Surgical news

Vol: 12
No:3
April
2011

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Beneath our feet

Surgeons on the ground in Christchurch PAGE 8

The College of Surgeons of
Australia and New Zealand

Professional Development WORKSHOPS

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

>Supervisors and Trainers for SET (SAT SET)

23 March 2011, Perth, 5 April 2011, Melbourne, 2 May 2011, Adelaide (pre ASC)

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. Participants will learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. The workshop offers an opportunity to explore strategies to improve the management of trainees; especially those that are underperforming. It focuses preparing for, conducting and reviewing a mid-term meeting. It is also an excellent opportunity to gain insight into the College's training policies and legal requirements.

>Keeping Trainees on Track (KToT)

2 May 2011, Adelaide (pre ASC) ***NEW***

'Keeping Trainees on Track' is a new workshop in the 'Supervisors and Trainers for SET' (SAT SET) series. Over 3 hours it explores how to performance manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. Participants are also given the opportunity to learn methods for encouraging self-directed learning by establishing expectations at the start of term meeting.

>Occupational Medicine

8 April 2011, Melbourne, 2 May 2011, Adelaide (pre ASC)

Doctors are increasingly expected to participate in the process of helping patients return to work. Understanding a patient's working environment, restrictions and the alternative work roles available can improve communication and assist doctors to better advise patients about the timing of operations and their return to work. Each one day course includes a guided tour of the operations for one or more factories, case study presentations of successful return to work events by recovering workers and treating doctor plus information about the sites' Return to Work programs.

Proudly supported by an educational grant from Worksafe Victoria

>Practice Made Perfect

2 May 2011, Adelaide (pre ASC)

This new whole day workshop focuses on the unique challenges of running a surgical practice. Learn more about the six principles of running a surgical practice. Practice managers and practice staff are encouraged to join these workshops for a valuable learning experience. Fellows are also welcome.

>Sustaining Your Business

27-29 May 2011, Brisbane

Effective business and financial planning is more important than ever for both private clinical practices and the broader health service delivery environment. This two and a half day workshop provides the foundation for the development and implementation of business plans to sustain business growth and performance. It explores financial management; from the preparation and analysis of responsible budgetary plans, decision making, management and reporting to the development of estimates and capital investment proposals.

Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development.

2011 DATES:
APRIL – AUGUST

NSW

>**11 June, Sydney**
Keeping Trainees on Track (KToT)

>**28 June, Sydney**
Supervisors and Trainers for SET (SAT SET),

>**8 August, Sydney**
Surgeons and Administrators: Working Together to Bridge the Divide

>**26-28 August, Sydney**
Process Communication Model,

>**TBC**
Occupational Medicine, Sydney

QLD

>**27-29 May, Brisbane**
Sustaining Your Business

>**6 July, Brisbane**
AMA Impairment Guidelines Level 4/5: Difficult Cases

>**5 August, QLD ASM**
Practice made Perfect

>**TBC**
Occupational Medicine, Brisbane

SA

>**29 April – 1 May, Adelaide**
Younger Fellows Forum

>**2 May, Adelaide (pre ASC)**
Introductory workshop- PCM Communication Course

>**2 May, Adelaide (pre ASC)**
Keeping Trainees on Track (KToT)

>**2 May, Elizabeth (pre ASC)**
Occupational Medicine

>**2 May, Adelaide (pre ASC)**
Polishing Presentation Skills

>**2 May, Adelaide (pre ASC)**
Practice Made Perfect

>**2 May, Adelaide**
Supervisors and Trainers (SAT SET)

VIC

>**25 June, Melbourne**
Making Meetings More Effective

>**12 July, Melbourne**
Keeping Trainees on Track (KToT)

>**22-24 July, Melbourne**
Process Communication Model

>**29-30 July, Melbourne**
From the Flight Deck: Improving Team Performance

WA

>**11 June, Perth**
Keeping Trainees on Track (KToT)

>**26 August, Perth**
AMA Impairment Guidelines Level 4/5: Difficult Cases

NZ

>**17 August, Auckland**
Keeping Trainees on Track (KToT)

ON THE COVER: The damage in Christchurch. Photo courtesy of Helen O'Connell.

contents

Participants gathered at the Royal Australasian College of Physicians (RACP) in Sydney for a Medical Education Seminar including RACS, the Royal College of Physicians and Surgeons of Canada and RACP.

Where is professionalism in health reform?

A number of things must be considered when dealing with political reforms

Ian Civil
President

As citizens we are well aware of the necessity for politicians to make changes and institute reform. With the passage of time, it is natural that the paradigms under which we deliver healthcare to the community will change and reform will be introduced to try and improve outcomes. As health professionals we have many obligations including the expectation that we will ensure the fair and just allocation of health resources to those in need. Our politicians, however, have some other drivers.

While commitment, altruism and morality are hopefully some of the tenets of both medical professionalism and political life, our representatives also have other imperatives. They work in a paradigm where success is inevitably judged by popularity and outcomes at the polls. So where does that leave us when we try and judge the applicability of medical reform? Ultimately we need to base our opinion on what, from our medical perspectives, is for the ultimate good of the community as a whole. We must think not only about how a reform would affect the delivery of healthcare to a specific patient, but also society at large.

But what would the patients really want out of health reform?

In the feedback that has been gathered in relation to the present round of Australian health reform, patients have indicated that they want to be able to reliably access health services, with the ▶

care being of a standard and quality where their safety is guaranteed and the delivery is supportive of them as individuals and also their families. They want to know what the impact of the many options really means.

If they do access the private sector then what are the requirements and the out of pocket costs? If they do rely on the public sector then what are the waiting times to gain an appointment to see the various specialists and if hospital care is needed then what are the waiting times for admission? Reasonably, the patients want some certainty about what is in front of them. Will the Australian health reforms provide that certainty? Much remains to be seen.

What about transparency?

A factor common to health reform on both sides of the Tasman has been the introduction of well publicised league tables, particularly those associated with KPIs. The oft-criticised four hour rule has now been instituted in Western Australia and in NZ the six hour rule forms part of a suite of six KPIs (another is improved access to elective surgery) that are enshrined in health policy. In NZ each District Health Board's performance against each of the six targets is published in the national newspapers every three months showing absolute performance as well as changes from the previous quarter.

The College has always been cautious of league tables because overseas experiences demonstrate that without risk adjustment, they are substantially flawed. There has been some evidence in the past that such rules inevitably lead to some gaming of the system with no particular improvement in the quality of the patient journey.

However, transparency is more than a reasonable expectation for our patients. We need to be able to measure improvements from the hospital reform. At an individual clinical level it is something that we support with our ongoing commitment to audit and peer review. It underpins the honesty of our clinical decision making and our technical skills.

Certainty versus uncertainty

Of course health reform and transparency are all about providing a clear expectation about health care delivery and ensuring that patients and society know not only what they are entitled to, but also how well they are receiving

International Committee Chair Professor David Watters presenting at the Medical Education Seminar.

"While commitment, altruism and morality are hopefully some of the tenets of both medical professionalism and political life, our representatives also have other imperatives."

it. This year has seen so much of the certainty that we associate with everyday life stripped away.

The floods and earthquakes in particular were widespread events that disrupted the fabric of society and placed the delivery of health services under severe stress. The on-going unfolding tsunami and nuclear disaster in Japan make us realise that despite the rigours of our own calamities, we have been spared so much.

Surgeons in disasters

As I am sure is happening in Japan, in Australia and NZ surgeons stepped up to the plate and delivered health care of a high standard despite the difficulties. Some events have clearly involved heroic acts, but underpinning those have been the efforts of every surgeon working hard to deliver standard care to members of the population in very non-standard circumstances. Those of us presently working largely in a business as usual environment can only admire the efforts of our colleagues and hope that in similar circumstances we would perform as well.

Professionalism

Both our calm and measured response to health reforms and our more frenetic and at times dramatic response to disaster scenarios have required surgeons to dig deeply into their reserve of professionalism. In times of calm this attribute can lay deeply within the medical community, with the underlying principles of honesty, commitment and competence the only overt signs.

In times of threat and disaster the underlying tenet of professionalism, namely the duty to put the interests of the patient ahead of those of the individual practitioner, becomes obvious. No one would doubt that the Urologist who performed an amputation in the cramped space of a collapsed building while the earth shook in Christchurch was behaving professionally; the challenge to surgeons is to ensure these principles are not lost in calmer times and less troubled settings.

Advocacy for our Fellows

Keith Mutimer
Vice President

A key role of the College is to ensure the right decisions are made

It has been a busy start to the year on the advocacy front with the College so far making three submissions to government.

