committee for all surgeons and advanced trainees, in particular those involved in:

- the management of major trauma
- and those working in remote or regional areas

**Expression of Interest forms:**

Sonia Gagliardi, Liverpool Trauma Dept
Lyn Journeaux, College Trauma Office
Phone: +61 2 9828 3262
Phone: +61 3 9276 7448
sonia.gagliardi@swsahs.nsw.gov.au
lyn.journeaux@surgeons.org

**Courses Dates and Locations:**

<table>
<thead>
<tr>
<th>Location</th>
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<tr>
<td>Sydney</td>
<td>26 &amp; 27 July 2006</td>
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<tr>
<td>Military module</td>
<td>25 July 2006 (Sydney)</td>
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<td>Auckland</td>
<td>31 July – 2 August 2006</td>
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<td>Melbourne</td>
<td>14 &amp; 15 November 2006</td>
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<tr>
<td>Military module</td>
<td>13 November 2006 (Melbourne)</td>
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You need a toga to be a mentor

Well actually that is no longer true…

The origins of mentoring are believed to be in the Greek story told by Homer where the King of Ithaca asked his friend Mentor to babysit his son Telemachus while he fought to win the Trojan War.

Mentoring is no longer the older, more experienced person fostering the hierarchical progress of a younger, ambitious protégé.

It is a formally structured, non-reporting relationship undertaken to enhance professional practice, personal knowledge and development.

I like to think of a mentor as a coach.

Most surgeons can identify someone who at some time in their life had a powerful positive influence on them, their decisions, their career.

Whether this was in a formally structured fashion or not, there are certainly those who were role-models and played the part of surgical coach.

With the recent suicide of a surgical trainee, mentoring in surgical training and beyond has been brought to the forefront of our minds as an association.

Both RACSTA and the College believe that mentoring is an important part of surgical training. Having a senior colleague who you can meet, phone or email when you feel you need some advice or support is gold. This colleague is ideally not the person filling out your assessment forms, and discussions are confidential.

On behalf of RACSTA I wish to encourage those trainees with no formal mentoring relationship in place to either approach the person you would like to be your mentor, or to use the new and improved Facilitated Personal Mentoring Scheme which aims to help trainees seek out an appropriate mentor.

To be part of this scheme as a mentor or mentee please contact mentor@surgeons.org

Some famous Mentoring partnerships in history

- Professor Dumbledore to Harry Potter
- Oprah Winfrey to Dr Phill
- Yoda and Luke and Obi Wan
- Mr Burns and Smithers (Simpsons)
- JD and Perry (Scrubs)

Kissing babies, spending dollars and mudslinging………

Elections for people to represent YOU on the College Trainees Committee will be held in November by email.

It is important that the RACSTA Committee is provocative, honest and makes a difference. We want to engage trainees to choose the people they want providing trainee representation in the College, and encourage those who feel they are up for the challenge of being a representative.

The Committee will include:
- Eight Basic Surgical Trainees regional representatives (seven states/territories of Australia, plus 1 from NZ), and
- 11 Specialist Surgical Trainees representatives (nine specialties plus ortho and general surgery will have NZ and Australian representatives).

If you are interested in being part of the RACSTA committee for 2007-2009, nominations are due in September.

If you are interested in choosing your representatives then make sure you vote in the email elections in November.

To be able to vote your email address must be up to date so go to the College website www.surgeons.org log on, and check your details are correct.
The required antibiotics and heart repair surgery were simply unavailable in the South Pacific nation.

On his return to Australia he decided to act by setting up Operation Open Heart, now coordinated through the Sydney Adventist Hospital and now also one of Australia’s most highly-regarded international surgical aid programmes.

Visiting 13 countries around the world, the programme provides scores of cardio-thoracic specialists to nations in need to not only conduct urgently required surgical procedures but also to provide training for local staff and to contribute medical equipment.

Since 1986, Mr Lee has undertaken 74 such visits.

"It was very dramatic, when I visited my parents in Tonga, to see young people with rheumatic heart disease and no treatment available to them," he said.

“So the idea was to send medical specialists to them and now we not only do surgery to repair the effects of this disease but also treat children born with abnormalities of the heart.

“Some of the countries we visit have a ratio of one to 1,000 of congenital heart abnormalities so the need is significant.

“There has been so much enthusiasm for this programme by medical staff throughout Australia that we have now been able to send teams to Fiji, Vanuatu, Nepal, New Guinea, Vietnam, China, Mongolia and the Solomons.”

Speaking in the days leading up to a programme visit to Rwanda, Mr Lee said each trip was preceded by a scoping tour to understand the needs of each locale and the enormous logistical issues involved given that each visit includes up to 35 medical specialists and up to three tonnes of equipment.

He said a typical team included Cardio-Thoracic surgeons, a Cardiac Anaesthetist, Perfusionists, Theatre nurses, Anaesthetic nurses, an Intensivist, a team of Intensive Care and Ward nurses, a Physiotherapist, Radiographer, Biomedical engineer and a Chemist.

Approximately half a million dollars worth of equipment travels with the team, with transport at times provided through the Australian Air Force.

And all this, at the start, with no official state funding.

“When we first set up Operation Open Heart we had no Australian funding except that which we raised ourselves,” Mr Lee said.

“Later we received some Federal Government funding and then began to run some visits through the Pacific Islands Project.

“But still now a significant proportion of our funds come from the Adventist Development and Relief Agency, an NGO, with team members donating their time and covering their own travel costs and equipment donated or discounted by medical companies.

“But one of the most rewarding aspects of this programme is the dedication and enthusiasm of the members of the Australian medical teams, the vast majority of whom have all been on more than one trip.

“They come from around Australia, they are all volunteers and when you have doctors and nurses working with local staff the skills transfer is invaluable, which is what drives many to become involved and stay involved.”

Now working as a business consultant and on-going coordinator of Operation Open Heart, Mr Lee said the most recent trip to Rwanda was part of an international campaign to contribute to the country during the annual mourning period following the genocide of 1994.

