The Royal Australasian College of Surgeons

Annual Report 2012

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RACS - The College of Surgeons of Australia and New Zealand

Governance Management Report

Mike Hollands, PRESIDENT

I am writing this annual report at a most important time in the College's history. Since becoming President last May, I have grown convinced that we need to challenge the fundamentals of our College, its key roles, its aspirations and its future direction.

Although this annual report of necessity deals with our many achievements over the past 12 months, I wish also to challenge you to think afresh about what your College should focus on into the future. I say this most deliberately, for while there is a critical role for professional organisations such as the Royal Australasian College of Surgeons in our society, we must always be able to adapt to changes in our environment and provide a more flexible model of leadership for our profession.

Surgical wisdom

I would like first to challenge you at the individual level. Two years ago, I had the privilege of co-authoring an article published in the British Journal of Surgery with Professor Russell Gruen and Professor David Watters. It spoke to what all practising surgeons ardently hope will characterise their own practice: a combination of ethos, personal qualities and professional attributes that we innately admire, identify with, and aspire to. This ideal combination was characterised as 'Surgical Wisdom'. This embraces the concept of superior judgement within a context of rich understanding, enabling a surgeon to determine what is right and best.

At the individual level, we can appreciate the importance of these qualities and we have hopefully been mentored by senior colleagues who demonstrated surgical wisdom in abundance.

But what do we do as a 'group of surgeons' to promote these qualities that constitute surgical wisdom? There are many descriptors of these groups of professionals; associations, communities of practice, academies or societies. Most of them are groups of like-minded professionals who come together to achieve some common goals.

In our case, I want to challenge you to reaffirm the purpose of your College.

Was it founded to aspire to greatness for the surgical profession, just as surgical colleges around the world were? And is this as pertinent for the College of Surgeons of Australia and New Zealand today as it was for the Edinburgh College – the first College formed by Royal decree – more than 500 years ago? Most importantly, as we steer the College on the course we want it to take, what aspirations to greatness do we have for the surgical profession into the future?

The challenges

There is no doubt that healthcare, surgery and surgeons face substantial challenges. The College held a Surgical Leaders' Forum late last year which addressed the sustainability of our healthcare systems and the vulnerability of surgical services and surgical education in the face of ever tightening budgets. Since then more beds have been closed across Australia and New Zealand and more operating lists cancelled, many permanently – testimony to the diminishing role of surgical clinical activity in our public hospital systems. It is not surprising that more than 60 per cent of elective surgery in Australia and 50 per cent of elective surgery in New Zealand is undertaken in the private sector. These changes, along with the varied demands of our individual working weeks, as demonstrated in the 2011 Surgical Workforce Census, challenge the more traditional scopes of surgical practice and the role of training that we have for decades associated with public hospitals.

Shortly after this Surgical Leaders' Forum the College held an international symposium on the Global Burden of Surgical Disease. There is enormous unmet surgical need internationally. Trying to address this need must be an ongoing priority, one that requires sustained and effective advocacy at the highest levels.

However, the challenges we face are not just about demand for services. There are ongoing interactions about 'who does what' in our complex systems. All Fellows will be aware of the ongoing dialogue between the College and the progressively more substantial and autonomous Specialty Societies, and the effort to develop an effective partnership model that will ensure the FRACS remains the definitive standard for specialist surgery in Australia and New Zealand. However, the various societies are themselves challenged by sub-specialty groups, and commonality of practice is being eroded by the demands and the attractions of sub-specialisation.

The College already has positive arrangements in place with a number of sub-specialty groups and with universities who increasingly identify sub-specialty surgical training as an area of their academic strength. Alongside these developments, government agencies and regulators have become far more interested in the issue of training, devising new training models and pursuing ambitions to manage what they see as a workforce in crisis. We ignore all these changes at our peril. So, as we look to an uncertain future, what should be the College's key areas of activity?

Pushing to be aspirational. Firstly, who are we talking about?

In trying to focus this discussion, the Constitution of the College and its purpose is still instructive. In the Constitution as it was agreed in the referendum of 2010, the purpose of the College is clearly stated:

1. Advance education, training and research in the practice of surgery;
2. Determine and maintain professional standards for the practice of surgery in Australia and New Zealand;
3. Provide an environment promoting fellowship development and support; and
4. Provide authoritative advice, information and opinion to other professional organisations, to governments and to the public.

These are all encompassing and enabling goals. However, let us start pushing at the boundaries; to be aspirational by embracing a far broader definition of 'surgeon' or 'surgery' than that which we might currently employ. I would deliberately like to pose the challenge of using the word 'proceduralist' to encompass our broader professional group. Surgery has changed dramatically over the past 50 years. Due to changes in technology, many of us may not make an incision that is greater than one centimetre in length. Endoscopic surgeons do not incise the skin at all! Within our professional careers, manipulating robotic appliances may become more routine than handling a retractor. We frequently operate in ways and on areas of the body that are quite apart from our formal pre-Fellowship training. And these changes will continue to occur. ▶

Surgical Leaders' Forum October 2012

In the face of this change, however, we are bound together by a common need to understand, and make decisions about, procedures to improve the well-being of our patients. Let us not necessarily be constrained by the so-called nine specialties of surgery. We already know that these are not internationally consistent and that their arbitrariness is confusing to many. However, being trained in what is the appropriate way to undertake procedures and when to undertake them is important. Again, we need to look beyond the traditional boundaries of our surgical specialties.

The College is actively involved in discussions around health services – it is a most important part of our advocacy. Consistently, the critical issue confronting surgical services in our communities is access to generalist and non-specialist services. It is the most common subject of discussion in current health workforce debates and it will need to be addressed by a number of models.

One will be to ensure that the ongoing sub-specialisation of general surgery and orthopaedic surgery still honours and trains the true generalist. Another is to recognise that the College needs to move more fully and formally into a supportive role for generalists and particularly the General Practitioner – the proceduralists of rural and remote areas. Without this type of aspirational goal, the ongoing sub-specialisation of surgery will consign this College to irrelevance.

Changes over the past 10 years in medical undergraduate programs and the early post-graduate years have left the preparation for surgical training under-profiled and under-supported. This is another fundamental challenge to a core purpose of the College. Although the merging of Basic Surgical Training and Advanced Surgical Training into the modern Surgical Education and Training (SET) program was educationally valid, it diminished the role of surgeons in the important early years of post-graduate training.

The College is now reviewing, and will need to make decisions about, what areas of its activities and assessments it can make available to medical students and medical graduates. Again, the involvement of the College in these areas is 'a must'. The strength of surgery in the future will be a reflection of our attractiveness to the best and brightest medical graduates in our two countries.

The College's support for surgeons and their surgical practice must surely remain the key issue for a membership based organisation. However, Fellows will not look to the College to provide answers on all issues. The world has moved on from this. All organisations will focus on their strengths. One of our strengths is being there for all Fellows throughout the totality of their professional career. All Fellows understand that in a professional career they go through distinct transitions; from being a Trainee, to establishing their surgical practice, often becoming a surgical leader in a number of senior roles, and then moving through phases of retirement. These transitions involve change and often a need to acquire new, often quite different skills.

The College is well regarded for the work it has undertaken in areas of competence and performance which now underpin our training and ongoing professional development activities. It is pleasing that College staff, as well as Fellows, are being invited internationally to talk about this outstanding work. However, in my view this work needs to be advanced and to be more focused on the key transitions of a surgical career.

I hope my comments have challenged you to think anew about who the College should be interacting with, and the moments in a surgical career when that interaction is most timely and effective. I would now like to examine what the key areas of the College's activity should be.

College core activities

If we acknowledge these aspirational goals of extending our reach into the broader preparation of proceduralists, and have a keener understanding of the requirements associated with the transitions of practice, then what exactly should the College focus on within these areas?

As I attend many meetings of surgeons around Australia and New Zealand, my discussions with Fellows have left me in no doubt as to their concerns. The most frequently mentioned issues pertain to professional standards and the requirements to maintain these, and the dependence our health sectors have on International Medical Graduates, and the College's role in supporting these surgeons.