The House of Representatives Standing Committee on Health and Ageing is currently conducting an inquiry into registration processes and support for Overseas Trained Doctors. This being a core activity for the College, we made an informed and constructive submission to the committee, highlighting the means by which OTDs (or International Medical Graduates as we call them) can be better supported.

Our key recommendations to the House of Representatives inquiry into OS Trained Doctors were:

- Satisfying a standard substantially comparable to Fellowship of the relevant specialist medical college should remain the standard for registration as a specialist in Australia.
- It is fundamental to patient safety that any Overseas Trained Doctor wishing to practise surgery in Australia attains the same standard.
- Federal and State/Territory jurisdictions consider funding assessment posts which are reserved for Overseas Trained Doctors wishing to practise surgery in Australia. These assessment posts should be based in major teaching hospitals with access to educational resources.
- Hospitals establish cooperative arrangements with each other to facilitate the movement of Overseas Trained Doctors between dedicated assessment posts and the more traditional posts currently utilised for the assessment of Overseas Trained Doctors.
- Overseas Trained Doctors should be encouraged to improve their language skills, and education providers and jurisdictions should develop courses to assist in this regard.
- Resources should be made available to enable Overseas Trained Doctors to familiarise themselves with, and prepare for, the examinations they are required to pass in order to practise in Australia.

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

Letters to the Editor should be sent to:
letters.editor@surgeons.org

Or The Editor, Surgical News
Royal Australasian College of Surgeons
College of Surgeons Gardens
250-290 Spring Street
East Melbourne, Victoria 3002
T: +61 3 9249 1200 F: +61 9249 1219
W: www.surgeons.org

ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd.
ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

At the time of writing the committee is conducting a series of public hearings into this matter and the College has been invited to participate in this process.

The Department of Health and Ageing recently sought responses to a discussion paper on Lead Clinicians Groups. These are being developed as part of the Federal Government's commitment to involve clinicians in the decision making processes which determine health policy and its implementation.

Regrettably, the discussion paper was narrowly focused, suggesting that clinicians should only be involved in decisions relating to issues of clinical practice. If this is indeed the government's intention and it has failed to honour earlier undertakings that clinicians would have genuine input into deliberations on such fundamental issues as resource allocation, service planning and provision, proposed investment in infrastructure, staffing and training.

The College's submission makes the point that Lead Clinicians Groups, if they are to have any value at all, must address the frustration felt by clinicians whose voices are no longer heard and who live daily with the effects of ill informed decisions made in distant bureaucracies.

We have also made a submission to the National Health and Medical Research Council in response to its discussion paper on proposed Advanced Health Research Centres in Australia.

The College endorsed the concept but added some important caveats. We expressed concern that the selection of such centres might be biased towards entities already receiving higher levels of NHMRC funding.

The College believes that a key determinant should be the overall funding that centres attract, as commissioned research is a reliable measure of excellence. The national and international profiles of those doing work at research centres should also serve as selection criteria.

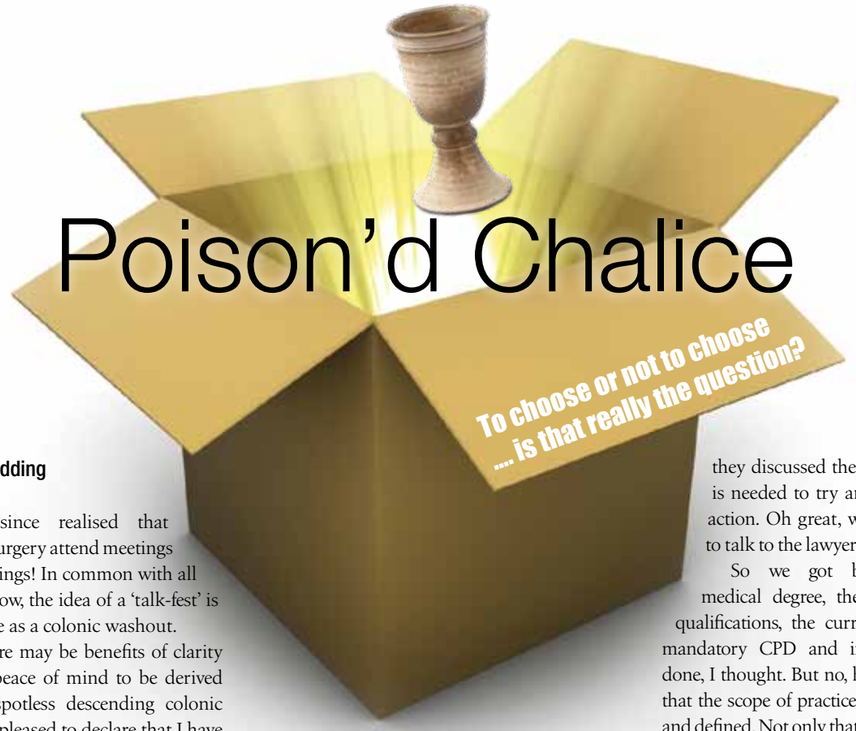
We further suggested that the proposed funding should be spread as widely as possible, rather than being aimed predominantly at academic units in Australia's large cities. This is because an academic presence is known to attract registrars.

If Advanced Health Research Centres have the effect of attracting clinicians to regional centres, and thereby helped redress the maldistribution of the Australian health workforce, they will have served a very useful, albeit secondary, purpose. Accordingly, we suggested that some of the centres would be ideally placed on the campuses of regional universities. Careful consideration should also be given to ensuring links between the centres and the delivery of primary care.

It was also noted that while research in the health sector has traditionally been focused on the biomedical and scientific areas, research also needs to be broadly focused, looking at such areas as health service delivery, quality analysis and broad system review. Given the perpetual reform of the health sector, formal research into organisational structures and change management is also important.

Indeed, it is this perpetual reform of the health sector which requires the College to invest time and effort in the work of advocacy. Irrespective of the colour of governments, the huge cost of health systems in Australia and New Zealand will always drive those governments to seek new ways of achieving more for less. Some of their ideas will be sound, others folly. It is imperative that surgeons help them make the right decisions.

I urge all Fellows to follow the College's efforts in this regard on the advocacy page of our website.



Poison'd Chalice

Professor U.R. Kidding

I have long since realised that Directors of Surgery attend meetings – lots of meetings! In common with all the surgeons I know, the idea of a 'talk-fest' is about as palatable as a colonic washout.

Of course there may be benefits of clarity of thought and peace of mind to be derived from having a spotless descending colonic mucosa but I am pleased to declare that I have no personal knowledge.

When the invitation to attend a Department of Health forum for Surgical Directors from around the state arrived, I began to formulate the development of a "last minute emergency" requiring my attendance – lame maybe, but understandably legitimate.

Alas, my plans unravelled when I was contacted by my CEO with warnings that the Department was a wake up to me and they had been mentioning my name as a virtual appointment.... Sheepishly I had hung up the phone, mumbled and decided that perhaps I had better attend.

The forum was on the changes to the requirements for selection processes and credentialing for surgeon appointments. The Department was really going to be looking closely at it. Apparently ACHS was still worried about Dr Patel and the detailed selection and review requirements were now mandatory.

Glad someone is worried about it, because if you looked at issues like AHPRA, the Medical Board of Australia and Senate Enquiries you could believe that standards were always going to be the second and poorer cousin to "just give me someone who can cut".

There seems to be the prevailing view driven by the bureaucrats that any surgeon is better than no surgeon. Of course the bureaucrats are driven by their political masters who don't want their constituents deprived of easy access to surgical care. Whatever happened to Hippocrates' "primum non nocere"? But then again politicians are not required to take or even know the Hippocratic Oath.

Sitting next to me was a colleague from a more regional if not remote area of the state. He was equally bemused by all of this, but for entirely different reasons. His predicament was the total lack of locally trained medical practitioners of any type and the endless bureaucracy of area of need, visas, and assessment processes. He didn't sound too happy about it...

I must admit I always preferred the selection process where the conclusion of "He (she) is a jolly good chap (chapess)" was enough of an answer. Was the nepotism system really that bad? Are our current selection procedures really going to improve the quality of surgeons in the future? Best of all, if a trainee was not working out, if a surgical career was clearly not for them, you could get rid of them.

Now we are embroiled in a legal system much more interested in the rights of the individual than the future welfare of the unsuspecting society that will be subject to their detected ineptitudes. Where is the balance between standards of care, individual rights and access to care? Maybe we shouldn't be seeking a balance at all??