He said the project, called Hope Rwanda, involved international medical, education and construction teams working to improve conditions in the ravaged country from April to July.

But he said that like all trips, choosing which patients to treat was one of the most difficult emotional aspects of the programme.

“We conducted a scoping tour in November and visited the King Faisal Hospital which has very good levels of service provision for a developing country,” Mr Lee said.

“While there we plan to do 20 heart operations, half open and half closed,” he said.

“Two-thirds of the patients will be children but to make sure they get the most from this medical treatment we are often forced to choose the most healthy which is very, very tough because there is such great need.”

Cardio-thoracic Surgeon Mr Ian Nicholson has also had an extensive involvement in Operation Open Heart since 1992.
As the Specialty Coordinator of the Pacific Islands Project Mr Nicholson undertakes up to three international aid visits each year in between his work at Sydney’s Westmead Hospital, the Children’s Hospital at Westmead and the Sydney Adventist Hospital.

Both an adult and paediatric heart surgeon, he said the majority of his work through Operation Open Heart involved treating congenital cardiac lesions and both ventricle and atrial septal defects.

He said that while the work was “greatly rewarding”, he agreed with Mr Lee that choosing the patients for treatment was often the most difficult aspect of his involvement.

“Obviously with such visits, we fly in, we set up and we operate but then we have to allow time for post-surgical recovery,” he said.

“This means that we have to choose those patients whose outcome we can reasonably predict. We can’t afford to do anything too fancy because we can’t have one patient on a ventilator for three days because of all the other patients who need it.

“This is difficult both emotionally and professionally in that you often see interesting things and think you’d like to fix them, but you simply can’t."

“At the same time we often pick those teenagers with heart abnormalities who only have a few years to live so we can make the biggest difference each visit.”

Mr Nicholson said passing on skills, techniques and experience was also part of the ongoing attraction of his involvement in the aid programme.

“Sometimes it feels like you can achieve more professionally in a week in some of these countries than you can in a year here,” he said.

“For example we can transfer our skills to local staff to help them deal with the relatively common condition of Patent Ductus Arteriosis which requires tying the tube with a silk suture in a procedure that takes less than half-an-hour and has the effects of what can be done via open-heart surgery.

“We will be teaching staff this procedure while in Rwanda to show them that just because they haven’t done it before, it can be done and they can do it.”

Mr Nicholson said meeting patients during subsequent visits was also a great joy.

“On a few visits to New Guinea, between 10 to 20 people have turned up at the airport to show us their scars and to thank us,” he said.

“They had travelled for days from all over the archipelago and we had no idea how they even knew we were coming but they felt it important to show us, given that we fly in and then disappear, that they were OK.

“But heart surgery is a team activity and none of this could be achieved without the commitment of the paramedical people and a strong team that works very well.”
The College website now lists national and international surgical conferences. These can be found in the Library area of the website. The conferences are listed as either Surgery, for the major meetings, or by Specialty. Further information can be found on the meeting websites.

**CARDIOTHORACIC SURGERY**

**CSANZ 2006 54th Annual Scientific Meeting**
incorporating ISHR Australasian Section 30th Annual Scientific Meeting 4 - 7 August 2006
Canberra ACT Australia

**Joint ASCTS ISMICS Winter Workshop**
26 - 28 October 2006
Cairns QLD Australia
Phone: +61 7 3366 2205
Fax: +61 7 3366 5170
Email: 2006wintersurgery@tayloredimages.com.au

**Society of Thoracic Surgeons 43rd Annual Meeting**
29 - 31 January 2007
San Diego California USA
Website: http://www.sts.org/sections/annualmeeting/

**GENERAL SURGERY**

**Endocrine Society of Australasia Annual Scientific Meeting**
20 - 23 August 2006
Gold Coast QLD Australia
Website: http://www.esa-srb.org.au/

**ACORD - Australia and Asia Pacific Clinical Oncology Research Development Workshop**
3 - 9 September 2006
Sunshine Coast QLD Australia
Website: http://moga.org.au/acord/

**Australian and New Zealand Burns Association Annual Scientific Meeting**
12 - 15 September 2006
Hobart TAS Australia

**Australian Paediatric Endocrine Group Annual Scientific Meeting**
20 - 22 September 2006
Hobart TAS Australia
Website: http://www.willorganise.com.au/apecg06

**Colorectal Surgical Society of Australasia - Spring CME 2006**
27 - 30 September 2006
Queenenew Zealand
Website: http://www.cssa.org.au/aboutarticle.asp?ArticleNo=56

**TRAUMA 2006**
28 September - 01 October 2006
Gold Coast QLD Australia
Website: http://www.truma2006.com/

**Australian Gastroenterology Week 11 - 14 October 2006**
Adelaide SA Australia
Website: http://www.gesa.org.au/meetings/index.htm

**NZ Society of Gastroenterology & NZNO Gastroenterology Nurses Section - Annual Scientific Meeting 15 - 17 November 2006**
Blenheim New Zealand
Website: http://www.gastro2006.co.nz/

**American College of Colon and Rectal Surgeons 2006 Annual Meeting**
3 - 7 June 2006
Seattle Washington USA
Website: http://www.fascrs.org/displaycommon.cfm?an=9

**23rd Annual Meeting of the American Society for Bariatric Surgery**
26 June - 1 July 2006
San Francisco California USA
Website: http://www.asbs.org/html/about/meeting06info.html

**World Transplant Congress 23 - 27 July 2006**
Boston Massachusetts USA
Website: http://www.wtc2006.org/

**15th International Congress and Endo Expo Society of Laparoendoscopic Surgeons Annual Meeting**
5 - 9 April 2006
Melbourne VIC Australia
Website: http://www.aht.org.au/programme.htm

**American Association for the Surgery of Trauma 2006 Annual Meeting**
28 - 30 September 2006
New Orleans Louisiana USA
Website: http://www.aast.org/annualmeeting/AnnualMeeting.html