Others ask how they might access the College more effectively and would like to see a significantly more personalised service. Pleasingly, many Fellows would like to become involved with our International Development work. Although the College undertakes a lot of activities, these are the issues that are reliably raised from one meeting to the next.

However, let us take a step back, to view the totality of our activities and perhaps to group them. I believe the two core functions for a medical college are to establish and maintain professional standards and then to support the communities with which it is involved.

Maintaining standards is not the same as being an educational body, but there are some obvious similarities. It is often stated that the core functions of an educational body are the development of curricula, the delivery of material which conveys that curricula and then assessment to ensure the knowledge retained matches the curricula and the learning objectives. Let us take that simple model and apply it to the College. There is a broad consistency as long as we continue to focus on life-long educational objectives, maintaining standards and a commitment to the assessment of standards through multiple means.

How do we achieve these objectives, working with multiple partners and providing infrastructure that is modern, while still focusing on our traditional strengths within the apprenticeship training model of surgery?

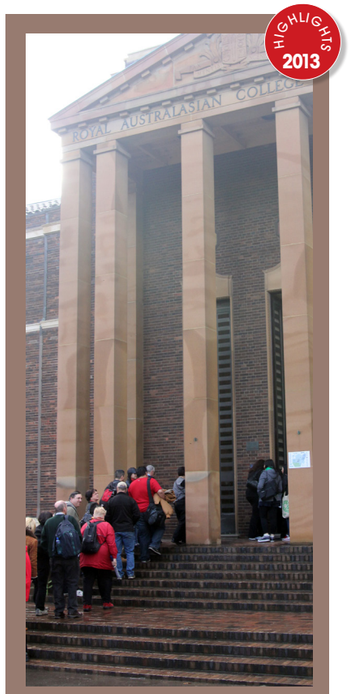
Maintenance of standards – curricula

The College will continue to focus on its core strength of ensuring that high standards of surgical care (indeed of procedural care) are identified and maintained. We will do this progressively through better partnership models with many organisations and the Fellowship as a whole.

The original partnership models with the Specialty Societies are now more than 10 years old and are being rewritten as we speak. We have partnership models with universities in a number of different areas and these will develop and broaden as the number of sub-specialties continues to increase. These sub-specialty societies, in turn, are seeking greater recognition and asking for representation at College level. We will also need to look to the commonalities between our College and other Colleges such as Obstetrics and Gynaecology, Ophthalmology, Anaesthesia and General Practice. As I have already outlined we must be in a position to identify and define what we have in common, not the differences that distract us.

The College has established curricula in the nine specialties and these are being progressed by the various surgical specialties. As expected, our standards are driven by the breadth of our interaction with a Fellowship at large which is progressively more diverse. Equally, the delivery mechanisms of these curricula are becoming increasingly diverse. ▶

HIGHLIGHTS 2013



Resources

Project Refresh, the redevelopment of the College's IT systems, was completed.

The College secured Museum Australia accreditation.

Hundreds of visitors toured the College's Melbourne building as part of the city's Melbourne Open House weekend.

Delivery

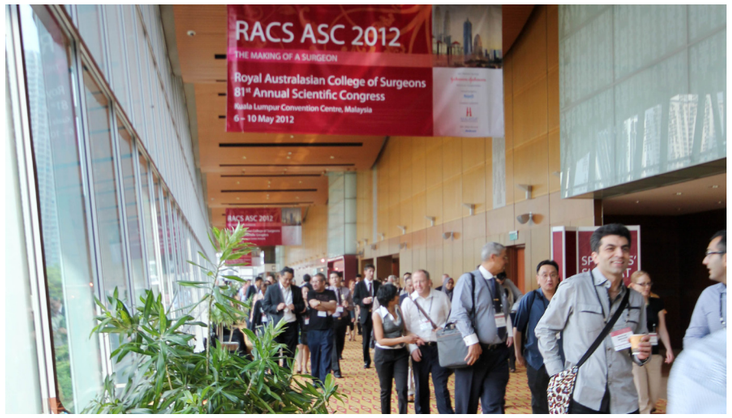
The College can combine its core strengths of providing courses and events with web-enabled e-learning. The skills training department delivered 140 courses to 2,435 participants in 2012, as well as launching a new course 'Training in Professional Skills' (TIPS). Professional development courses particularly focused on skills for educators were progressed, with substantial review of the course content.

E-learning modules for supervisors and educators, NOTSS, cultural competence and neurotrauma were developed and made available on the web. Eleven further modules are in development. The Annual Scientific Congress combines the best of both the classical and digital worlds, with the largest scientific program on record having 1,213 presentations, expanded master class programs and a substantially improved Virtual Congress that even included a live web-cast of the 2012 Convocation.

The College is progressively and positively embracing the digital age in the delivery and communication of its activities. The world of simulation in clinical training and clinical care is also continually assessed and is becoming more focused, particularly through the ongoing Commonwealth Government funded research led by Professor Guy Maddern and the ASERNIP-S staff.

Assessment

The College fully supports assessment of standards throughout a professional career. Within training, the number of candidates formally presenting for examinations continues to rise, with 1,313 surgical Trainees or International Medical Graduates undertaking examinations in 2012, from the early Surgical Science Examination through to the Fellowship Examination.



2012 Annual Scientific Conference, Kuala Lumpur

At the same time we have progressively introduced a variety of In-training assessment tools. Although demanding of time in a time stressed environment, tools like the Mini-CEX and DOPS, as well as regular completion of the In-training assessment forms, do provide feedback to Trainees about their progress, provide opportunities to establish or confirm the educational goals and objectives required, and ensure satisfactory progress is achieved.

We can now combine that with the electronic collection of logbook and audit data through MALT (Mobile Audit and Logbook Tool) which was launched by the College during 2012. This will be progressively made available across all the nine specialties in 2013.

The mortality audits have now reached a maturity demonstrated by improvements in clinical outcomes in Western Australia where the program has been running for 10 years. Equally, the audits' national reports provide a basis for comparison that is robust and ongoing. Publications in peer reviewed journals are now being achieved both nationally and internationally. Both mortality audits and peer review based morbidity audits remain very important components of the re-vamped annual CPD program that was developed and approved for introduction in 2013.

The College remains very active in health technology assessment, with contracted work from a number of national and international bodies producing systematic reviews, rapid reviews, critiques and decision analytic protocols.

One of the College's core strengths is its ability to undertake assessments and then to evaluate their consistency. So, it is of concern to Council that pass rates have been decreasing over the past five years and that there appears to be a regional bias for success. This became more apparent through 2012 and the reasons for it require ongoing analysis and assessment by the Training Boards, with subsequent actions through 2013.

One of the key roles that the College undertakes on behalf of the Australian Medical Council, Medical Board of Australia and the Medical Council of New Zealand is the assessment of International Medical Graduates. Separate to this report, the Activities Report highlights the number of surgeons, trained outside Australia and New Zealand, who successfully complete the assessment processes to become Fellows of the College.
This highlights the need for the College to provide greater support to these surgeons, not only at the time of their assessment, but at those points of transition during their professional career.

The transition into the Australian or New Zealand healthcare systems is a major cultural challenge for many. The College needs to move from the 'assessor' to the 'supporter' of International Medical Graduates as they establish themselves in Australia and New Zealand. Ongoing reviews by parliamentary committees highlight the challenges for these committed individuals who are trying to secure a professional future in our communities. Anecdotally the feedback provided to me as I have met with Fellows around our two countries is that this is an issue that needs to be handled more comprehensively.

Standards through times of transition

As already highlighted, transitioning from one part of a professional career to another is not necessarily an easy task and I am challenging the College Council to consider all the major points of transition where the College could put more effort into support and education. I have already highlighted the importance of our re-entering the early post graduate years, and of our facilitating the transition from International Medical Graduate to younger Fellow in Australia or New Zealand.