But dutifully I tried not to let my mind wander and watched the PowerPoint slides on the correct policies and procedures to make it all work and reliably select the best candidate. As the Bard reflected in The Merchant of Venice, "All that glisters is not gold". Then they discussed the Appeals process that is needed to try and prevent any court action. Oh great, will really love having to talk to the lawyers about our decisions.

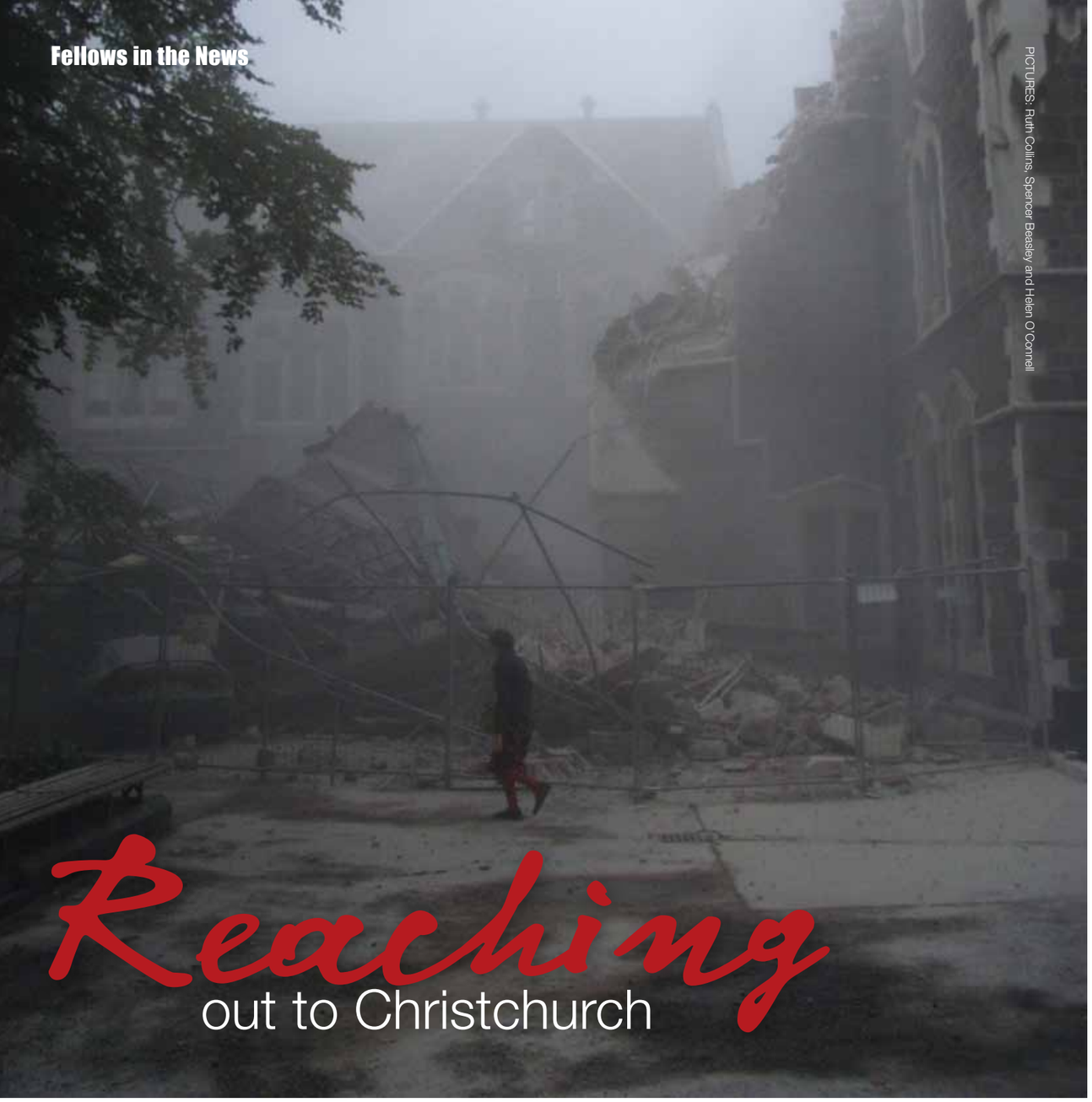
So we got beyond the correct medical degree, the approved specialist qualifications, the currency of practice, the mandatory CPD and insurance status. Job done, I thought. But no, how do we make sure that the scope of practice is clearly understood and defined. Not only that, but how is it checked on an ongoing basis with annual reviews and confirmation that the scope of practice matches the training and currency of practice of the individual, but also the infrastructure and support teams in the hospitals? Isn't the ordeal of achieving a FRACS enough? Clearly not in this brave new world.

One occasionally hears of the adventurous doing Whipples or oesophagectomies or complicated fracture repairs in places where triage and transfer would have been a better decision. But isn't this the role of adverse event meetings, morbidity and mortality meetings and audit. Isn't this what peer review is meant to be about?

It occurred to me that the process overall is perceived not to be working. As I drifted further into my own dream world, I had the uneasy realisation that peer review – the constructive questioning by peers of one's management of a patient – has either been lost or never been properly achieved.

Is it possible to discuss how things might have been done better or are surgeons now so competitive, so ego protective that such analysis and accountability is no longer possible? If so, our independence as a profession is going to be threatened – the manifestation of which is the very forum that I find myself embroiled in. I resolved to discuss this at the next Heads of Unit meeting.

Perhaps my colleague from the bush had it easier. He could hardly keep his hospital staffed and they rarely stayed more than two years...



PICTURES: Ruth Collins, Spencer Beasley and Helen O'Connell

Reaching out to Christchurch

The devastation in Christchurch has been felt by many in our community

It was meant in jest, a bravura allusion to the fears that lurked in the minds of those attending the Christchurch gathering of the Annual Scientific Meeting of the Urological Society of Australia and New Zealand (USANZ) held in February.

That jest was a comic video, presented at the opening ceremony and made by local urologists. Filmed to the music of "We Will Rock You", it was a reference to the ability of locals to endure with stoicism and good humour the hardships caused by the September earthquake which caused so much damage.

As laughter spilled through the room filled with hundreds of urological surgeons and trainees from across Australasia and around the world, few would have imagined the looming catastrophe that lay before them and Christchurch a few hours later.

As the world now knows, however, a 6.3 magnitude earthquake hit Christchurch at 12.50pm on February 22, a disaster made deadly by its proximity to the city and the shallowness of the epicentre which increased its impact.

Now, weeks later, the death toll is believed likely to stand at about 180 victims with scores of injured people still receiving medical treatment and hundreds made homeless. More than 340 of the 849 heritage-listed buildings in the city still remain unsafe to enter. Aftershocks continue to the rattle Christchurch and more than 70,000 people have fled the city out of a population of just over 360,000.

College Councillor Associate Professor Helen O'Connell, a director of USANZ, was at the meeting and said that while there had been light-hearted references to the previous earthquake, Convenor Dr Jane McDonald had given a briefing on what to do should another one hit the city.

Christchurch buildings only minutes after the quake hit; Inset: With members of the USANZ prevented from returning to their hotels, many congregated in Christchurch gardens where temporary tents were set-up.

"I was meeting with the trainees, about 200 of us on the first floor of the Convention Centre," Professor O'Connell said.

"The building lurched and the underlying movement continued as a cacophony of broken glass, alarms and sirens combined with an unfamiliar roar from the earth itself alerted us to a devastating event. It took a few seconds to recognise this was a major earthquake and take action.

"Because of the briefings we had some idea of what to do, cover our heads and make for open space. With glass smashing and ongoing tremors, people did their best to stay calm and get out of the building. Immediately the gravity of the quake was apparent. The convention centre overpass had been wrenched from its connections on either side, the roads had already buckled and surrounding buildings had been turned into rubble. The grey ooze known as "liquefaction" started breaking through the roads. The Avon River, crystal clear only minutes before, became a vile grey sludge. The air filled with dust and developed a solid greyness, reflecting the sadness and tragedy given how bravely Christchurch had rebuilt and so recently."

Surgeons in need

While hundreds of Urologists, urology nurses, partners and industry partners brought themselves to safety and gathered to make a plan, a significant number of Urologists became involved in rescue efforts – moving trapped and traumatised people to safety, getting injured people to hospital having stabilised injuries.

"Though a number of us (Urologists) risked personal harm, one of the most heroic moments was borne of the tragedy of not being able to liberate the trapped lower limbs of a 52-year-old male," Associate Professor O'Connell said.

"Using only tradesman's tools, Dr Johns-Putra, from Ballarat, performed bilateral above knee amputations to save his life.

"The circumstances were horrendous – a terribly confined space with little light, oxygen and with on-going tremors putting her own life at risk, it must have required incredible focus as she got on with the job of saving the man's life. Dr Johns-Putra did an outstanding job.