**NEUROSURGERY**

**Spine Society of Australia Conference 28 - 30 April 2006**
Sydney NSW Australia

**Annual Scientific Meeting of the Neurosurgical Society of Australasia 17 - 20 September 2006**
Cairns QLD Australia
Website: http://www.nsa.org.au/meetings.htm

**ORTHOPAEDIC SURGERY**

**Arthroplasty Society of Australia 17 - 19 August 2006**
Glenelg SA Australia
Tel: 08 8232 4799
Website: http://www.aoa.org.au/arth.aslibmeatngs
Australasian Association of Paediatric Surgeons Annual Scientific Congress (in conjunction with Pacific Association of Pediatric Surgeons) 15 - 20 April, 2007
Queenstown, New Zealand
Phone: +61 3 9276 7416

PLASTIC AND RECONSTRUCTIVE SURGERY

New Zealand Association of Plastic Surgeons - Annual Scientific Meeting 26 - 28 September 2006
Wellington New Zealand
Website: http://www.plasticsurgery2006.co.nz/

Australian and New Zealand Association of Oral & Maxillofacial Surgeons Annual Scientific Meeting 2006 19 - 21 October 2006
Wentworth NSW Australia
Website: http://www.anzaoms.org/index.php?pagename=OUR%20CONFERENCES

Australian and New Zealand Burns Association Annual Scientific Meeting 12 - 15 September 2006
Hobart TAS Australia

61st Annual Meeting of the American Society for Surgery of the Hand 7 - 9 September 2006
Washington DC USA
Website: http://www.assh.org

American Society for Reconstructive Microsurgery Annual Meeting 13 - 16 January 2007
Rio Grande Puerto Rico
Website: http://www.microsurg.org/meeting.html

UROLOGY

ANZSN 42nd Annual Scientific Meeting in conjunction with the Renal Society of Australasia 16 - 18 August 2006
Melbourne VIC Australia

Urological Society of Australasias Annual Scientific Meeting 18 - 22 February 2007
Adelaide SA Australia
Website: www.urologymeeting.com.au

Atlanta Georgia USA
Website: http://www.aua2006.org/am06/?CFID=1149886&CFTOKEN=51324418

British Association of Urological Surgeons Annual Meeting 26 - 30 June 2006
Manchester England UK
Website: http://www.baus.org.uk

British Association of Urological Surgeons Annual Meeting 18 - 22 June 2007
Glasgow Scotland UK
Website: http://www.baus.org.uk

VASCULAR SURGERY

Vascular 2006 meeting 1 - 6 September 2006
Cairns QLD Australia
At home with International Medical Graduates

Orthopaedic surgeon Dr Olubukola Oloruntoba’s idea of a holiday doesn’t involve much travel.

Born in Nigeria, with his post graduate training completed in South Africa, further study undertaken in the US and the UK and now in Australia, clearly he’s done a fair amount of journeying already.

Now based at Whyalla in South Australia, Dr Buki as he is known, also spends hours driving to outlying hospitals dotted over the massive region spanning hundreds of kilometres from Coober Pedy to Roxby Downs to Port Augusta.

And along the way, as the hours and miles stretch out before him, he consults over the phone with general practitioners seeking advice and guidance.

Now he says a holiday simply means turning off that phone to give him time with his wife and two young children.

Dr Oloruntoba is one of scores of surgeons who have come to Australia from around the world to fill area-of-need positions. His arrival in 2001 was warmly welcomed given the Orthopaedic surgeon then covering the remote region was in the process of winding-up his practice, leaving the entire area without such a specialist.

“At the time this would have meant no Orthopaedic Surgeon resident north of Adelaide,” Dr Oloruntoba said.

“So they were quite happy for me to come here and there was a lot of good fortune and coincidence in how the move worked out.”

Dr Oloruntoba said the family made the decision to move from Durban, South Africa, after his wife, a General Practitioner, filled-in as a locum for a colleague in Port Lincoln.

“She liked it so much she wanted to stay and when your wife likes something you don’t argue,” he laughed.

“But it has been fantastic and the community has been very welcoming.

“When I can, I play soccer in the local team and basketball, we’re involved in the church and the children love it here.”

Dr Oloruntoba works out of the Whyalla Regional Hospital, the major trauma referral centre outside Adelaide and travels one day a week to operate in Port Augusta and one day driving to consult in Roxby Downs.

He said the majority of his work involved treating the sports injuries and accidents of the young as well as the degenerative conditions of the older members of the population.

But he said that while he appreciated the broad spectrum of the work, the distances involved in his new life in Australia were a challenge.

“Every decision involves pros and cons and the isolation here has a down-side,” he said.

“I’m on call every day of the week and get up to 20 calls a day from GP’s asking for advice about patient care which can at times feel a bit overwhelming.

“But I also have a good network of other Orthopaedic surgeons I can call to discuss matters for the purposes of Continuing Professional Development.

“These issues are always a challenge but the big advantage of working in the country is that the people are very nice and straight forward, the work is very satisfying and the people are receptive which makes it an easy decision to stay.”

Thousands of kilometres away, almost a world away, Professor Michael Schuetz is working to create a world-class management system for multi-trauma patients in Queensland.

As a Professor of Traumatology, he was head-hunted from Berlin, Germany, four years ago to contribute international knowledge to Queensland to help develop a state-wide trauma plan.

Now operating out of the Princess Alexandra Hospital in Brisbane, Professor Schuetz also holds the Chair in Traumatology at the Queens-
land University of Technology and is involved in teaching activities with the University of Queensland.

He arrived in Australia in 2004 from his position as Associate Professor of Trauma and Reconstructive Surgery at the Charite Hospital, the largest university teaching hospital in Europe.

"Trauma surgery has a long tradition in Germany and has been an established specialty with its own departments there for more than 30 years," Professor Schuetz said.

"It is this recognition of the trauma specialty field that ensure the highest level of trauma care.