Establishing a practice is a major undertaking which can be either an enormous positive or an ongoing trial. Then there is the transition from busy surgeon to senior surgeon and leader. Finally, there is the transition to retirement. The College has actively run a number of courses and activities over the years that provide the skills, and allow the development of aptitudes, that help surgeons assume leadership roles.

As an example, all College Councillors are encouraged to undertake the diploma course offered by the Australian Institute of Company Directors so they might more fully appreciate their role in governance. There is more, much more, to achieve in this area. How do we encourage, and provide training and experience for those surgeons with an interest in, and an aptitude for, areas like health policy and health leadership?

Unfortunately, the structures of the healthcare sector can actively discourage surgeons from taking on leadership roles in both the public and private sectors. In contrast to the more full-time and paid environment of the National Health System or the academic centres of North America, the roles of surgeons in Australia and New Zealand have been marginalised, with surgeons having a lower profile in both the public hospital system and universities. It was once a mark of seniority and excellence to be Head of Department. Unfortunately within the public hospital system in both countries, this position has been so disenfranchised that it is no longer highly sought-after.

Developing skills and ensuring the leaders of the future are appropriately nurtured is crucially important, but far from easy. The College needs to be focussed on this important activity – the

Relationships

The 2011 Census analysis and report was mailed to all Fellows, detailing important workforce trends across the College.

A larger, new look *Surgical News* was launched.

The College advocated successfully for greater support for General Surgeons working at Alice Springs Hospital.

There was a successful migration to a new centralised payroll system, incorporating New Zealand for the first time.

A strategic planning weekend was held in March, with subsequent changes to the format of Council meetings. There is a renewed emphasis on strategy, with special input from Specialties, Younger Fellows and Trainees.

As part of its commitment to address the health inequities in Australia's Indigenous and remote communities, the Foundation provided the Tharawal Aboriginal Medical Clinic with an Ecleris OM100 ENT Microscope. This equipment enables the clinic to conduct regular outreach clinics to more than 3,800 active patients in the south-west region of Sydney.

The Foundation also provided the Cherbourg Aboriginal Health Clinic in Queensland with a Flexicam Mobile Imaging System to assist them to gain a more accurate diagnosis of ear disease and to better monitor and treat the condition at its outreach clinics in remote regions.

More than 40 Foundation for Surgery scholarships and grants were awarded to Fellows, this includes three scholarships that were awarded for the first time.

Phil Truskett and James Kong (far right), Myanmar 2012

development of, and transition to, surgical leadership.

The College continues its program for senior surgeons who are transitioning to retirement. One of the issues that I consider particularly important is the development of mentoring programs where these highly experienced and very knowledgeable people can contribute to the ongoing support of their younger colleagues.

I challenge you all to think of key transitions in a professional career where the College could be more pro-active.

Supporting our communities. The community of surgeons

So the first core function of our College is to understand the standards of care by which surgeons are measured. I have deliberately focused on the issue of standards across our nine competencies and these do vary through the transitions of a surgical career. They can be clearly understood through a framework of curriculum development, content delivery and ongoing assessment. As we work through our various, but important partnering arrangements the College needs to be clear about the aspirational role we should undertake.

The second core function that I have defined is the support that we provide to the various communities in which we have a key role. It is easy to say the College is a community of surgeons. It is undeniably true, and the real importance of this community is its role in defining the standards and identifying the qualities that make up 'surgical wisdom', and then supporting its development. Supporting its development is achieved primarily through the various educator groups of the College. Be it as instructors, supervisor, trainers, examiners or mentors, the impact of what we do and how we do it is vital to surgical standards into the future. Over the past 12 months the Academy of Surgical Educators has been re-invigorated to give it a particular focus on the skills and aptitudes, the recognition and the reward that our educators need.

However, the College is also the community of all surgeons. Like any membership organisation we have a responsibility to support those members who are experiencing difficulty, either personally or in maintaining the professional standards that are required. This should be at the core of our membership services. Work aimed particularly at supporting surgeons through the key, and sometimes difficult, transitions of surgical practice is a must for the College.

Communities in which we practice

I have already highlighted the difficulties that confront us in providing surgical services to the community, particularly through the public hospital sectors of Australia and New Zealand. It is likely that funding for health will become even more constrained in the future, with healthcare close to bankrupting the smaller states of Australia already. The standard public hospital response of restricting 'elective surgery' needs to be exposed for the fallacy that it is. Somehow the endless 'blame game' that exists in Australia, whereby the two levels of government accuse each other of short changing patients, needs to stop. The College's regional committees have engaged fully in this space, with ongoing meetings with Departments of Health in most regions. Regional committees have also instituted an ongoing program of meeting surgeons at regional and rural hospitals to identify the issues 'on the ground' so that advocacy might be better informed. In the area of politics and advocacy, these activities are a 'must'.

While recognising the 'bigger picture' of health policy and budget shortfalls, the College also needs to highlight the outstanding service to the community provided by surgeons through their professional careers. Most surgeons having established their careers will spend decades providing service to a particular community or a small number of hospitals. The College through its regional committees is now endeavouring to ensure recognition of this service, not only by the College but by the community that has been served.

It is a fact of modern life that various government bodies take it upon themselves to interpret and articulate the expectations of the communities they represent. And these government bodies increase in number and in their demands. Long gone are the days when professionals or professional bodies could truly act with autonomy. Expectations are real. Accountability is significant. In previous annual reports, the President of the day has highlighted the challenges of the ACCC / NZCC or the AMC / MCNZ. These organisations are still with us, but their demands are more manageable because the systems that support our activities are robust and transparent and we are thorough in handling concerns that are raised. We are accredited by the Australian Medical Council and the Medical Council of New Zealand until 2017.

However, newer government bodies like Health Workforce Australia (HWA) and the Australian Health Practitioners Regulation Agency (AHPRA) now demand our attention. The significant change from my perspective is how surgery, and indeed the medical profession more broadly, is being 'diluted' in these discussions. It is of no surprise that HWA is looking at all health professionals and their initiatives deliberately blur professional boundaries. It is also unsurprising that AHPRA is concerned with no fewer than 14 health professional groups. The 'body of surgeons' is just a small dot amidst some 560,000 health professionals in Australia. Similar directions and trends are discernible in New Zealand as well. The more we fragment ourselves as surgeons, the less relevance or critical mass we have in these broader discussions. As I meet with the increasing number of Specialty Societies I repeatedly emphasise this.

These government bodies are actively planning to train and promote health professionals with different scopes of practice and are resourcing alternative training providers. So working collaboratively with these groups is at times difficult. Based on different, and some would say ideologically driven, models that often see no role for professional organisations like medical colleges, the new arrangements proposed by government must not be allowed to undermine education and

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External Affairs

The College established a training program in collaboration with the Myanmar Medical Association, Australasian College of Emergency Medicine and the International Federation for Emergency Medicine, enabling local specialists to be trained and to lead the development of an Emergency Medicine service throughout the country.

Thirteen surgeons from ten countries in South East Asia and the Pacific region undertook surgical attachments in Australasian hospitals through the International Scholarship Program.

The College hosted a conference on the Global Burden of Surgical Disease over three days in September. Specialists and leaders in global surgery and anaesthesia from North America, Europe, Asia and the Pacific region participated.

The Annual Scientific Congress, held in Kuala Lumpur, was the most successful on record, featuring a record number of scientific presentations (1,213), the highest number of attendees (2,429) and a new and improved Virtual Congress. A record 566 verbal presentations were uploaded to the Virtual Congress.

The College is progressively and positively embracing the digital age in the delivery and communication of its activities

Surgical Simulation ASERNIP-S Adelaide

standards as they relate to surgical care. These challenges have always been present, but now have the form, function and funding to change the dynamics of health professional training. Again, it is issues of access to generalism and the standards of procedural medical care that our broader community demands we address, and that we must address in unison. The public still expects the generalist surgeon to attend their healthcare needs, with ready access to sub-specialty expertise where necessary.