"It is difficult to engage Dr Johns-Putra in a conversation about this individual example of surgery in the field, as her thoughts are deflected to the number of Urologists who became involved in the rescue efforts.

"Of our almost 600 delegates we were extremely fortunate to not sustain any major injuries. Now safely back home, it is heartbreaking to reflect on the people of Christchurch, particularly after they had shown such incredible courage in rebuilding after September. It's impossible not to feel great compassion for the choices that they now confront.

"Like many of the buildings in the centre of Christchurch, our hotels were deemed too dangerous to enter, and weeks later our luggage, passports, computers and any personal belongings remain there. We still don't know if or when they will be returned."

In contrast to Associate Professor O'Connell's experience, local Christchurch paediatric surgeon Professor Spencer Beasley was in Melbourne with his family when the earthquake struck.

Professor Beasley said that while he found it frustrating not to be able to return immediately upon hearing the news because the airport had been closed, he was reassured within hours when told that few children had been injured. He said, however, that upon his eventual return he had found the destruction confronting.

"Some buildings that were undamaged by the earthquake in September, were destroyed this time," he said.

"Power, water and sewage were all shut down and that damage to underground infrastructure meant that road damage was also extensive.

"Most houses in Christchurch have been considerably damaged not only by the intense tremors but also because of liquefaction where the ground behaves like a liquid such that houses, cars and roads sink into it. Holes are ripped into streets and the foundations of buildings have been shifted and weakened."

Professor Beasley said that the most extraordinary aspect of the natural disaster was the speed with which both the authorities and citizens of Christchurch dealt with the aftermath.

He said that while the September quake may have acted almost as a training drill, given the limited injuries and loss of life, the determination of people to help each other and restart vital services after the second more severe earthquake had been exceptional.

"It was amazing to see how quickly and courageously people began to work to help each other during this disaster," he said.

"Christchurch Hospital, for instance, which has one of the busiest ED departments in Australasia, coped extremely well in treating the injured even though many hospital staff were struggling to balance their responsibilities to those in need at the hospital with those to their families.

"All the hospitals in Christchurch, public and private, worked on a co-ordinated response basis, with patients with particular injuries being treated in particular hospitals. The hospitals of other regions also accepted patients and their staff provided additional support.

"Most injuries needed the services of orthopaedic surgeons who worked extremely long hours during the first few days as they treated the many injured patients. The operating theatres worked extremely efficiently."

Professor Beasley said that while the aftershocks continued to un-settle the city, with expectations of another magnitude 5 earthquake still to come, a great and growing sense of community spirit was helping the people to begin the long and arduous process of grieving, accepting the losses and then rebuilding.

"Some Australian media commentators have predicted the demise of Christchurch, but they are wrong," he said.

"There is a very strong and dynamic commitment to rebuild and there is no doubt that the community spirit and determination so characteristic of Cantabrians has been enhanced by this disaster."

With Karen Murphy

80th Annual Scientific Congress

An outstanding program prepared for the most important event on the College calendar

Mr Tom Wilson,
Congress Scientific Convener
Mr Suren Krishnan,
Congress Convener

All the preparations are complete and Adelaide surgeons are looking forward to welcoming all Surgeons, Trainees and Associates to the 80th Annual Scientific Congress.

Over the past two years, the Adelaide convening teams of the Executive and the Scientific committees have worked closely to compile an outstanding program. The city of Adelaide is looking its best and the Adelaide Convention Centre is ready to host this, the most important event on the College calendar.

With College funding and industry support, the sponsored visitor program will benefit from the attendance of more than 40 experts across the specialties, in addition to experts from Australia and New Zealand.

Convocation

At the Convocation on Monday evening, over 60 Young Surgeons will convocate and this is our opportunity to welcome these fine young surgeons to the fellowship of the College. The Syme Oration will be delivered by former Australian Foreign Minister, Alexander Downer.

John Collins, Ian Gough, Swee Tan, Ian Carlisle and Leo Pinczewski will be presented with College awards for illustrious service to the College and to surgery. Associate Professor David Little is the 2011 recipient of the College's most prestigious research award, the John Mitchell Crouch Fellowship and this will be officially presented to him on the evening.

During the scientific program, Professor Stephen Deane will be presented with the 2011 Gordon Trinca medal and Dr Brandon Adams will receive the John Corboy medal.

Vascular surgery program

The Vascular surgery program is convened by Rob Fitridge and the Vascular Surgical Scientific Program will be held over three days – Wednesday May 3 to Friday May 5. The section's invited visitors include Matt Thompson (London), Mario Lachat (Zurich), Stephen Cheng (Hong Kong) and Jon Golledge (Townsville). The main themes of the program are the pathophysiology of aortic dissection and aneurysm disease, and management of complex pathologies such as ruptured AAA and graft infection in the endovascular era.

We are also fortunate to have the core international members of the TASC working group meeting in Adelaide and these leaders in peripheral arterial disease diagnosis and management will contribute to a session during the meeting. Rob has convened several combined sessions and Masterclasses with the rural and trauma surgeons. These will cover complex trauma to the chest, abdomen, pelvis and lower extremities and the diabetic foot. The Masterclass on Thursday morning will include two internationally recognised experts from Denver, David Armstrong and Joseph Mills.

The Vascular section dinner is on Wednesday night.

Upper GI surgery program

The convener, Harsh Kanhere has planned an exceptional scientific program led by our overseas visitor, Professor Michael Griffin (UK) along with distinguished Australian and New Zealand speakers.

The wide ranging program incorporates debates on the management of gastro-oesophageal cancers and interactive sessions on benign disorders, difficult upper GI problems and upper GI emergencies, sessions that will be invaluable to both Upper GI and to General surgeons and trainees.

The Masterclasses and video session on fundoplication are to be presented by experienced senior surgeons and will be of great appeal to fellowship candidates as well as practicing Upper GI surgeons.

A combined session mini-symposium in keeping with the theme of 'unity through diversity' will focus on pathways of sub-speciality training. Extending over two hours, it will feature contributions from local and international speakers and academics and the current state and future direction of sub-specialty training.

The Upper GI program thus provides great attractions for everyone and will most certainly provide an interactive and engaging forum for intellectual discussion. The section dinner is combined with Bariatric and HPB groups on Wednesday night.

Bariatric surgery program

Lilian Kow is the convener of the Bariatric program and she has invited two very highly regarded international experts to contribute to the program – Daniel Scott from Dallas and Helmuth Billy from Los Angeles. The Bariatric Surgery scientific program consists of a diverse range of topics ranging from bariatric procedures to robotics and telesurgery.

In Dr Scott and Dr Billy, the program is very fortunate to have two extremely experienced surgeons who have been at the forefront of innovation in the specialty; both are engaging speakers and excellent educators. On the local front, a number of prominent bariatric surgeons will discuss issues that might face the everyday surgeon on the management of bariatric patients and in the performance of bariatric surgery. Hence the bariatric program will bring together almost everything a practicing surgeon would like to learn and share in the expanding field of bariatric and metabolic surgery.

The Adelaide convening group looks forward to welcoming you to our city... Adelaide. Online registration is easy – just go to asc.surgeons.org and follow the links.

asc.surgeons.org
Convocation: Monday 2 May
Scientific Congress:
3 May – 6 May 2011

Building skills in Myanmar

College Treasurer Michael Hollands recently travelled to Myanmar to report on what collaboration the RACS can offer in building Myanmar's health system

LEFT-RIGHT: Michael Hollands, Jane Brooks and James Kong; Yangon General Hospital; The new emergency department at Irrawaddy Delta; The PTC course held in conjunction with RACS has been a great success. Inset, Dr Maw Maw Oo who set up the new emergency department.

Dr Maw Maw Oo

> *"Enthusiasm shown by health authorities and senior surgeons (In Myanmar) to establish more structured curriculum-based training systems for young doctors was most notable"*

The International Committee of the College is in the process of giving consideration to a proposal to extend educational ties with Myanmar following the great success of the Primary Trauma Care (PTC) Course, which was co-ordinated and delivered through the RACS and introduced there in 2009.

With limited funds available for international work in Myanmar, the project has been given a boost via a donation from the Kimberley Trust through the Peter F. Williams International Surgery Grant.

The Kimberley Trust is a private charitable trust that was established by, and honours the memory of, Mr Peter F Williams AO, FRACS, a leading orthopaedic surgeon who played a major role in advancing orthopaedics in Australia and internationally.