"I was approached by senior orthopaedic and general surgeons to come here and help develop a more coordinated management of trauma patients, streamlining the existing strengths of the system here and setting up a system to manage those severely injured patients."

He was asked by Professor Gerry FitzGerald, the then Chief Health Officer, and Dr Cliff Pollard of the RACS to be on the Trauma Plan Working Group which included representatives of the Queensland Ambulance Service, the RACS, Queensland Health, researchers and the nursing profession.

He said he was confident the plan would go forward as a Cabinet submission to the State Government.

"I felt it was important to assist in the development of an over-arching plan and many people have so far put a huge amount of work into this, including RACS President Russell Stitz who has taken this to the highest levels," he said.

"The Queensland health system needs some fairly rigorous analysis but I feel that we are now on the right track and so much momentum has now built up that I am pretty certain the Government will accept the plan."

With four children and a wife who is a Gynaecologist, Professor Schuetz said the decision to move from Germany had not been easy but had been rewarding.

"These things are always family decisions but we decided that you can only take such a huge step with four children at certain times of your life," he said.

"You can’t be too old but you have to have sufficient professional standing to be able to make the move work as you would like.

"But Australian society is very welcoming and the children love it here, their schools and friends, and my wife is now going through the long process of medical registration requirements in Queensland."

In conjunction with Dr David E. Theile, Professor Schuetz received a 2006 RACS Fellowship to analyse costing of multiple injured patients to allow for more appropriate funding, which will then help establish a strong trauma service at Princess Alexandra Hospital, working alongside Dr Daryl Wall.

Through the University of Queensland, his research team is focusing on aspects of fracture healing, computer modelling and the development of implant devices.

"I have a certain vision of where I’d like to see trauma management heading in Queensland as well as within Australia, so we will see what can be achieved and what the future will bring."

Also in Queensland is Dr Willem Pretorius, an Orthopaedic Surgeon from South Africa.

Now coming under new registration rules covering overseas-trained surgeons, Dr Pretorius originally intended to practice in Rockhampton but has had to undergo a supervised period in Ipswich first.

He said the altered arrangements had caused some family and professional disruption, with his wife and son already there because of school requirements, but said that he looked forward to joining them to take up his position in Rockhampton later this year.

"This supervised period is probably quite a good thing even as a way of getting to know the system and the paperwork," Dr Pretorius said.

"It’s also given me a chance to get to know some of the guys in Brisbane and that’s very helpful and will be over time when I begin at Rockhampton.

"I’ve got no problem being evaluated it simply would have been easier had I known earlier because I sold my practice and our home so we had nothing to go back to.

"Partly, however, I think it’s just about being in the wrong place at the wrong time and there is no one to blame for that. It’s just that I am one of the first surgeons to go through this new system."
The Cowlishaw Symposium was established in 1996 as a forum for recognising the value and interest contained within the Cowlishaw Collection. The Symposium is a biannual meeting with invited speakers who present papers each based on one or more of the works from the collection. The Symposium has grown over the last 10 years and has now become one of the important events in the College’s calendar.

Invited Speakers include:
- Gabriel Kune
- Phil Sharp
- Wyn Beasley
- Sam Mellick
- Alan Thurston

Invited Speakers include:
- Gabriel Kune
- Phil Sharp
- Wyn Beasley
- Sam Mellick
- Alan Thurston
on the Australian and New Zealand Surgical Skills Courses

Take fresh budding surgical trainees, bursting to get their hands on the tools of their chosen trade and DO something! Add a group of your surgical peers willing to give their time to share their clinical and technical experience and expertise, and mix it into an educationally robust course programme designed and supported by Fellows and Staff of the College... The result: three days of stimulating interaction with your peers and with your future colleagues.

For many trainees, the Basic Surgical Skills Course is their first opportunity for relaxed communication with a surgeon. They see it as a tremendous privilege, and they thrive on it. Their enthusiasm for the one tutor to two trainees ratio over a three day period, speaks for itself. Most surgeons are too busy during their working day to spend time with their trainees. I have found that this course gives me that time. Surgeons who tutor on the course unanimously express sentiments such as “I had no idea it would be such a rewarding experience”.

One of my biggest thrills in teaching on this course is to see a diffident, awkward trainee struggle to tie a reef knot at the beginning of day one, then perform a slick endoscopic dissection on day three. Their rate of progress never ceases to amaze me, and the exhilaration they feel is infectious. And the tutors learn too! I couldn’t tie a two handed knot before I started teaching on the course! I continue to learn new things from the other surgeons as they share their experiences and tricks of the trade with the trainees on the course. As surgeons, we often work in relative isolation from our peers, and the BSSC is a chance for us to interact and share experience in an informal environment.

Yes, it is a time commitment…but somewhere between one and three days every couple of years is not really much to give, and the rewards are tremendous. Think about it... It is fun, it is appreciated and valued by the trainees, and it is a chance to share a little of your experience and expertise.

Asset Committee
The ASSET course was officially launched at the Royal Australasian College of Surgeons on Friday 7 April 2006. Debra Kruske, Manager Skills Training, hosted the event introducing Mr Iain Skinner, Chair ASSET Committee, and Associate Professor John Collins, Dean Of Education. The following is a synopsis of the brief addresses given by Mr Skinner and Professor Collins.

The asset course has been developed over a four-year period by the former BSS (Basic Surgical Skills) Course committee. In an attempt to improve the teaching elements of basic skills for the Basic Surgical trainee group it was decided that the emphasis must be on the teaching of excellent skills. These individual skills (tying, suturing, instrument handling, tissue handling, dissecting, diathermy use and safety etc) are taught on day one of the course. These skills are highlighted in their use, during integrated task-based exercises (anastomoses, wound creation and repair etc), on the second day of the course. Basic management of traumatic wounds and bone (including debridement, bone cutting, drilling, plating and plastering) are also covered in day two. With a short introduction to the skills of rigid endoscopy, including crossover elements of open tasks from day one being performed in an endoscopic simulator on day three, the course introduces trainees to the essential elements of all the skills they will need to begin their training.

