

CROSS DISCIPLINE

**AL01
PACIFIC ISLANDS PROJECT – PAST PRESENT AND FUTURE**

D. A. K. WATTERS

University of Melbourne Barwon Health, Victoria, Australia

The Pacific Islands Project began in 1995 and in its early years had a focus on providing specialist services that were not available in the 10 island nations visited. In 2002 Nauru was added and PIP Phase III will end its 9 month bridging/extension phase in September 2007. During the last 12 years Fiji School of Medicine has commenced a postgraduate medical training program in surgery similar to that has been in existence in PNG since 1975. There are now a growing number of Pacific-trained surgeons who can select suitable cases, do some of the surgery, and supervise the postoperative care. Increasingly visiting teams have focused on transferring skills and building local capabilities (capacity building). The RACS, the Project Director and the speciality coordinators have managed the first three phases of the project in Australia. Phase III had on-going evaluation by an internal RACS committee under the chairmanship of Professor Hamish Ewing. AusAid also externally reviewed the project late in 2006. That review was generally complimentary as to what has been achieved but also points to some new goals for the future. At the time of writing this abstract the future direction of PIP is yet to be decided and designed. This will be done mid 2007. However, it is to be hoped there will be a new program, focused on capacity building, that is managed in the Pacific and employs the skills of Pacific Island Specialists wherever possible. RACS is likely to continue to play an important role in sourcing visiting specialists, organising training positions, arranging courses. We have much expertise to offer but there is no longer any need for us to set the agendas.

**AL02
CUMULATIVE SUM (CUSUM) TECHNIQUES TO MONITOR
PERFORMANCE AND PROVIDE FEEDBACK**

D. A. K. WATTERS

University of Melbourne Barwon Health, Victoria, Australia

CUSUM was first used in 1954 as a quality control measure in industrial processes. It was first applied to surgery in 1994 and has been adopted by cardiothoracic surgeons spurred on to some extent by the Bristol Inquiry. CUSUM can be applied to any procedure (or process) where a binary outcome can be obtained; for example, did an anastomotic leak occur? Yes or No. If yes the operation is a failure and if no it is a success. Having determined what outcome is being assessed the next challenge is to decide (in advance) what is acceptable and what is unacceptable performance. This might be determined by consensus of a group of surgeons or derived from the literature. However, the literature is subject to publication bias of good results and might not be reflective of a true "whole practice" audit. Most operations have obvious outcome endpoints that can be assessed though some form of risk stratification and subdivision of outcomes needs to be applied. For example emergency colorectal surgery has a higher mortality rate compared with elective surgery. The workshop will show how CUSUM plots are derived and used in practice. The technique requires no more than an add-in option in Microsoft excel to calculate the graphs. There are two types of graph: 1 a cumulative failure graph identifies changes in performance early as the plot crosses predetermined performance lines. 2 a CUSUM graph gives an immediate visual impression of performance as the plot crosses action lines. This means that a previously competent surgeon whose outcomes start to change (perhaps for health reasons) would be noticed soon after the change.

**AL03
RECONCILIATION**

A. W. BEASLEY

Wellington, New Zealand

This paper traces the career and achievements of Sir Edward 'Weary' Dunlop, not least that he forgave his Japanese captors. It examines the problem of forgiveness and the reconciliation that forgiveness permits, and considers the application of these considerations to three problems faced by surgeons: the problem of litigious patients; the problem of managerial overgrowth; and the problem of political ignorance.

**AL04
INTRODUCTION: THE CONCERNS OF THE FOUNDERS**

A. W. BEASLEY

Wellington, New Zealand

When the Founders met in Dunedin in 1927, they had been working for seven years towards what became the College. During that period they had identified four areas of concern in their search for surgical quality in the two countries: surgical standards; hospital standards; anaesthetic standards (somewhat obliquely identified) and research for the public good. Subsequent speakers will examine the College's activities in these four areas of concern over the past 80 years.

**AL05
OF STRINGS AND SPLINTS AND WARS AND WOUNDS**

A. K. JEFFERY

University of Otago, Otago, New Zealand

Robert Hamilton Russell (1860–1933), a Melbourne surgeon of international repute, played a pivotal role in the formation of the College. In 1925 a letter signed by G.A.Syme H.B.Devine and Russell was sent to senior surgeons in Australia and New Zealand suggesting the establishment of a body to improve surgical standards, a proposal first put by Louis Barnett in 1920.

Born in Kent with medical training at King's College, Hamilton Russell was House Surgeon to Lister and profoundly influenced by Lister's mentoring. Russell emigrated to Melbourne in 1890 and with appointments at the (Royal) Children's Hospital and the Alfred, developed wide surgical interests including fracture management.

At the start of World War I, Hamilton Russell was in England and joined the Australian Voluntary Hospital in France. On returning to Melbourne in 1915 he presented a paper on the treatment of war wounds and in 1916 a paper on fractures included his new method of continuous traction for femoral shaft fracture. At this time the proper management of war wounds and fractures was being vigorously debated.

It was not until the Spanish Civil War, three years after Hamilton Russell's death, that significant advances were made in the management of war injuries. In Barcelona, Joseph Trueta successfully combined the principles of triage, blood transfusion, early surgery, wound excision and plaster immobilisation. In 1939 Trueta escaped to Britain and with the aid of influential colleagues his techniques with some modification were adopted during the 1939–45 conflict and form the basis of war wound management today.