With its central focus on training the trainers, the PTC course has been such a success and so enthusiastically embraced that while it was originally delivered by a team of Australasian and Hong Kong surgeons into Myanmar, it is now run entirely by local faculty.

The success of the program can be attributed to the time and effort of Dr James Kong and his wife Jane Brooks in facilitating everything.

Last year, one of the surgeons who did the PTC course decided to start an emergency room in his hospital in the Irrawaddy Delta about 250km from Yangon after raising funds from local benefactors and opened his new department recently.

Yet according to the College Treasurer, general surgeon Mr Michael Hollands, there remain significant and urgent areas of need facing the country's health workforce given the absence of any structured emergency service in any hospital, the lack of an ambulance service, rehabilitation and intensive care facilities and little structured specialist training of surgeons.

Following a visit to Myanmar in January to attend the 57th Scientific Meeting of the Myanmar Medical Association, Mr Hollands has written a report suggesting areas of assistance for both the College and individual surgeons to pursue if funding can be found.

He said the enthusiasm shown by health authorities and senior surgeons to establish more structured curriculum-based training systems for young doctors was most notable, along with their desire to create similar professional links to those which now exist between the RACS and the Royal College of Surgeons of Thailand.

"Myanmar is a nation approximately the size of New South Wales with a population of nearly 60 million and yet while it is rich in natural resources, it has a GNP of only US$60 billion," Mr Hollands said.

"Surgeons there are very keen to improve surgical services and especially surgical education, yet while medicine there is still based on a British system of residents, registrars and Fellows they do not have any structured specialist training as we would know it.

"They do not have very well developed Intensive Care systems, they have limited investigative tools at their disposal, yet they are extremely hard working and conscientious within those limitations."

Mr Hollands has suggested to the International Committee that if funding could be found, providing such educational packages as the Care of the Critically Injured Surgical Patient (CCrISP) course or the Basic Surgical Skills course could be of great value.

He said that while in Myanmar he met with the Dean of the No 1 Medical School in Yangon, Professor Pe Thet Khin, to discuss possible educational projects and priorities and said that while there appeared to be good synergy between the University and clinical surgeons at undergraduate level, surgeons were keen to develop a more structured post-graduate curriculum.

"We discussed courses such as Basic Surgical Skills as a way to get started and it was made clear to me, given the success of the PTC course, that they would prefer a faculty to fly into Myanmar and teach a course and then an instructor course which seems a sensible approach," Mr Hollands said.

"They were also very keen for interested Australian and New Zealand surgeons to come to Myanmar to teach at post-graduate and undergraduate level and they are particularly keen to get more laparoscopic training.

"This would include teaching in wards and theatres over perhaps a two-week period and I urge any Australasian surgeons interested in international teaching to give this some consideration."

"Ideally they would like a Scholarship program similar to the Weary Dunlop Boon Pong Scholarships that now exist between Australia and Thailand, but that would require the support of a benefactor," Mr Hollands said.

"In the meantime I have suggested that consideration could be given to Burmese surgeons receiving Rowan Nicks and similar scholarships.

"Two Burmese cardiac surgeons have spent time in Australia on these scholarships and have since established a cardiac surgical service in Yangon General Hospital. I visited the unit during my recent trip in January and was impressed with their work.

"The most common operations are for valvular heart disease and congenital anomalies while the unit runs a regular audit meeting and has an active teaching program.

"Between this unit and the establishment of the Emergency Department in the remote hospital in the Irrawaddy Delta, we should be assured that College aid is making a significant and practical difference to the people of Myanmar."

Mr Hollands said that while there, he and Daliah Moss, the College's Director of External Affairs, met with the Australian Deputy High Commissioner, Ms Ruth Stewart, to discuss aid proposals and said that while the Australian government was focussing most of its aid funding on World Health Organisation projects in Myanmar, there was some money available that could be used to support College-co-ordinated projects.

"While the Government does not see trauma as a major issue, over maternal health and communicable disease, it does appear to be supportive of the College's work," he said.

"There is a small fund of approximately $150,000 per annum for direct aid, but we believe officials would prefer that spent on small purchases of equipment rather than scholarships.

"However, at least this may be a valuable way of funding equipment for any courses that we may wish to establish."

Mr Hollands said the President and Vice President of the Myanmar Medical Association would be coming to Australia to attend the ASC where all these matters could be further discussed.

"There is a great deal that the RACS can do and that surgeons as individuals can do if we can find the resources," he said.

"This first formal contact with Myanmar via the introduction of the PTC course shows how successful such a collaboration can be and it would be pleasing to know we were able to leave a footprint in Burma that was appropriate to the people and resources of that country."

The International Committee of the College provides advice to the Council on matters concerning the international activities of the College; aims to provide a framework for the College to develop surgical practice, education, training and research in collaboration with overseas colleges, universities and governments; and promotes the international work of the College by assisting with the implementation of aid programs in the Asia Pacific region.

With Karen Murphy

Research for an underestimated cancer

Associate Professor Damien Bolton has joined a list of surgical luminaries by receiving the John Mitchell Crouch Fellowship

The highest award for research given by the College to a surgeon/scientist – the John Mitchell Crouch Fellowship – was last year awarded to Associate Professor Damien Bolton, the first Urologist to be given the honour since the award was created in 1977.

Established by Mrs Elizabeth Unsworth in memory of her son, the Fellowship is bestowed upon young surgeons deemed by their peers to be making an active and outstanding contribution to the advancement of surgery or fundamental scientific research in the field.

Members of Austin Hospital Department of Surgery renal cancer research group: Prof D Bolton, Lin Xiao (scientist), Joseph Ischia (RACS surgeon scientist scholar and PhD candidate), Peter Wong (urology trainee and PhD student) and Prof Graham Baldwin.

After more than 30 years, the list of names of recipients of the John Mitchell Crouch Fellowship reads like a "who's who" of Australasian surgical science and includes such luminaries as transplantation pioneer Professor Robert Burton and more recently the internationally renowned ear surgeon Professor Stephen O'Leary and acclaimed orthopaedic surgeon Professor Peter Choong.

Associate Professor Bolton received the award and the attached $75,000 funding for his research into the ability to non-invasively measure cellular proliferation in renal cell carcinoma.

He said that while positron emission tomography (PET) with F-fluorothymidine (FLT) had been used to test breast, thoracic, colorectal and soft tissue carcinoma, until recently little had been known of the role of FLT PET in renal cell carcinoma and cancers of the prostate and bladder.

"While renal cancer is not as common as other tumours which tend to grab the limelight, such as prostate or lung cancer, the cost to the health budget of renal disease each year is greater than the cost of treating prostate and lung cancer together," Associate Professor Bolton said.

"A significant issue facing those treating renal cancer is that it is often hard to clarify the nature of the tumour without biopsy or removal.

"Our work has shown that different types of renal cancer do seem to show different characteristics of FLT up-take which allows us to use a scan to non-invasively assess tumour grade and evaluate potential response to therapy which is, of course, of great benefit to patients.

"This in turn has allowed us to work towards more nephron-sparing approaches to treat renal cancer so as to maintain optimal renal function beyond the time of tumour clearance."

Associate Professor Bolton is the Director of Urology at the Austin Hospital, Heidelberg, and a Senior Associate at the Ludwig Institute for Cancer Research also in Heidelberg.

A scholar rewarded

After winning multiple prizes as an undergraduate, during the course of his research and clinical career he has been the recipient of a number of awards and Fellowships including the Bruce Pearson Scholarship from the Urological Society of Australia and New Zealand (USANZ), the BARD Silver Medal for Surgical Research from the British Association of Urologic Surgeons, the Keith Kirkland Prize also from the USANZ and a Certificate of Exemplary Endeavour from Cancer Australia.

However, Associate Professor Bolton said receiving the John Mitchell Crouch Fellowship was one of the great highlights of his working life.

"It is the professional honour of a lifetime to receive this Fellowship and to be the first Urologist to be chosen and I'm tremendously grateful for the recognition," he said.

"The endorsement it carries from senior surgeons and the College means that we have now been able to acquire a strong presence in urological research which is likely to be sustainable over a long period of time because of other grants that have flowed from that endorsement from Cancer Australia and the National Health and Medical Research Council.

"After more than 30 years, the list of names of recipients of the John Mitchell Crouch Fellowship reads like a "who's who" of Australasian surgical science"

"Throughout my career I have had great support from the Urological Society of Australia and New Zealand and to be recognised by the RACS through this Fellowship perhaps symbolises a justification of their investment."

Developing research

Associate Professor Bolton has spent more than a decade working to expand knowledge of renal cell carcinomas, heading a small research unit attached to the University of Melbourne's Department of Surgery at the Austin Hospital in conjunction with the Ludwig Institute for Cancer Research.