There are four elements to the course:

- an indexed DVD teaching with all practical course elements on it
- a benchside manual to provide major objectives, a guide for the exercises and space for writing notes
- a textbook of skills and practices (written by the committee)
- the practical exercise component of the course itself.

With three of the four elements being retained as a permanent reference the course provides a guide, and revision tool, for basic skills and practices throughout surgical training. Not only does this course improve the delivery of surgical training it benefits all patients as it ensures safe, competent surgical procedure and care within Australia and New Zealand.

Mr Skinner made the point that without the incredible drive of Debra Kruske, who has provided a focus for all of the people involved...
“The frank and candid assessment of specialists is one of the most important safeguards for patient safety, risk management and transparency of process.”

in the project, the course would not have been ready to run this year. Ground work support by Antoinette Moar and Janty Taylor was also vital. Kathleen Hickey (Director Basic Surgical Training and Skills) and Dr David Hillis (CEO of the College) have ensured that there have been no obstacles from a fiscal or administrative source and the entire project has been supported fully by Council.

It is impossible to neglect the critical role played by Professor Richard West, Professor Stephen Deane and Professor Jeff Hahmdorf in the vision they showed by integrating the Intercollegiate Basic Surgical Skills (BSS) course into our basic surgical training package. The subsequent support of Professor Deane and Mr Ian Civil (current Chair, Board of Basic Surgical Training) ensured completion of the project.

Our thanks must also go to the companies who have supported us for the entire BSS / ASSET programme and to all of the surgeons and technical support staff who have so diligently volunteered and laboured to make these courses a success.

Finally the BSS / ASSET committee have committed time and effort above that which could be expected of them, and will no doubt continue to do so during the constant process of revision and updating that must occur with this course. The Certificates of Outstanding service presented to the committee by Council are a fitting recognition for their efforts.

Professor Collins presented the committee members Mr Iain Skinner, Mr Matthew Carmody, Mr Matthew Lawrence and Associate professor Matthew Clark with Certificates of Outstanding Service. The others will receive their certificates at the appropriate subsequent forum.

Instructing on the ASSET courses is a rewarding experience providing a chance to interact with each year’s intake of new trainees. The Committee invites Fellows to join the dynamic and enthusiastic ASSET Faculty especially at such an exciting time. Fellows interested in coming on board to instruct, and any who may subsequently be considering applying for Committee membership, are encouraged to contact the Skills Training Department of the College on +61 3 9276 7450.
THREE DAY BUSINESS COURSE COVERING:
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Overcoming barriers to commencing haemodialysis with appropriate vascular access

The problem: Patients commencing haemodialysis with a catheter have a two to three-fold increased risk of death compared to those with an AV fistula. Regrettably, the use of catheters is becoming more common. While three-quarters of patients in Australia dialyse with an arteriovenous fistula, less than half (48 per cent) of those commencing haemodialysis treatment do so with a functioning AV fistula. Some 46 per cent of patients require insertion of a temporary catheter to commence treatment until an AV fistula can be constructed. This problem was identified in the National Institute of Clinical Studies (NICS) Evidence-Practice Gaps Report, Volume 2 (www.nicsl.com.au).

Dr Kevan Polkinghorne, a Melbourne nephrologist was awarded a NICS Fellowship to identify the barriers to vascular access and develop and test strategies to overcome them. Dr Polkinghorne argues that “catheter use in new patients commencing haemodialysis is unacceptably high, exposing patients to excess morbidity and risk of death. Compared to catheters and AV grafts, AV fistulas result in significantly lower rates of complications, such as infection and clotting. Additional benefits are longer patency, fewer hospitalisations and significantly lower costs.”

The evidence: All patients requiring haemodialysis must first undergo surgery to create access to the circulation. International evidence-based guidelines recommend the construction of the native AV fistula as the first choice. This is a surgically constructed connection between a peripheral artery and a vein, which takes several weeks to mature before it is functional. In the small percentage of patients for whom an AV fistula cannot be created an arteriovenous graft is constructed by implanting a synthetic tube in the arm between an artery and a vein. Another alternative is the central venous catheter, which is a synthetic catheter implanted in a large vein in the neck. The central venous catheter is regarded as an immediate, temporary form of vascular access.

The solution: Dr Polkinghorne surveyed nephrologists and surgeons on the barriers to timely vascular access creation. Late referral to the nephrologist was identified as the single most important factor. Other factors are waiting time for assessment by the nephrologist or surgeon, cancellation of procedures, lack of coordination of waiting lists, insufficient operating time or funding and patient co-morbidity. “Identifying the barriers to use of evidence is the first step in developing targeted interventions to address them” said Dr Polkinghorne. “The NICS Fellowship has provided me with a fantastic opportunity to look at ways of increasing best practice in this area, plus given me the time to do the work, and the connections to national and international experts in evidence implementation” he said.

The future: Quality improvement programs and a coordinated, multidisciplinary approach to pre-end-stage kidney disease are needed to help clinicians reduce catheter use in new haemodialysis patients. The decision about vascular access should be made jointly by the physician, surgeon and patient after assessment and education. Patient information should include material on the different methods of vascular access, pointing out the benefits of creating an AV fistula as soon as practicable. Early referral and planning are vital. Patients should be assessed by a surgeon skilled in vascular access well before the anticipated start of haemodialysis. This is to ensure that the AV fistular is functioning well at the commencement of dialysis, following a four to six-week maturation period.

The last word: Given the rising incidence of patients requiring long-term haemodialysis, the issue of ensuring timely vascular access is of paramount importance for good health care.