The International community

The final community I would like to mention is the international community. As President I am invited to a number of international meetings where I am impressed by the rigour of training programs, but reminded of the demands of providing surgical services. As an example, this College has been involved with Myanmar for a number of years, and in conjunction with other Australian based medical colleges is now providing a range of courses which are providing a distinct benefit, as the skills and capacity of this emerging country's health professionals increase. This deliberately builds on the considerable work undertaken over many years in the South East Asia and Pacific regions, funded through AusAID and NZ Aid sources. The College remains very committed to this developmental and capacity building work. In 2012 we conducted 90 clinical outreach and training visits to Pacific Island countries, East Timor, Papua New Guinea and Nusa Tenggara Timur, which involved 299 volunteer medical personnel. Importantly, we enabled 13 surgeons from 10 countries in South East Asia and the Pacific to undertake surgical attachments in Australian and New Zealand hospitals. It is in the context of this longstanding international involvement that the College is now in a position to advocate on issues pertaining to the global burden of surgical disease. Our communities all remain very important to us.

Our resources

It is said that medical college structures resemble the Guilds of England some 200 years ago; structured around and committed to experiential learning within an apprenticeship type model. Indeed the Hippocratic Oath which still underpins the ethical and values base of medicine speaks to this. With our strong and ongoing commitment to mentoring and close supervision, the model persists. However, we are now also in a world of constant interaction. I have been personally surprised at the rapid penetration of smart phones and tablet technology, to which I am also now addicted. It is easy to understand how they are revolutionising the delivery of educational material and healthcare. Despite their pervasiveness, they also speak to a sophistication of support and an educational approach that was not required just five years ago. The College continues to upgrade its information technology infrastructure, its core support systems and resources available over the website to meet these rapidly changing requirements.

However, these endeavours inevitably challenge our resourcing model. In a separate report, the Treasurer will outline how our current financial model is challenged and how 'one-off' costs reduce our capacity to build for the future. This has led to a less than satisfactory financial result for the College in 2012. We need to adjust our business model and prioritise expenditure to accord with our strategies for the future and meet the challenges we will face.

I hope that this discussion of the College's purpose and direction, its work and the people this work should involve, its role in maintaining standards and its responsibility to the communities it supports, has proved a useful focus for this annual report. The challenges I have identified confront us all because we are all the Fellows of "our" College.

Commitment

The College remains deeply indebted to the Fellows who contribute so substantially to its endeavours. Whether it is through representation, educational and training courses or formal involvement in the College's governance groups, this commitment is critical to the ongoing work of the College. I do thank you all.

In particular, I would like to thank the Councillors retiring from Council this year. The commitment of Ian Civil as President was outstanding. I now more fully appreciate the time and dedication that this senior role involves. Keith Mutimer as Vice-President and Mark Edwards as Censor-in-Chief performed their roles with distinction. I also acknowledge the dedication of Sam Baker, Rob Black, Vince Cousins, Hugh Martin, Greg O'Grady and David Walsh, all of whom contributed enormously during their time on Council in a number of roles. Without the willingness of these Councillors to get the hard work done, many of our initiatives would still only be 'great ideas'. The College is in your debt.

I would particularly like to acknowledge the contribution of the two Expert Community Advisors on Council. The depth of experience of both Bettina Cass and Garry Wilson in the development of social policy, the management of complex organisations, and the deft handling of government to organisation interfaces has been invaluable. We are ▶

HIGHLIGHTS 2013

Education Development and Assessment

The number of candidates presenting for examinations continued to increase, with 1,313 Trainees or IMGs undertaking exams, from the early examinations through to the Fellowship Examination.

The Skills Training Department delivered 140 courses to 2,435 participants, and a new course, Training in Professional Skills (TIPS), was introduced.

An eLearning department was established to support the in-house development of on-line learning modules for Fellows, Trainees and IMGs. Seven modules were released to the website and a further 11 are in various stages of development.

HIGHLIGHTS 2013

Education and Training Administration

An in-house legal service was implemented.

Partnering Agreements were successfully negotiated with five specialty societies.

The Specialist Training Program (STP) Agreement was extended for an additional two years.

HIGHLIGHTS 2013

Fellowship and Standards

In collaboration with the Australian Institute of Health and Welfare, the College reviewed and redeveloped the categorisation system for elective surgery in Australia.

Six eLearning modules were introduced (SAT SET, SAT SIT, NOTSS, Indigenous Health, Neurotrauma, Cultural Competence).

A new online CPD program was introduced. It is now annual and features greater transparency and accountability.

A new College website, personalised and interactive, was launched.

New resources and services were made available through the online library.

particularly fortunate in having their wisdom around the Council table, actively contributing to College debates and deliberations. Bettina Cass has indicated that she will not be continuing on Council and we are now seeking a replacement for her.

New Councillors welcomed after the Annual General Meeting were Lawrence Malisano, Julie Mundy, Alan Saunder, Anthony Sparnon, David Theile, Neil Vallance and Carolyn Vasey.

I would like to thank all the staff of the College who daily support the activities of the College at the discretion of Council. I have always been impressed by the willingness of the staff to provide an enthusiastic service and to go that extra mile to ensure the success of our activities. The College management has been particularly focused on upgrading the College's information technology infrastructure and handling the change management issues associated with this. Emphasis remains on the recruitment and retention of capable staff, and we deliberately have in place policies that ensure flexibility of practice and the provision of the highest levels of support. Only then can we achieve the excellence of service that Fellows and Trainees quite rightly expect. The College Chief Executive Officer, David Hillis, who co-authored this report, continues to provide management support to myself as President and to Council in all its activities. I thank him for his great work.

The College employs a number of Fellows on staff who undertake distinct roles where surgical input is critical. Bruce Barraclough AO retired from the role as Dean of Education and Stephen Tobin has been appointed to this key role. I would personally like to thank Bruce for his decades of contribution to the College in many roles. Campbell Miles also retired from the role of ASC Coordinator after the highly successful ASC in Kuala Lumpur, with Roger Wale being appointed as his successor. Andrew Roberts retired from the role of Clinical Director of the IMG Assessment Unit with Peter Dohrmann now appointed. Other Fellows on staff include John Quinn, Executive Director of Surgical Affairs Australia; Allan Panting, Executive Director of Surgical Affairs New Zealand; Don Murphy, Clinical Director Victoria Skills Centre, and Guy Maddern, Clinical Director ASERNIPs.

The Clinical Directors of the Mortality Audits play a key role. Colin Russell retired from the role in Victoria with Barry Beiles now appointed as his replacement. Other Clinical Directors are James Aitken (Western Australia), Glenn McCulloch (South Australia), Bob Bohmer (Tasmania), John North (Queensland), John Tharion (ACT) and Michael Fernside AM who is involved with the Mortality Audits in New South Wales.

Serving the Fellowship as President is an enormous honour and privilege. I do extend my thanks to you all. I particularly thank my partner Jane who provides incalculable support to me in this role and in all my other activities. Without the support of our partners, our roles would be very different.