"During the 14 years I have been working in this field on a number of different projects, I have had the invaluable assistance of 23 researchers, surgical trainees and Fellows all of whom, without doubt, have taught me more than I have taught them," he said.

"Many have gone on to become leaders in urology such as Nathan Lawrentschuk, Scott Donnellan and Lydia Johns-Putra.

"I was also able to co-ordinate and focus my research because of the projects already established by Professor Andrew Scott, and by Professor Arthur Schulkes and Professor Graham Baldwin both of whom worked in an analogous area of small protein research. This meant that the scientific facilities were very much in place to allow for an easy transition to urological research.

"Our ability to apply their world-leading work to urology means that we are now, too, at the forefront of research into renal cell carcinoma, so really, I was in the right place at the right time to advance our knowledge in this area.

"I have also been greatly assisted in my work by the heads of the University department at the Austin, Professor Ken Hardy and Professor Chris Christophi, and also by the other 12 Urologists in our unit who take an active role in these projects."

Designed to assist surgeon/scientists advance their work rather than honouring them for it later, the John Mitchell Crouch Fellowship is awarded only to those surgeons working actively in their field and must be used to assist the continuation of that work. The grantee must be a Fellow of the College and in most circumstances be aged under 50 years.

With Karen Murphy

In Memoriam

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

>**William MacKenzie,** QLD General surgeon
>**Edward Gibson,** NSW Plastic surgeon
>**Emil Popovic,** WA Neuro surgeon

We would like to notify readers that it is not the practice of Surgical News to publish obituaries. Obituaries when provided are published along with the names of deceased Fellows under In Memoriam on the College website www.surgeons.org go to the Fellows page and click on In Memoriam.

Informing the College

If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office.

ACT Eve.edwards@surgeons.org
NSW Beverley.lindley@surgeons.org
NZ Justine.peterson@surgeons.org
QLD David.watson@surgeons.org
SA Daniela.giordano@surgeons.org
TAS Dianne.cornish@surgeons.org
VIC Denice.spence@surgeons.org
WA Penny.anderson@surgeons.org
NT college.nt@surgeons.org

Mr Freedman on one of his recent creative trips to Head Rock, Mangawhai Head Beach, New Zealand.
Inset L to R: Spoil Mounds, Kalgoorlie, WA; Still life; Channel, Swan Hill, Vic.

Artistic passion with surgical detail

Mr David Freedman has been filling his retirement days with a creative passion

General Surgeon Mr David Freedman has dodged the spears and arrows of tribal disputes in Papua New Guinea, operated by flashes of lightning during tropical thunderstorms and been moved by the beauty of the people and places he encountered during his aid work across the Pacific region. Yet, for most of his working life, his great passion lay in his working life in his home town of Swan Hill in northern Victoria.

Recently, Mr Freedman began his transition into retirement when he closed down his practice to work part-time as a locum around Australia. With his wife Barbara, he swapped the bush for the beach and after putting down the scalpel picked up a paintbrush. Self-taught and greatly motivated, he tells Surgical News how his passion for painting represents a new vocation.

When and why did you decide to retire?

I ceased practice as a General Surgeon at Swan Hill and District Hospital, where I had been working for the past 33 years, 15 months ago. Like all provincial surgeons I found the work extremely challenging and rewarding, but the demands of the practice, the long hours on call, plus the 'it's time factor' helped me decide to commence a new phase of my life.

Why did you leave Swan Hill?

My wife Barbara and I relocated to Mt Martha on the Mornington Peninsula to be closer to our five children and eight grandchildren. Since then I have worked part-time as a locum in provincial centres around Australia. This work is less demanding and the intervals in between locums provide me plenty of time to pursue my longtime interest in painting. Previously I had been only an occasional weekend painter. For many years I have looked forward to having the time to develop my understanding in this area.

Why did you take up painting?

The replacement of my interest in surgery with the passion of painting has greatly assisted me in facing the end of my career. I have attempted to approach this transition with as much enthusiasm, vigour and curiosity as I had in my former occupation. It is an immense challenge to paint well.

What do you hope to achieve with your artistic endeavours?

My aim now is to gain a deeper understanding of the vast world of painting and pictorial art. Eventually I want to be able to produce works which are both interesting and hopefully sometimes beautiful and to paint an image conveying something of my emotional reaction to the subject. This requires me not only to look carefully at the subject, but to digest, interpret and understand what I am seeing. I hope to acquire a greater facility in handling the various media and tools required and to refine the techniques involved.

Why do you concentrate on landscapes?

It is important to choose a subject which has elicited degrees of emotional response. It is difficult to be successful without this feeling. Like most painters, I am interested in the effect of light as it strikes an object and defines its colour, shape and volume.

The great challenge of traditional painting is to create the illusion of three dimensions on a two dimensional surface. However, there should also be an underlying abstract idea before commencing any painting.

It is also important to know when to finish. Many of my paintings have been ruined immediately after acting on the words: "I'll just add this".

Which medium do you enjoy working with the most?

Over the years I have tried most of the common media and attempted to paint landscapes, portraits and still-life. I feel that working in many areas helps develop a deeper understanding. I have found working with pastel very handy for painting on location. This is an opaque medium, but it is quick to execute and blending colour directly is fun. It is much easier to make alterations and corrections. There are no messy solvents or painting tools to master.

However, oil painting is much more robust and versatile. Colours can be both opaque and transparent. After drying, the surface is extremely stable. Mixing colour is done on a palette before application so as to avoid producing a grey mess.

Painting with watercolour can give a spontaneity and transparent brilliance, a glow and sparkle, all of which are difficult to obtain with other media, but it is a more difficult medium to control or adjust. Experience is required to understand the properties of the pigments.

Weather is important too as temperature determines drying time and the paper's texture and angle of inclination play an important role. There is a greater chance of obtaining an accidental interesting effect as the pigment particles float into position under the influence of gravity.

Why do you choose to paint outdoors?

Plein Air painting has the advantage of giving the best chance of incorporating the atmosphere of the landscape into the painting. It is my preferred option, but has many disadvantages. Adverse weather conditions, including wind, rain, dust, frequent changes in light and shade (with cloud and sun movement) to name a few.

Also insects, flies, ants, mosquitoes and even locusts can be frustrating. Occasionally I have encountered snakes. Yet, the greatest setback is that urgent call from the casualty department. Many a good painting has been wiped off half-finished in favor of an urgent laparotomy.

Do you only paint Australian landscapes?

I have been on a couple of short painting trips to Europe and found the landscape breathtaking. I also find plenty of excellent subjects in Australia. In fact, just about any landscape can be interesting if the conditions are right. A featureless desert with a dramatic sunset can be just as interesting as the magic of the sun shining through the trees and early morning mist at a bend in the river.

Have your works been on exhibition?

I have not yet given any serious thought to the commercial side of painting or exhibitions. This is not my aspiration. Rather, it is to gain a greater understanding of how to obtain the best aesthetic result for the problem at hand.

It is exciting to be at the beginning of an interesting journey and a new challenge and I feel fortunate to have the work of so many great painters past and present to guide me.

I have not had any formal training or instruction in painting and have not attended any workshops. My journey, so far, has been by learning from my own mistakes and by studying the work of the masters.

It is a great privilege to now have the time and energy to begin the day in the hope that at its end I will have created something new and reasonably interesting.

To see more of Mr Freedman's work, go to the website www.davidfreedman.net.au

What you can do for your College

Bring more value to your College by becoming involved

Greg Harvey
Chair, Tasmanian State Committee

I have struggled to write this year. Like last year this is written at the last minute. I will keep this year's short and sweet.

Last year a lot of work was put in to make the College more attractive to the Fellowship as a whole. It appeared to me that a lot of this was driven by issues about "value for money" for the fees we pay. Being involved in College duties makes it clear what the value of our organisation is.

Sitting in a Regional Chairs Teleconference on Monday listening to the work that is being put in by my Interstate Chairs I feel it is time to ask the Fellowship what it can do for the College.

I wonder if many of the Fellows truly realise the hours and hours that are put in at all levels of College fighting off governments, self interested bodies and the like in our country.

I take my hat off to Jessica Yin for the work she has put in with the new four-hour rule in Western Australia. This is all done pro bono and I do not hear her asking what value she gets from the College. We will all benefit from this work.

In the state of Tasmania, we have more than 80 practicing surgeons yet we struggle to put a Committee together and we joke when we actually had to have an election this year gone.

I am the first to admit that College duties in Tasmania are very straight forward compared to the larger states and territories in Australia, yet we have very little interest shown.