NICS Fellowships will be advertised nationally in late April. For application details, or to see the NICS Evidence-Practice Gaps Report, visit www.nicsl.com.au.
Duxton Hotel, Wellington, New Zealand
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www.plastic.surgery2006.co.nz

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Dr Charles Davis

Organising committee: Francis Hall, David Hamilton, Craig MacKinnon

Conference managers: Medical Industry Association of New Zealand

Phone: +64 9 917 3645
Email: admin@mianz.co.nz
Website: www.mianz.co.nz

Important dates:
Abstract Submission Deadline  Friday 30 June 2006
Abstract Notification  Monday 17 July 2006
Early Bird Registration Fee Deadline  Monday 10 July 2006
Online Registration Closes  Wednesday 13 September 2006

North West Private Hospital
Fellow in Breast & Endocrine Surgery

This fellowship in Breast and Endocrine Surgery is to be offered again in 2007. It is for one year at North West Private Hospital. The fellow will also work in the Centre for Breast Health at the Royal Women’s Hospital and in the Endocrine Surgery service at the Royal Brisbane Hospital. This fellowship offers an outstanding opportunity for training in breast and endocrine surgery with a substantial clinical workload in dedicated outpatient clinics, operating sessions and weekly multi-disciplinary meetings. The holder of the fellowship will also be encouraged to participate in clinical research programs and will be offered the opportunity to initiate clinical/collaborative research study.

You will hold a FRACS; be eligible for registration with the Medical Board of Queensland; have recently completed advanced training in general surgery, and be seeking further experience in breast and endocrine surgery. You will work under the supervision of three specialist surgeons and assist with private surgical operations.

You will require personal medical indemnity cover, but employer indemnity will be offered by Ramsay Health Care Hospitals and Queensland Health respectively.

Further information regarding the Fellowship & application requirements may be obtained from:
Professor Ian Gough - North West Breast Clinic
North West Private Hospital,
137 Flockton Street Everton Park QLD 4053

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Remember, all College Fellows also have full and complete online access to the College’s official journal, ANZ Journal of Surgery. It’s FREE for Fellows and available through the RACS Member website. Log on today for more information.
Breast cancer surgeons in Australia and New Zealand are participating in an innovative auditing process for the treatment of early breast cancer.

In April, the web-based data entry system that had been in use since early 2004 was replaced with a new, secure industry-standard on-line database. The move to the new system took place following extensive discussions with surgeons and the Royal Australasian College of Surgeons (RACS) Section of Breast Surgery to understand what features should be retained and which ones needed changing.

We are confident that the new design will enable faster and more accurate data entry. We also aim to make the audit process more informative with new and improved reporting features.

In 2005, breast surgeons were provided with information about quality measures of surgical care. These benchmarks had been formulated by an expert group comprising breast surgeons and representatives from both the National Breast Cancer Centre and the Breast Care Network Australia. It was important to ensure that the benchmarks were evidence-based and strongly representative of quality treatment in Australia. Surgeons can now compare their practice results (for episodes diagnosed after 1 January 2004) against these benchmarks. Making these results available to surgeons will form the first step in the implementation of a process to identify variations in practice from that expected.

All full members of the Breast Section are required to participate in the National Breast Cancer Audit. However, the audit is also available to any surgeon who treats patients with early breast cancer. Further information is available from the Audit Help Desk at the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S office) in Adelaide +61 8 8363 7513.

The use of audit data as a research tool

A major aim of the audit is to analyse the audit data to detect underlying trends. Extra funding was made available by the National Breast Cancer Centre during 2005 to help fund the preparation of two research papers. The first provided a general overview of audit data and the second concentrated on the treatment of Ductal Carcinoma In Situ (DCIS). A third paper, describing the process of establishing the audit was published during 2005 in the Australian and New Zealand Journal of Surgery. Further research papers are in preparation.

Following a successful Australian Research Council (ARC) grant application, two PhD studentships will be offered to develop techniques for handling change in systems that collect and analyse data by combining the areas of pattern languages and data mining. The $225,000 project was jointly devised by ASERNIP-S/RACS, Flinders University and the Australian Computer Society. The students will base their research on the National Breast Cancer Audit data repository. Data mining aims to discover interesting, useful and previously unknown facts using large quantities of data. Pattern languages are used to describe the manner in which generic processes and designs are constructed. This two-part project will draw these ideas together, firstly using the ability of pattern languages to aid the search for interesting knowledge and secondly using data mining to support the process of pattern construction and validation, particularly in relation to medical systems.

Building a library of images

As part of promoting the project through the website and through publications we would like to create a library of images associated with the treatment of breast cancer. If you believe you could contribute to this, we would like to hear from you.

For more information on the National Breast Cancer Audit please contact Professor Guy Maddern, ASERNIP-S Surgical Director or Mr Jim Kollias NBCA Clinical Director, by telephone +61 8 8363 7513, fax +61 8 8362 2077 or email (breast.audit.college@surgeons.org), or visit the audit website at http://www.surgeons.org/asernip-s/breast.htm.

ASERNIP-S and the National Breast Cancer Audit are part of the Research and Audit Division at the College.

Maggi Boult
Morbidity Audit Manager, ASERNIP-S Office
Professional Development Opportunities

**Practice Management for Practice Managers**

**FRIDAY 28 JULY, GOLD COAST (½ DAY)**  
**SATURDAY 12 AUGUST, MELBOURNE**  
**COST: $340 (½ DAY $170)**

This workshop is suitable for practice managers who wish to update their skills in practice management. Content includes staff recruitment and management, business plans, practice systems and the use of information technology.

**MORE INFORMATION**

Contact the Department of Professional Development  
Phone +61 3 9249 1106  
Facsimile +61 3 9276 7432  
Email caroline.gonzalez@surgeons.org

All Professional Development workshops accrue points towards 2006 totals in the College Continuing Professional Development (Recertification) Program.

**Training and Assessment**

"THE ART OF TEACHING IS THE ART OF ASSISTING DISCOVERY"  
- MARK VAN DOREN

**MENTORING IN THE WORKPLACE**  
**MONDAY 05 JUNE, BRISBANE**  
**COST: $100 FOR COLLEGE MEMBERS**

This three hour workshop provides participants with the essential skills to understand the role of mentor, and has been developed for those involved in leadership roles and/or facilitation of learning in the workplace.