ACTIVE SET TRAINEES

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	Total 2012	Total 2011	% Change 11/12
Year 1	5	86	6	42	17	4	59	19	238	42	0	280	290	-3.4
Year 2	8	90	2	35	12	3	48	19	217	44	1	262	242	8.3
Year 3	1	64	0	27	14	2	54	15	177	42	1	220	253	-13.0
Year 4	0	51	1	42	11	1	53	13	172	29	2	203	351	-42.2
Year 5	0	35	0	22	6	0	28	7	98	4	0	102	55	85.5
Year 6+	0	6	0	1	2	0	5	1	15	3	1	19	33	-42.4
Total	14	332	9	169	62	10	247	74	917	164	5	1086	1224	-11.3

ACTIVE FELLOWS OF THE COLLEGE

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	Total 2012	Total 2011	% Change 11/12
CAR	5	54	0	34	9	3	53	11	169	23	22	214	209	2.4
GEN	16	524	15	256	127	27	416	120	1502	229	154	1885	1806	4.4
NEU	4	74	0	38	15	5	56	17	209	20	28	257	246	4.5
ORT	24	385	6	239	102	19	280	108	1163	256	52	1471	1419	3.7
OTO	8	140	2	78	42	7	104	39	420	77	23	520	503	3.4
PAE	4	30	0	13	8	2	23	8	88	16	25	129	125	3.2
PLA	5	108	2	59	38	10	122	40	384	56	21	461	440	4.8
URO	4	116	1	73	29	10	92	33	358	52	21	431	412	4.6
VAS	3	57	1	35	16	4	46	12	174	17	2	193	184	4.9
Total	73	1488	27	825	387	87	1192	388	4467	746	348	5561	5344	4.1

Treasurer's Report

Marianne Vonau, TREASURER

It is my pleasure to present this report and highlight the financial position of the College. The year under review has seen continued positive financial performance achieved from the combined business activities of the College. The investment portfolio has performed strongly and achieved a positive return of 17% as capital markets experienced a considerable period of growth in the second half of the year. This continues to provide a secure ongoing source of funding for the College's commitment to scholarship and research grant related activities. The year has also seen continued investment in information technology for key education initiatives. As well there has been substantially increased funding to the Specialty Societies to deliver surgical training programs in partnership with the College.

Statement of Comprehensive Income

Total operating revenue (excluding investment activities) in 2012 was $53,623k compared to $47,878k in 2011 while expenditure was $54,845k compared to $48,014k in 2011. Due to the gain on investments of $5,805k compared to a loss of $1,476k in 2011 the overall surplus was $4,583k compared to a deficit of $1,612k in 2011.

Dominant revenue streams were Subscriptions and entrance fees of $11,406k, Training examination and assessment fees of $18,881k and Project income and associated fees of $15,367k. Dominant expenditures were on Personnel of $17,373k, Travel and accommodation of $5,349k and Specialist Society funding costs of $4,030k. It is worth noting that travel and accommodation costs are substantially funded from income generated from skills training courses, examinations and co-ordination of domestic and international health service project programmes.

The most meaningful way in which to review this overall result is to analyse the separate activities of the College being College Operations, College Projects funded by external agencies, and Scholarships, Fellowships and Research Grants funded through the Foundation and Investment Reserve.

College Operations are the core operational activities including Fellowship Services, Education and Training, the Annual Scientific Conference and Conferences and Workshops with the required supporting leadership, governance and administrative structures.

In 2012, this revenue amounted to $35,538k compared to $34,407k in 2011 while expenditure was $37,167k compared to $34,638k in the previous year. The deficit in 2012 was $1,629k compared to a deficit of $231k in 2011.

The following significant items were of considerable impact on the reported operational result.

The revenue recognised from subscription fees was approximately $290k less than budgeted due to higher than projected number of Fellows applying for a concessional subscription rate.

As reported previously, the New South Wales building has been sold with a subsequent move into rented offices. The Queensland building is in the process of being sold. The New Zealand property located in Wellington is subject to seismic strengthening requirements. Although Council is yet to decide on the options for the future, a cost provision of NZD$815k (AUD$647k) has been recorded to recognise a present legal obligation to remedy the building.

Payment to the Specialty Societies for delivering their component of the training program increased from $3,536k in 2011 to $4,030k in 2012. Additional support to the Specialties also continues in activities like the RACS Speakers at scientific meetings and the expansion of the on-line library. Legal support is increasingly required in our educational activities with the overall audit, legal and professional fees increasing from $609k in 2011 to $770k in 2012.

The College continues to invest in upgrading the information technology platform to support educational initiatives. The costs of this are reflected in the Information System costs of $1,111k in 2012 and $1,342k in 2011.

The College is challenged to maintain a balanced operational budget, but due to the College's diverse business activities its funding reserves continue to grow and underpin the College's long term financial stability and ability to invest in its core operations into the future.

College Projects relate to activities funded by external agencies and funding providers.

The College is responsible for managing international and local aid projects as well as research and audit projects with a total value over the project life in excess of $86.8 million (2011 - $71.9 million). Projects currently being managed include the Timor Leste Program (ATLASS), Pacific Islands Program IV, Pacific Islands Program Tertiary Health Services, Rural Health Continuing Education Program, Specialist Training Program, MSAC, Horizon Scanning, Mortality Audit and Morbidity Audit and Surgical Simulation.

In 2012, total project revenue amounted to $15,472k compared to $11,957k in 2011 and expenditure was $16,347k compared to $11,857k in 2011 resulting in a deficit of $876k in 2012 compared to a surplus of $100k in 2011.

The main reason for the reported 2012 deficit was accounting for the internal surplus transfer of $716k from the Pacific Islands Program III closed project to the Foundation for International projects. In real terms after removing this internal transfer the overall deficit result was $160k.

The majority of projects are fully covering their overhead costs, which has resulted in a steady decrease in the need for cross subsidisation by the College

The net overhead charge levied on projects was $923k compared to $893k in 2011 which reflects the costs of the College's infrastructure and governance.

Foundation and Investment Reserve – Scholarships, Fellowships and Research Grants

The Foundation activities encompass the areas of scholarships, fellowships and research grants as well as direct oversight of its philanthropic endeavours. The Investment Committee provides the direct oversight of the investment activities, the Board of Surgical Research the oversight of the research scholarships and grants and the International Committee the oversight of the international scholarships and other initiatives.

Revenue included the positive investment return of 17% on bequest funds, donations from the Rowan Nicks Estate, transfer of the Pacific Islands Program III surplus, together with ongoing support of the RACS Scholarship Corpus and other philanthropic activities. The overall increase in the Foundation related funds was from $22,863k (2011) to $28,150k (2012). The investment reserve also increased to $4,482k.

Scholarships of $637k (2011 - $819k) were funded from bequest funds with $547k (2011 - $397k) funded from the RACS Scholarship corpus. The total commitment was $1,184k (2011 - $1,216k).

Statement of Financial Position

In 2012, College Funds and Reserves have increased by 9.5% to $53,088k.

Key movements in assets included an increase in cash and cash equivalents of $798k primarily due to timing of receipts from annual subscription and training fees in 2012 and decrease in current receivables of $2,922k. Investments held for trading increased by $8,516k mainly due to the positive investment return of 17% and capital contribution $2,080k to the Rowan Nicks Scholarship corpus. Current liabilities increased by $1,613k which was mainly due to an increase in subscription, training and examination billed in 2012 for income related to 2013. The Investment Reserve has increased from $2,649k to $4,482k due to the positive investment return.

Statement of Cash Flows

The Statement of Cash Flows indicates a net cash inflow for 2012 provided from operating activities of $5,183k and a net increase in cash held of $798k from 2011 mainly due to the combined effects of early billing of the 2013 annual training fees, donation income from Rowan Nicks estate and net sale proceeds of $2,811k from the NSW property.

In summary, some of the key 2012 achievements of the College included:

- Delivered 140 skills training courses to 2,435 participants.
- Increased resources and services via the online library with approximately 70% of visits to the College website to source online library information.
- Development of 6 new eLearning modules and the new CPD program.
- Continued work in partnership with AusAID to deliver training and strengthen surgical skills in a range of international aid programs for the Pacific Islands, Papua New Guinea, East Timor and Myanmar with a combined contract value of $14.3 million.
- Launch of the Morbidity Audit and Logbook Tool (MALT) to replace the legacy logbook system.

In closing I would like to acknowledge the services of our Honorary Advisers for which the College remains indebted. I note my thanks to Mr Anthony Lewis (Audit & Finance), Mr Brian Randall (Investment), Mr Stuart Gooley (Audit & Finance), Mr Reg Hobbs (Property), Mr Michael Randall (Investment), Mr John Craven (Information Technology) and Mr Chesley Taylor (Investment) for their generous and valued support during the year. The College is extremely grateful to all our Honorary Advisors for their wise counsel and support in relation to finance, investment, property, IT and audit matters. I would also like to thank the management and staff of the Division, led by the Director of Resources, Mr Ian T Burke, for their ongoing hard work and commitment in support of my role.