Until this year we had difficulty with reaching a quorum for our meeting.

Yet we attend and we do this for nothing as we feel it is important that our representative body remains strong and in a position to take the views of members to political and hospital groups where needed.

Of course we will not win every time, but major concessions have been granted to the College as a result of the tireless work put in by our colleagues.

I think it is time for all members of the Fellowship to stand up and take part in College life and issues as much as possible as we face politically uncertain times with our new National Registration Legislation, the four hour-rule, podiatric foot operators and the continued decline of surgical services in public hospitals.

> *"I feel it is time to ask the Fellowship what it can do for the College."*

I think it is time for our members to stand up against the devaluation of surgeons in the public health sector. Sitting in the regional chairs meetings it seems that the Tasmanian perspective about the "value" of surgeons (or lack of as the case is) is endemic around Australia.

I think this is in-keeping with the decline in standing of the Family Medical Practice and other areas of medicine.

I 'jokingly' suggested it was time for us to have a "no doctor day" in Australia as so many groups feel they are able to do our work with ease.

I remain committed to my role in the College and I would encourage all Fellows in 2011 to contact their regional office to offer their time, service and voice to the coming fight we as a group will face to maintain the highest standard of care and training in our country.

I look forward to 2011; it is bound to be a very interesting year in the world of surgery.

Conference

ANZSVS Meeting relocated

On behalf of the ANZSVS I wish to express our heartfelt empathy to the people of Christchurch and especially all our Colleagues who have been displaced or whose families may have been affected by this natural disaster.

Due to this devastating earthquake, the ANZSVS Meeting for this year will be relocated to Brisbane Convention Centre. The meeting will still be held 12-15 November 2011.

Brisbane is a vibrant, sunny and exciting city with warm weather and welcoming people who are excited to host the ANZSVS meeting this year.

The organising committee has compiled an exciting scientific programme exploring "Vision & Reality" in vascular surgical practice. Guest speakers from the US, UK, Europe, Singapore, Australia and New Zealand will challenge current practice regarding aneurysm screening, carotid intervention, endovascular surgery and treatment options for patients with varicose veins. State of the art imaging and intervention will be displayed and discussed by our world class faculty including cerebral perfusion, leg pain in young athletes and multi-energy "true colour" imaging technology.

Go to www.vascularconference.com for details of the conference that will be updated regularly. Please register early to secure the special early bird registration rate.

The ANZSVS will be donating 10 per cent of the profits from this meeting to the Red Cross, NZ Earthquake fund.

Rob Fitridge, President, ANZSVS

Recognising the deteriorating patient

Early signs of deterioration can be critical in a prompt response

James Aitken,
Clinical Director, Western Australian Audit of Surgical Mortality (WAASM)

The Western Australian Audit of Surgical Mortality (WAASM), funded by the Western Australian (WA) Department of Health, recently hosted a symposium on 'Recognising the Deteriorating Patient'. This was in response to the 2009 WAASM Annual Report[1], which noted that over a two year period, 73 (5.3 per cent) of 1,371 deaths occurring while the patient was under the care of a surgeon, were attributed to some form of delay. The symposium was heavily oversubscribed.

Presenters included consultant surgeons, intensivists, a senior nurse and the WA Chief Medical Officer. The common theme emphasised was the critical importance of recognising that the early signs of deterioration are often subtle and difficult to detect. This therefore prevented early recognition, possibly delayed an immediate response and could adversely impact on the outcome.

Delays were further seen to be heightened by indecision, which can be a consequence of limited clinical experience. The value of early review by senior clinicians was seen as advantageous. The importance of a multidisciplinary 'post event' review by the clinical team was also considered a very valuable educational process.

Use of the new trigger charts generated much discussion. It was felt one important role of the trigger charts was that they would empower senior nurses to call for clinical help, when others felt hesitant to do so.

In WA, the Office of Safety and Quality in Healthcare has convened a "Recognising and Responding to Clinical Deterioration Network" and the "Recognising and Responding to Clinical Deterioration" Executive Steering Committee to align clinical deterioration activities across WA. The WA Country Health Service (WACHS) piloted an observation chart (including a single parameter system with four response categories) in 2010. An updated chart was endorsed by WACHS in January 2011 and is intended to be piloted in WA metropolitan hospitals during the course of 2011.

Recognition of the deteriorating patient is an international issue and the focus of extensive initiatives overseas. In 2010, the Australian Commission on Safety and Quality in Health Care released a National Consensus Statement.[2] Early recognition and an immediate response with appropriately trained staff is a key recommendation.[2]

The symposium was recorded and is available via the WAASM website.

For more information on:

WAASM Symposium, www.surgeons.org/waasm
Australian Commission on Safety and Quality's Recognising and Responding to Clinical Deterioration Program, www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/prog-patientsrisk-lp
Observation Response Charts, www.safetyandquality.gov.au
WA Recognising and Responding to Clinical Deterioration Initiatives, www.safetyandquality.health.wa.gov.au/initiatives/clinical_deterioration.cfm

References
1. Western Australian Audit of Surgical Mortality. WAASM Annual Report 2009. Perth: Royal Australasian College of Surgeons, 2009. www.surgeons.org/WAASM
2. Australian Commission on Safety and Quality in HealthCare. National Consensus Statement: Essential elements for recognising & responding to clinical deterioration. 2010. www.safetyandquality.gov.au

INTERNATIONAL SOCIETY OF SURGERY (ISS/SIC) AUSTRALIAN CHAPTER

AUSTRALIAN TRAVEL AWARDS
ISW2011 will be held in Yokahoma, Japan from 28 August-1 September 2011. The Australian Chapter of the International Society of Surgery is offering two Travelling Fellowship Awards of AUD$3,000 each, for trainees and young surgeons.

If you have had an abstract for a paper or poster accepted by ISW2011 and you fit the criteria below, you may apply for an ISS/SIC Australian Travelling Fellowship award.

ELIGIBILITY
>Trainees who are Australian citizens or working in Australia on an Australian working visa.
>Surgeons under 40 years of age or who are within ten years of obtaining FRACS.

REQUIREMENTS
>Documentation from ISW2011 indicating that an abstract has been received and accepted.
>A copy of the abstract.
>A current curriculum vitae.

DEADLINE
A letter of application, abstract, and curriculum vitae must be received Saturday 30 April, 2011. Applications to Mr Peter Malycha at email: peter.malycha@adelaide.edu.au

WEBSITE
www.isw2011.com

QUESTIONS
Mr Peter Malycha, 333 South Terrace, Adelaide, +61 8 8223 5106. The recipients of the travelling scholarship will be notified via electronic mail no later than Tuesday 31 May, 2011.

Directors of not-for-profit organisations

Directors of the not-for-profit sector should have a good understanding of their legal responsibilities

"Given its size and the diverse nature of the services it provides, a healthy NFP sector is essential to Australia's long-term economic prosperity."

Michael Gorton
College Solicitor

The emergence of the not-for-profit [NFP] sector in the Australian economy as a powerful force is underscored by the fact that there are over 600,000 NFP organisations in Australia with the sector contributing some $43 billion in 2006-2007 to GDP, growing from $21 billion in 1999-2000, and attracting over 4.6 million volunteers.

Given its size and the diverse nature of the services it provides, a healthy NFP sector is essential to Australia's long-term economic prosperity. The importance of both the sector and the work that it undertakes is underscored by the critical role NFP organisations play in the provision of healthcare, aged care and community services – to name but a few areas.

Despite the vital role these organisations play in our community and that the workload, level of responsibility and skill required of many of the volunteers in these organisations is increasing, the duties associated with the role of director, in a NFP organisation, is not well understood in all cases. In fact, some individuals who volunteer their time and expertise as directors of NFP organisations may fail to understand the important legal responsibilities that come with the territory of being a director. This is in stark contrast to the considerable amount of attention, and column inches that has been devoted to chronicling the responsibilities of directors involved in profit seeking enterprises, in the wake of the GFC.

The legal exposure of Directors in a NFP

Volunteers agree to serve on NFP boards because they believe strongly in the cause and want to be of service. The challenge for NFP's is combining this passion with effective corporate governance that enables directors to understand their rights, duties and potential liabilities and simultaneously protects these honest volunteers.

The reality is that directors of NFP organisations have the same exposure to legal liability as a director of any public company. In Commonwealth Bank of Australia v Friedrich the Victorian Supreme Court suggested as much, stating, 'there is nothing in the Code [now Corporations Act] to suggest that the standard to be expected of a part-time non-executive director of a company not-for-profit is different from the standard expected of any other director of a profit making company.'