**SURGICAL TEACHERS COURSE**  
**THURSDAY 13 - SATURDAY 15 JULY, BRISBANE**  
**THURSDAY 05 - SATURDAY 07 OCTOBER, MELBOURNE**  
**COST: $200 FOR COLLEGE MEMBERS**

This course provides intensive training designed to enhance the educational skills of surgeons responsible for the teaching and assessment of trainees. Participants are taught the foundation of improved educational skills, which can be further developed by practical application.

Content includes adult learning, teaching skills, feedback and assessment and leadership and change.

**Surgeons as Managers**

**FRIDAY 07- SUNDAY 09 JULY, GOLD COAST**  
**FRIDAY 15 - SUNDAY 17 SEPTEMBER, NOOSA**  
**COST: $815 FOR COLLEGE MEMBERS (INCLUDES 2 NIGHTS ACCOMM FOR SINGLE DELEGATE; PARTNER OR FAMILY RATES AVAILABLE ON REQUEST)**

The workshop covers a range of practical business and management skills and is conducted as a weekend retreat; partners and families are welcome. Content includes financial management, practice management, leadership, and legal issues. The workshop can also be taken as a core module of the Graduate Certificate in Business administration.

**Expert Witness**

**SATURDAY 2 SEPTEMBER, MELBOURNE**  
**COST: $700 FOR COLLEGE MEMBERS**

Legal and surgical experts present a full day of practical exercises with individualised attention. Content includes the role of the expert witness in court proceedings, what to expect in court, appearing in court, practical exercises in examination-in-chief, cross- and re-examination.

**Winding Down from Surgical Practice**

**SATURDAY 24 JUNE, ADELAIDE**  
**SATURDAY 14 OCTOBER, BRISBANE**  
**COST: $125 FOR COLLEGE MEMBERS**

This workshop provides information to assist surgeons considering retirement from operative or other types of surgical practice. Content includes planning for retirement, options after retirement, and the legal and financial issues associated with retirement.
Pioneering New Zealand heart surgeon Sir Brian Barratt-Boyes died recently following aortic and mitral valve surgery at the Cleveland Clinic. Sir Brian led the team which established open-heart surgery in New Zealand in 1958 and his subsequent achievements established him as an international leader in this rapidly developing specialty.

Born in Wellington, Brian was educated at Wellington College and Otago University Medical School. After early surgical training in Wellington and Palmerston North Hospitals he obtained his FRACS in General Surgery in 1952, a rare achievement at a time when most New Zealand surgeons went to Britain for postgraduate training. He became a Fellow at the Mayo Clinic from 1952-55, working with John Kirklin in the early days of heart surgery. He held a Nuffield scholarship at Bristol University in 1956.

Returning to New Zealand in 1957 he took over leadership of a team which had been fostered by his predecessor Sir Douglas Robb. In 1958 he successfully performed the first open-heart operation in N.Z.; closure of a ventricular septal defect in a 10-year-old girl. He quickly established Greenlane Hospital as an international leader in the treatment of congenital heart defects. Notable amongst the major achievements which followed was his work with allograft aortic valve replacement first performed in 1962 (independent of and almost simultaneously with Sir Donald Ross in London). He contributed actively to tissue valve research almost until his death.

His passion was paediatric cardiac surgery and his work, starting in 1969 with the use of deep hypothermic circulatory arrest in young infants, led to techniques which were quickly adopted worldwide. Brian was a single-minded man with clear goals and a vision for the future. He combined high intelligence and superb technical expertise. His drive and charisma inspired his team during the often traumatic formative years of the specialty. He was a superb teacher and attracted many overseas visiting surgeons and trainees. Several of those who worked with him have had distinguished careers worldwide, leading major departments in Australia, India, Britain, Thailand and America.

The book “Cardiac Surgery” which he co-authored with John Kirklin was by his own assessment his greatest contribution. This was the product of several years of work and considerable conflict but was finally published in 1985 and has since become the classic text. It is now in the third edition. It is unique among major medical textbooks in that the first two editions were entirely written by just two authors rather than the usual multi-author format.

This was all achieved at considerable cost to his own health. He developed angina and required coronary artery surgery in 1974 and again on two subsequent occasions. It is a tribute to his dedication that he continued to work with undiminished vigour, establishing the first private cardiac surgical department in N.Z. after years of frustrating struggles with the public health bureaucracy.

He became a national icon. He was awarded a K.B.E. in 1971 and received innumerable awards from many countries including recognition from the Pope. Only last year he was awarded the Distinguished Alumni Award from the Mayo Clinic. He declined many lucrative offers to work overseas, preferring to continue in the department he had developed.

He was hugely respected and admired by all who worked with him and much loved by his many patients.

He is survived by his wife Sara and two stepchildren and his first wife Norma, their five sons and their families.
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Information available from Congress Secretariat, Carrie Green at Ph (+613) 9347 6625; Fax (+613) 9347 8440; e-mail: tjandra@connexus.net.au
The known history of the containers began when Dr Thomas Walpole, a graduate of Melbourne University, presented me in 1981 with the two containers. They were packed in transportable layers forming a brilliant array of unused surgical instruments in perfect condition. He informed me that he had brought the containers back from the campaign in New Guinea, adding that they were of Japanese origin.

Dr Walpole had served with distinction with the 2nd Field Ambulance and the 11th Division Headquarters. He was awarded the M.B.E Military Division for his outstanding work in setting up and administering field hospitals in Milne Bay, Port Moresby, Central Highlands, Jaquinot Bay and Rabaul.

Early in his general practice career, (following his marriage to the daughter of Dr E.R Felstead, a Foundation Fellow of the College), Dr Walpole had a close clinical and family relationship with the Fellows of the College. When I joined the Lister House Clinic in 1961 Thomas proved to be an exemplar of sound clinical and ethical practise, based on deep religious convictions.