The College continues to maintain a strong Balance Sheet and is financially well positioned to meet its ongoing commitments and I recommend these accounts to the Fellows.

Councillors' declaration

The Councillors of the Royal Australasian College of Surgeons declare that the summarised financial report set out below have been derived from and are consistent with the full financial report of the Royal Australasian College of Surgeons for the year ended 31 December 2012.

On behalf of the Councillors
M J HOLLANDS, President
M VONAU, Treasurer
D J HILLIS, Chief Executive Officer
Melbourne, 22 March 2013

Independent Audit Report to Members of Royal Australasian College of Surgeons

We have audited the summarised financial report of the Royal Australasian College of Surgeons as at 31 December 2012, comprising the Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows, in accordance with Australian Auditing Standards. The summarised financial report has been derived from the Royal Australasian College of Surgeons annual statutory financial report for the year ended 31 December 2012.

Audit Opinion

In our opinion, the information reported in the summarised financial report is consistent with the annual statutory report from which it is derived and upon which we expressed an unqualified audit opinion. For a better understanding of the scope of our audit, this report should be read in conjunction with our audit report on the annual statutory financial report.

ERNST & YOUNG,
PAUL GOWER
Partner

STATEMENT OF COMPREHENSIVE INCOME
For the financial year ended 31 December 2012

	Notes	2012 $	2011 $
Continuing Operations			
Revenue from operating activities		53,629,356	46,716,893
Gain on sale of NSW property		(5,833)	1,160,905
Other income / (loss) – from investments		5,805,262	(1,476,130)
Revenue		59,428,785	46,401,668
Expenditure			
Personnel costs		17,373,023	15,939,017
Consultants fees - clinical		850,745	882,240
Consultants fees - management		1,732,543	1,370,693
Telephone, teleconference and audio visual costs		726,148	731,249
Printing, stationery and photocopying		1,650,171	1,490,627
Postage and courier costs		701,380	621,534
Information system costs		1,111,898	1,342,248
Travel and accommodation		5,349,380	4,675,054
Associations and publications		449,548	285,799
Audit, legal and professional fees		770,818	609,085
Bank fees and merchant charges		534,419	464,497
Rent, rates, power, repairs and other property costs		2,168,537	1,550,629
Insurance		330,360	327,427
Project equipment purchases, hire and repairs		994,015	478,217
Training manuals and consumables used in education and field projects		524,176	731,951
Scholarships, fellowships and research grants		1,196,593	1,215,979
Awards, other grants, gifts and prizes		440,324	1,188,158
External grants		6,393,501	3,661,611
Facilities hire and catering costs		3,557,930	2,649,508
Foreign exchange loss		20,468	7,397
Depreciation expense		2,500,863	2,574,002
Impairment charge		9,305	-
Amortisation expense – lease incentive		44,038	-
Specialist societies funding costs		4,030,205	3,536,041
Committee and office bearers costs		69,219	65,588
Doubtful debts expense / (reversal)		18,749	13,648
QSEC write-off – development and legal costs		106,958	1,351,852
Provision charge – NZ building strengthening works		646,415	-
Other expenses from operating activities		511,979	202,155
Expenditure		54,813,708	47,966,206
Surplus / (Deficit) for the period		4,615,077	(1,564,538)
Other Comprehensive Income			
Foreign currency translation		(32,041)	(47,276)
TOTAL SURPLUS / (DEFICIT)	5	4,583,036	(1,611,814)

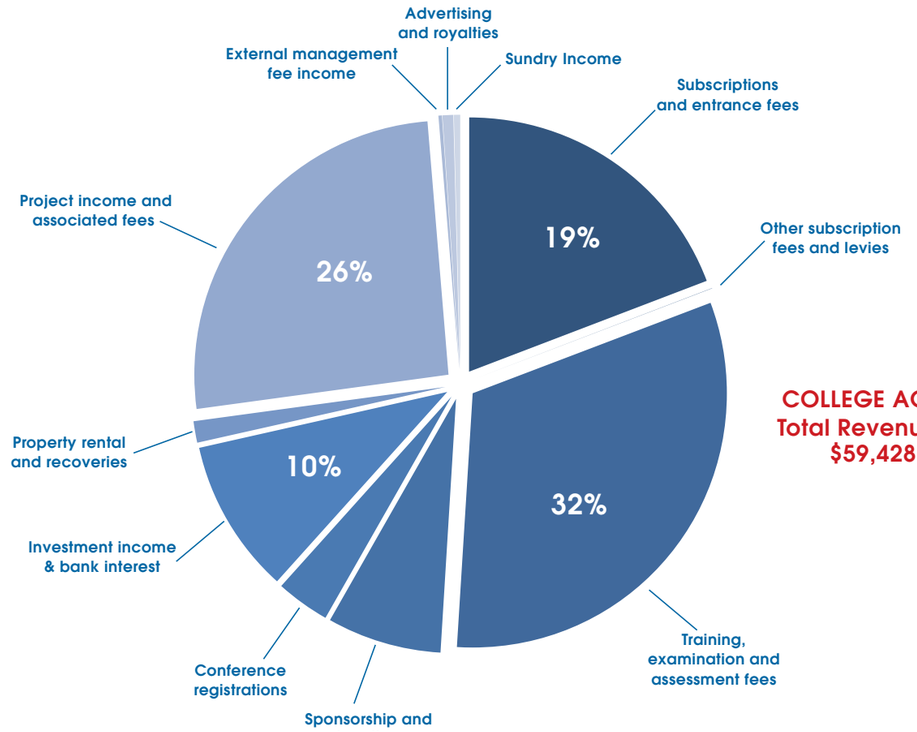
STATEMENT OF FINANCIAL POSITION
For the financial year ended 31 December 2012

	Notes	2012 $	2011 $
ASSETS			
Current Assets			
Cash and short term deposits	6	11,379,273	10,581,605
Trade and other receivables	7	16,046,462	18,968,151
Inventories	8	220,094	167,138
Prepayments		1,927,022	1,547,226
Held for trading financial assets	9	37,435,219	28,919,322
Property held for sale	10	872,150	-
Total Current Assets		67,880,220	60,183,442
Non-Current Assets			
Trade and other receivables	11	832,451	763,798
Property, plant and equipment	12	23,863,091	24,768,464
Lease Incentive	13	604,422	-
Total Non-Current Assets		25,299,964	25,532,262
TOTAL ASSETS		93,180,184	85,715,704
LIABILITIES			
Current Liabilities			
Trade and other payables	14	4,025,926	4,189,733
Provisions	15	2,485,147	2,391,274
Income in advance	16	20,203,353	19,298,200
Government grants received in advance		7,414,923	7,325,662
Funds held on behalf of others	17	4,405,549	3,716,987
Total Current Liabilities		38,534,898	36,921,856
Non-Current Liabilities			
Provisions	18	1,556,866	288,464
Total Non-Current Liabilities		1,556,866	288,464
TOTAL LIABILITIES		40,091,764	37,210,320
NET ASSETS		53,088,420	48,505,384
Retained earnings		48,505,384	50,117,198
Current year surplus / (deficit) – operations		2,749,764	(948,702)
Current year surplus / (deficit) - investment reserve		1,833,272	(663,112)
TOTAL COLLEGE FUNDS AND RESERVES		53,088,420	48,505,384