He did not discuss or suggest what should be done with the instruments. I sensed that the instruments had not been used for the 36 years after the end of the Pacific war and it would have been inappropriate to incorporate the instruments into the General Surgical Instruments available at the Wimmera Base Hospital. Vague ideas of presenting the instruments to the College museum; the War Museum in Canberra or returning them to the Japanese Embassy, did not seem to be appropriate. The instruments were given to me as a trustee. Their value intuitively was more than their material use. They had formed part of a Japanese Medical Facility in the New Guinea campaign in a bitter and cruel conflict between Australian troops compassionately aided by the indigenous tribal people of New Guinea.

In March 2004, at a Melbourne Symphony concert, Mr David Price, a Fellow of the College, discussed his forthcoming surgical locum in Baucau hospital in East Timor to provide voluntary respite to Dr Felipe Mwaura; 48-year-old Nairobi-trained Kenyan surgeon. Dr Mwaura had provided surgical services to the 100-bed hospital on call 24 hours a day for two and a half years. David expressed some anxiety concerning the availability of appropriate surgical instruments in a rural hospital primarily servicing general practice procedures.

After a brief discussion in the interval between sleep-inducing violin concertos, I returned home and relocated the instruments in a custom-built sea chest manufactured in Leith Harbour after a completion of the Edinburgh Fellowship and subsequent migration to Australia in 1961. The lock was rusted and had to be jemmied open, breaking the wooden lid and yielding treasure.

The instruments, to quote David were ‘in exceptional condition’ and put into immediate use – the spectrum of General Surgery included thyroidectomy for goitre, nephrolithotomy for renal colic, varicose veins (using quite sophisticated avulsion forceps) limb amputation for neglected squamous cell cancer, mastectomies, hernias and paediatric shunts for hydrocephalus.

In June 2005 David returned to Baucau Hospital for similar assistant work. Prior to this I had kept Dr Walpole’s daughter, Elizabeth, informed about the instruments, as her father had passed away in 1998. Elizabeth arranged a visit to Dili in June which included a visit to Baucau.
Two final links between the past and the present is the finding of the role of Baucau during the Timorese Resistance to the Japanese occupation. It became an important Japanese base in the eastern sector of the state being particularly suitable for an airstrip construction making supplies difficult to access for the Australian “Independent Company” 2/2 and 2/4 in what was then Portuguese Timor.

The second link is recorded in an eyewitness account given by Alfredo Pires: “In 1942 I saw fighting in the air between Australian and Japanese planes and an Australian plane fell. The pilot was alive and they took him to Baucau Hospital. The doctor, Elvira Teles, wouldn’t give him up to the Japanese and joined the Australians in the bush”. She assisted in their escape to Darwin.

There appears to be a striking similarity here between events in Timor and New Guinea. The obvious difference being that the East Timorese again became the victims of a second and brutal invasion from 1975 to 1992.

I now hope that the staff of Baucau Hospital will honour their trusteeship.
Thane update

In the March issue of Surgical News I wrote an article on a presentation set of male urethral catheters, awarded as a prize in the late 19th century.

The set was donated to the College by the late Frank Rees Magarey, former Professor of Pathology in the University of Sydney. Professor Magarey was awarded Honorary Fellowship of the College in 1964.

On the lid of the presentation box is a small brass plaque engraved with the inscription: “The Middlesex Hospital Medical School Prize in Medicine and Pathology awarded to Mr P.T. Thane. Session 1879-80”.

I concluded the article by saying that unfortunately we know not much more about Mr P.T. Thane. He must have been a diligent student for the College also possesses a military amputation kit, presented again by Professor Magarey, which bears an engraved plaque saying: “The Middlesex Hospital Medical School Governor’s Prize for General Proficiency awarded to Mr P.T. Thane. Session 1879-80”.

I expressed the view that Thane’s story may one day come to light.

It did indeed not take long for his story to come to light. Answers came from Philip Sharp FRACS, convenor of the Surgical History section, and from Richard Beaver FRACS, both of whom kindly sent an extract from the genealogical database maintained by the National Library of Australia.

Phillip Thornton Thane MRCS LRCP was born in 1859, the son of a London GP. After tuberculosis had claimed his brother Charles in 1878, Phillip and another of his brothers Tom (b.1856) emigrated to Australia, arriving in 1882 in Sydney aboard the Devitt & Moore square-rigger *Parramatta*. He worked his passage as ship’s doctor at one shilling per day.

He set up practice in Walgett, but moved to Yass in 1884 and joined the elderly Dr Allan Campbell. He was immediately elected MO to the Yass Hospital. His first operation was an emergency procedure on a young boy suffering from strangulated inguinal hernia. Chloroform was administered by Dr Blake. The boy recovered well. Thane also acquired a reputation in the treatment of hydatids, which was rife in the Yass area, and he wrote two papers on the subject.

In 1891, during an influenza epidemic, Phillip Thane was able to persuade another brother Edgar Thane MD (1862-1929) to join him in New South Wales. Edgar first practised in Yass, where he had to learn to ride a horse, and subsequently practised in Wagga Wagga and the Sydney suburb of Gordon.

Phillip Thane returned to England for a visit in 1895, following the death of his wife Annie. There he embarked on a course in Practical Bacteriology at University College, London, where his eldest brother (Sir) George Dancer Thane (1850-1930) was Professor of Anatomy. At this time he married again, to Pauline Beatty. On the return voyage tuberculosis flared, and full recuperation took about five years.

Phillip Thane became a municipal alderman in Yass c.1898, and mayor in 1902, on a platform of ridding the town of its cesspits. By 1903-04 these had all been decommissioned and replaced with a pan system. There was a dramatic drop in the number of typhoid cases, and Thane resigned from Council with his mission complete. He was also active in the Mechanics’ Institute and the Pastoral & Agricultural Association. In 1912 he was elected President of the Central Southern Branch of the BMA.

From his first marriage Phillip Thane had three sons, and from his second, three sons and a daughter. In 1913 he sold out to Dr Colquhoun of Melbourne, and moved his family to Sydney, where he practised for the rest of his life. He died in 1944.

Geoff Down
College Curator
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