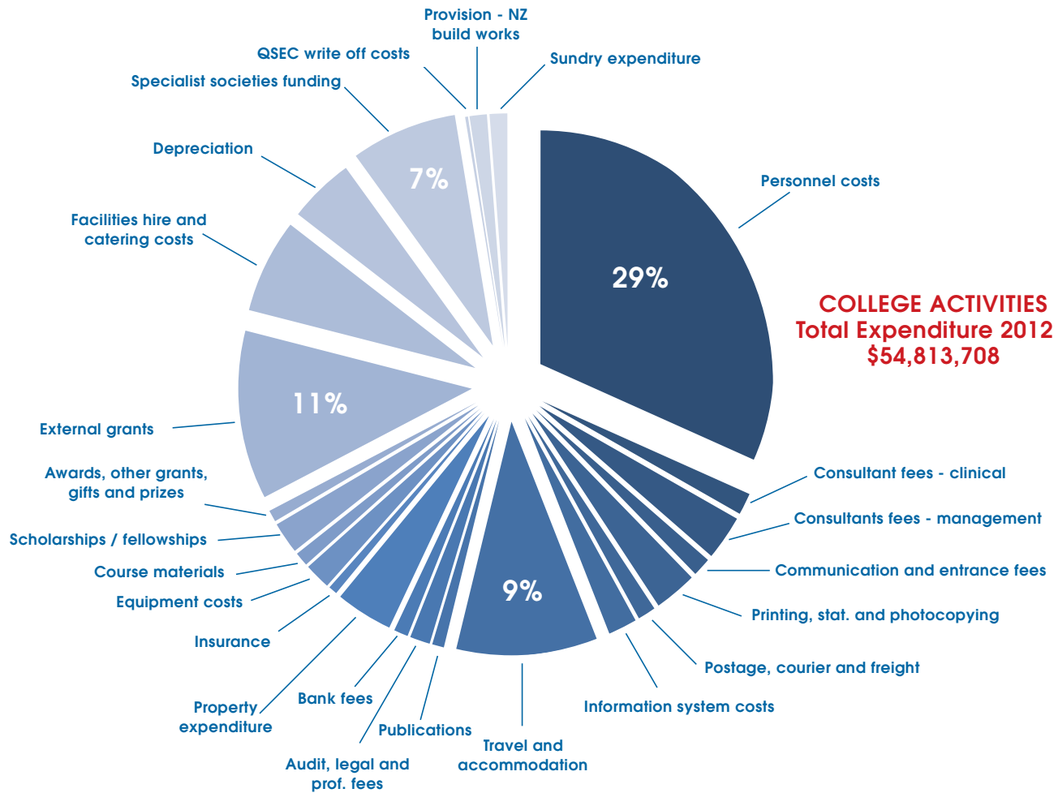
Certain lines of items required in the ACFID Code of Conduct reporting including but not limited to investment property, intangibles, borrowings and current tax liabilities have nil balances for both the reporting periods covered.

STATEMENT OF CASH FLOWS
For the financial year ended 31 December 2012

	Notes	2012 $	2011 $
ASSETS			
Operating Assets			
Subscriptions and entrance fees		11,510,863	9,563,176
Training, examination and assessment fees		19,061,703	17,889,752
Sponsorship and donations		1,796,896	2,153,330
Other donations – Rowan Nicks estate		2,078,647	1,000,000
Conference registrations		1,991,674	1,283,351
Property rental and recoveries		792,575	927,881
Project income and associated fees		14,862,465	16,987,601
Interest income		37,701	35,671
Other income		641,270	336,535
Payments to suppliers and employees		(47,590,368)	(42,544,266)
Net cash flows from operating activities	6	5,183,426	7,633,031
Investing activities			
Net movement from investment securities		(4,494,227)	(3,823,815)
Payments for property plant and equipment		(2,702,084)	(3,932,412)
Net proceeds from sale – NSW property		2,810,553	-
Net cash flows used in investing activities		(4,385,758)	(7,756,227)
Financing activities			
Net cash flows used in financing activities		-	-
Net increase/(decrease) in cash and cash equivalents		797,668	(123,196)
Cash and cash equivalents at 1 January 2012		10,581,605	10,704,801
Cash and cash equivalents at 31 December 2012	6	11,379,273	10,581,605



COLLEGE ACTIVITIES
Total Revenue 2012 - $59,428,785



COLLEGE ACTIVITIES
Total Expenditure 2012 - $54,813,708

ACFID CODE

International Aid and Development

Information provided under the ACFID Code of Conduct

The College is a signatory member of the Australian Council for International Development (ACFID). The ACFID Code of Conduct is a voluntary self-regulatory code of good practice that aims to improve international development outcomes and increase stakeholder trust by enhancing the accountability and transparency of signatory members.

As a signatory to the Australian Council for International Development (ACFID) Code of Conduct, the College is committed to high standards in financial reporting, management and ethical practice. Further information on the code , including how to make a complaint, can be obtained from ACFID by visiting www.acfid.asn.au or emailing code@acfid.asn.au. Complaints in relation to the Code can be made directly to the International Development Program by telephone: +61 3 9276 7436 or email: international.projects@surgeons.org. Any complaints will be handled in line with the College Complaints Process Policy.

The Summary Financial Reports disclosed below have been prepared in accordance with the requirements set out in the ACFID Code of Conduct. For further information on the Code please refer to the ACFID Code of Conduct Implementation Guidance available at **www.acfid.asn.au**

An independent audit of the Royal Australasian College Of Surgeons financial accounts for 2012 was conducted by:

Paul Gower – Partner – Assurance
Ernst and Young
8 Exhibition Street
Melbourne VIC 3000
+ 61 3 9288 8218

STATEMENT OF CHANGES IN EQUITY
For the year ended 31st December 2012

	Retained Surplus	Investment Earnings Reserve	Total College Funds & Reserves
At 1 January 2011	43,705,337	6,411,861	50,117,198
Surplus / (Deficit) for the year	(1,564,538)	-	(1,564,538)
Other comprehensive income	(47,276)	-	(47,276)
Surplus / (Deficit) for reserve	663,112	(663,112)	-
Transfer to / (from) reserve	3,100,000	(3,100,000)	-
At 31 December 2011	45,856,635	2,648,749	48,505,384
Surplus / (Deficit) for the year	4,615,077		4,615,077
Other comprehensive income	(32,041)		(32,041)
Surplus / (Deficit) for reserve	(1,833,272)	1,833,272	-
Transfer to / (from) reserve	-	-	-
At 31 December 2012	48,606,399	4,482,021	53,088,420

INCOME STATEMENT
For the year ended 31st December 2012

	2012 $	2011 $
International Aid and Development Programs		
REVENUE		
Donations and gifts – monetary	238,432	273,606
Donations and gifts – non-monetary	-	-
Bequests and legacies	2,078,647	1,000,100
Grants – AusAID	3,759,893	4,251,054
Grants – Other Australian	278,465	376,512
Grants – Other Overseas	218,525	197,123
Investment income	893,839	(99,927)
Other income – International programs	25,083	418
Revenue for international political or religious proselytisation program	-	-
Total Revenue	7,492,884	5,998,886
International Aid and Development Programs		
EXPENDITURE		
International Programs		
Funds to international programs	1,463,463	1,550,165
Other international program costs	2,058,167	1,152,174
Program support costs	757,288	774,613
Community education	-	-
Fundraising costs		
Public	-	-
Government, multilateral and private	-	-
Accountability and administration	139,751	144,218
Non-monetary expenditure	-	-
Expenses for international political or religious proselytisation program	-	-
Total Expenditure	4,418,669	3,621,170
Balance of bequests, legacies, grants and income for use in following years	3,074,215	2,377,716

STATEMENT OF CASH MOVEMENTS
For the year ended 31st December 2012

	Cash available at beginning of financial year	Cash raised during financial year	Cash disbursed during financial year	Cash available at end of financial year
International Projects	3,558,090	4,245,804	4,345,319	3,458,575
International Scholarships provided by the College from bequest funds	2,995,970	2,864,262	261,130	5,599,102
Foundation – International Projects	789,523	1,147,653	587,850	1,349,326
Total	7,343,583	8,257,719	5,194,299	10,407,003

NEW FELLOWS

Dr Eric Slimani
Dr Gregory Rice
Miss Indra Nordstrand
Dr Michael Harden
Mr Philip Hayward
Dr Prashant Joshi
Dr Adam Cichowitz
Dr Aileen Yen
Dr Alan Tien
Dr Amanda Foster
Mr Amro Labib
Prof Andrea Mueller
Dr Andrew Finlayson
Mr Anthony Ciccocioppo
Dr April Wong
Dr Arif Valibhoy
Dr Ba Nguyen
Dr Benjamin Woodham
Mr Bernard McEntee
Dr Carolyn Jameson
Dr Casper Pretorius
Dr Chek Tog
Dr Chilton Chong
Dr Christopher Dobbins
Dr Christos Apostolou
Dr Chuan Tan
Mr Damien Loh
Dr Daniel Nguyen
Dr David Links
Dr David Wardill
Dr David McCallum
Dr Don Jayasuriya
Dr Douglas Stupart
Ms Elisabeth Rippy
Dr Emily Davenport
Dr Emmanouel Roussos
Dr Gareth Carr
Dr George Kalogeropoulos
Dr Gregory Nolan
Dr Heidi Cameron
Dr Irandi Jayatilleke
Dr Jacob McCormick
Dr Janine Arnold
Dr Jason Brown
Dr Jiun Lai
Dr Joy Chakraborty
Mr Kareem Marwan
Dr Katherine Gale
Mr Kian Tan
Dr Kim-Chi Phan-Thien
Dr King-Sang Wong
Mr Lee Ong
Dr Lee Brewster
Dr Luke Rayner
Dr Manju Chandrasegaram
Dr Mara Clarson
Prof Marc Gladman
Dr Maria-Pia Bernardi
Dr Marianne Lill
Dr Marius Jordaan
Dr Mark Romero
Dr Meegodage Perera
Dr Melinda Van Oosterum
Dr Mena Shehata
Dr Michael Ng
Dr Michael Tan
Dr Michael Yunaev
Mr Mohammed Ballal
Mr Moses Balabyeki
Dr Muzib Abdul Razak
Dr Naseem Mirbagheri
Dr Natalie Zantuck
Dr Navin Rudolph
Dr Nicholas Ngui
Mr Nicholas Evennett
Mrs Nita Bartlett
Dr Paul Lambrakis
Dr Penelope De Lacavalerie
Dr Phillip Malouf
Dr Priscilla Martin
Dr Rajeshbhai Patel
Dr Ramez Bassari
Dr Ravi Rao
Dr Rezvaneh Shakerian
Dr Rosemary Hepworth
Dr Samuel Rice
Dr Sanjaya Karunaratne
Dr Sanjeev Golani
Dr Sebastian Rodrigues
Dr Shahrir Kabir
Dr Shanta Velaiutham
Mr Simon Harper
Dr Simone Ramsay
Dr Simone Geere
Dr Sinan Albayati
Dr Siva Ravindran
Dr Sophie Nightingale
Dr Stephanie Chetrit
Dr Timothy Slack
Mr Todd Hore
Dr Tony Pang
Dr Tony Palasovski
Dr Tulsi Menon
Dr Universe Leung
Dr Vineeta Singh
Dr Yi He
Mr Ying-Ruey Yong
Dr Young-Chul Oh
Mr Alexis Adamides
Dr Christian Schwindack
Dr Damian Amato
Dr Ioannis Sergides
Dr Kelvin Woon
Dr Kristian Bulluss
Assoc Prof Matthias Jaeger
Dr Thomas Pitham
Dr Tony Goldschlager
Mr Abhay Khot
Mr Adriaan Smith
Dr Adrian Low
Dr Agus Kadir
Dr Andrew Matthews
Dr Audi Widjaja
Dr Brendan Ricciardo
Dr Brett McClelland
Mr Christopher Wainwright
Dr Constantine Glezos
Dr Craig Hughes
Dr Daniel Goldbloom
Dr Daniel Mandziak
Mr David Bartle
Dr David Bade
Dr David Shepherd
Dr David Bell
Dr David Templeton
Dr David Dillon
Mr Dion Noovao
Dr Farnaz Yassaee
Dr Gareth Prosser
Mr George Bousounis
Dr George Konidaris
Dr Hardeep Salaria
Mr Harry Clitherow
Assoc Prof Herwig Drobetz
Dr Ian Yuen
Dr Ikram Nizam
Dr Jai Kumar
Dr Jaideep Rawat
Dr James Canty
Dr Jason McDarra
Dr Jason Tsung
Dr Jeffrey Ling
Dr Jeremy Stanley
Dr Joerg Rhau
Dr Jonathan Robin
Dr Joseph Smith
Dr Joshua Hunt
Dr Justin Webb
Mr Kosta Calligeros
Dr Krishnan Rajesh
Dr Luke McDermott
Mr Luke Spencer
Mr Marc Hirner
Dr Marcus Chia
Mr Matthew Boyle
Dr Matthew Alfredson
Dr Melissa Rossaak
Dr Nicholas Lash
Dr Parminder Singh
Dr Paul McEniery
Mr Peter Misur
Dr Peter Sharr
Prof Richard Carey-Smith
Dr Satyen Gohil
Dr Sean Suttor
Dr Shane Prodger
Mr Simon Smith
Dr Simon Johnson
Mr Soong Chua
Mr Timothy Lording
Dr Timothy Small
Dr Vivek Shridhar
Dr Amanda Richards
Dr Angela Butler
Dr Claire Iseli
Dr Darin Bilish
Dr Daron Cope
Dr David Hall
Mr David Wright
Dr Emily Perry
Dr Jacques De Haan
Dr Kien Ha
Dr Lisa Wun
Dr Matthew Magarey
Dr Niranjan Sritharan
Dr. Peter Santa Maria
Dr Raewyn Campbell
Dr Sarah Morrison
Dr Sharad Chawla
Dr Theodore Athanasiadis
Dr Veronika Van Dijck
Assoc Prof Wouter-Jan Ten Cate
Dr Camille Wu
Dr Mohan Marulaiah
Dr Parshotam Gera
Dr Sarah Condron
Dr Warwick Teague
Dr Yves Heloury
Mr Ajay Chauhan
Dr Alex Yuen
Dr Amy Jeeves
Dr Andre Safvat
Dr Andrew Castley
Dr Brandon Adams
Dr Chaitanya Reddy
Mr Cheng Lo
Mr Clayton Lang
Mr Daniel Luo
Dr David Syme
Dr Edmund Ek
Dr Frank Lin
Dr Frederick Clarke
Dr Guy Watts
Dr Joseph Rizk
Dr Marcus Wagstaff
Mr Michael Thomson
Dr Michael Wagels
Dr Robert Toma
Dr Rostam Farhadieh
Dr Samuel Yang
Mr Siddharth Karanth
Dr Tai Lam
Dr Ahmad Ali
Dr Ailsa Wilson Edwards
Dr Andrew Lienert
Dr Anthony Kiosoglous
Dr Balasubramaniam Indrajit
Mr Benjamin Thomas
Dr Conrad Bishop
Dr Daniel Spernat
Mr David Pan
Dr Ding Yu Guo
Dr Elayne Ooi
Dr Elizabeth Dally
Dr Ian Vela
Dr Jacob Gleeson
Dr Jason Paterdis
Dr Jen Lee
Dr Johannes Goossen
Mr Matthew Threadgate
Dr Nicholas McLeod
Mr Philip Dundee
Dr Richard Haddad
Dr Robert Coleman
Dr David Airey
Dr Delfino Di Mascio
Dr Isuru Nammuni
Dr Nadia Blest
Dr Rebecca Jack
Dr Shen Wong
Dr William Butcher

DECEASED FELLOWS

Australia

Mr Terence William Horne
Mr John Ernest Dunlop Goldie, AM
Mr George William Westlake, AM
Mr Robert Fyfe Zacharin, AO
Mr Harold Keith McComb
Mr Lionel Allenby Jacobs
Sir Keith Stephen Jones
Mr Franklyn Gilbert Bell
Mr Fergus Roy Wilson
Prof Richard Spencer Butler Gye, AO
Mr Richard Lloyd Cahill, MBE
Mr Peter John Heery
Mr John Egan Moulton, OAM
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