The extraordinary size and scale of the NFP sector and its continued growth, particularly in terms of the financial scale of the activities undertaken – often multi-million dollar projects, means that the consequences of potential legal liability for many directors in these organisations can be dramatic.

With this in mind, what is a director of NFP organisation required to do or not to do, in the discharge of their responsibilities?

Directors' duties under common law and statute

The complex nature of commercial enterprise is such that the Board of Directors is not required to actively engage in the minutiae of the business of the organisation. The role of the Board usually encompasses setting the policy for the organisation, monitoring the organisation's operations, including setting the annual budget and approving major contracts and grants, whilst often also serving as a public face for the organisation.

In carrying out these functions as a member of the Board, each director is individually subject to statutory and common law duties to act in good faith in the best interests of the organisation, to act for a proper purpose, and to act with reasonable care and diligence. In this way, directors occupy a special relationship with their organisation, much like that of a trustee. Most importantly, directors need to be attuned to the fact that these duties are inescapable personal responsibilities that will not necessarily be discharged merely by following the majority without actively engaging in the issues.

A breach of these statutory or common law obligations could leave the director personally liable to the company for any loss or damage suffered, and to account to the company for any profit or gain made as a consequence. In addition, in certain serious circumstances, a breach of these obligations could result in an imposition of a criminal sanction, of fines and/or imprisonment.

Many directors of NFP organisations act in good faith in what they believe to be the best interests of the organisation and for a proper purpose. However, given the nature of many NFP organisations administered by well-intentioned, though inherently time-poor volunteers, directors, of necessity, must often engage in a challenging juggling act of competing priorities in endeavouring to exercise a reasonable degree of care and diligence. In particular, this duty remains a potential source of liability for many directors in the NFP sector.

The juggling act: The duty to act with reasonable care and diligence

The test for whether a director has exercised reasonable care and diligence is if they:

a. "make the judgment in good faith for a proper purpose; and
b. do not have a material personal interest in the subject matter of the judgment; and
c. inform themselves about the subject matter of the judgment to the extent they reasonably believe to be appropriate; and
d. rationally believe that the judgment is in the best interests of the corporation.

The director's or officer's belief that the judgment is in the best interests of the corporation is a rational one unless the belief is one that no reasonable person in their position would hold" (Section 180 of the Corporations Act).

In determining whether a director has breached their duties, or acted negligently, the courts will apply the standard based on the following principles:

a. The degree of skill that may be expected is no more than may reasonably be expected from a person of that director's knowledge and experience.
b. If a director does have special knowledge about the company's business, the director is required to give the company the benefit of that knowledge.
c. A director is obliged to obtain at least a general understanding of the business of the company and the effect that the changing economy may have on that business, and directors should bring an informed and independent judgment to bear on the various matters that come to the Board for decision.
d. The director must be diligent and, although only acting on an intermittent basis, the director is bound to attend regular meetings when the director is reasonably able to do so, and remain informed of the company's activities and performance through regular reports.
e. Directors are able, in reasonable circumstances, to rely on the skills and honesty of others, but cannot, on a blanket basis, simply refer the management to others.

There are many circumstances where directors can be liable through inactivity. It is simply not sufficient to adopt a laissez-faire approach and hand the affairs of the company over to a personal accountant and let them "work it out".

Mitigating the risks

The position of director, even in a NFP organisation should not be accepted lightly. At a minimum, directors should be aware of and engage with the basic management and audit measures for the company, such as control of signatories of company bank accounts, details of who is authorised to incur debts, details of any delegations that have been given to other employees or officers. In appropriate cases, in an organisation of some significant size, it may be appropriate to establish a separate audit committee.

The development of organisational policies and procedures and the training and educating of staff in these policies are valuable tools that should be exploited to ensure directors fulfil their corporate governance duties. Outside of ensuring effective corporate governance within the organisation, appropriate insurance should be taken out to protect directors and organisations against any future claims.

THE SECTION OF ACADEMIC SURGERY

Collaborations between RACS and universities

Developing the relationship between the College and universities is an important step for our Trainees

John A Windsor,
Chair, Section of Academic Surgery

Significant opportunities exist for the Royal Australasian College of Surgeons (RACS) and universities to work more closely together. Although their origins are different, surgical colleges (from barber surgeons and craft guilds) and universities (from monastic schools of higher learning) share many common features and functions in education today.

With respect to surgical education, the relationship between universities and colleges is very different in the US, UK, Australia and New Zealand. RACS is the only surgical college in the English-speaking world that still delivers surgical training (everything from selection, to training, to certification) without a formal relationship with the universities.

The Section of Academic Surgery convened a single-day meeting at the South Australian office of RACS on 18 November, 2010, to discuss opportunities for developing RACS-university collaborations. Speakers were drawn from both sectors.1

The theme was driven by the need for more collaboration between RACS and the universities, which could lead to the development of co-badged courses if there was a template, guideline or pathway. Provision of an overarching framework with coordination for courses would reduce course duplication, provide direction and help managers to set priorities.

With its new SET curriculum, RACS must develop teaching programs and assessments for the range of professional competencies. At the same time many universities are seeking an expanded role in postgraduate education. The meeting was an opportunity to explore how RACS and the universities could work together to achieve their mutual academic missions in education and research.

The future of surgery depends on strengthening surgical education and research; the Section considered that all Surgical Trainees should be trained to contribute to both. RACS clearly values its relationship with universities,

and the Academy of Surgical Educators has been established, in part, to foster this relationship. RACS strongly supports surgical research through its Scholarship Program; however, almost all research is undertaken outside of the College and there is significant funding from external sources.

At the meeting, the Dean of Education Professor Barraclough highlighted the many opportunities that RACS presents to universities, including involvement in the development of new courses; the accreditation of courses; and the development of standards for competence and performance for medical students, and PGY1 & 2 as prerequisites for the SET program. Collaborative activities already underway include the Masters of Surgical Education and Diploma of Anatomy (University of Melbourne), Doctorate in Clinical Surgery (University of Sydney) and the Basic Surgical Science course (The Dunedin Basic Medical Sciences Course Trust) and planned for the future is a Graduate Certificate in Learning and Management (RMIT). Other universities have expressed interest in collaborating on course development, including Monash, Wollongong, Western Sydney, Macquarie, Queensland, Auckland, Adelaide and Western Australia.

What courses could offer

Overall, there is a strong demand for courses delivered by universities, with significant growth in enrolments over the past five years. The target audience includes those wanting to get into SET, those in SET and for Fellows and seniors after SET. One issue identified was the different course requirements between universities, which are determined by university regulations and hence cannot be addressed by RACS. Also raised was the question of whether courses should be mandatory. For instance, should a course in education be required for all supervisors of surgical training? Issues pertaining to course costs, such as the determination of costs and margins, and profit and risk sharing, also need to be addressed.

Professor Maddern spoke about what the universities could offer RACS. He emphasised the need to strengthen the presence of surgery in undergraduate medical education, to expose students earlier to surgery and to provide training opportunities for more students interested in a career in surgery. The universities have significant expertise and resources in e-learning, distance learning and the area of assessment, which RACS could learn from. Furthermore, RACS depends on universities to provide opportunities in surgical research. For example, academic surgeons routinely obtain their higher degrees from universities. More specifically, the Surgeon Scientist Program needs universities to accommodate and supervise the scholars. Universities are also the base for surgical skills centres for learning by simulation, which will become an increasingly important part of training and re-training. It was suggested that university staff, represented in all teaching hospitals, could play a larger role in helping RACS achieve its mission in surgical education and training, and facilitate international links for Fellowships following completion of training. However, within teaching hospitals tensions between the clinical service and academic commitments may need to be addressed.

How RACS can collaborate

Universities have raised concerns about the educational quality of vocational training; at the meeting a question was asked as to whether RACS could improve the academic standing of the Fellowship examination. RACS could invite the universities to contribute more to the delivery of the SET program, especially the teaching and assessment of professional competencies. RACS has the primary role in setting standards for SET courses and in defining prerequisites for pre-SET courses. There needs to be discussion on how RACS might help advise and facilitate the development of the courses themselves. The opportunities presented by the new SET program need to be profiled and promoted, including the benefits of co-badged courses.

The Section of Academic Surgery would like to promote collaboration between the universities and RACS, and to contribute more meaningfully through the Academy of Surgical Educators and the Board of Surgical Research. At present the section makes two important contributions: it runs the Developing a Career in Academic Surgery Course at the ASC and supports the Surgical Research Society of Australasia (SRS) in its Annual Scientific Meeting. Aided by strong support from the meeting, the SRS will join with the Section of Academic Surgery via a Memorandum of Understanding.

The Section of Academic Surgery is also concerned by the research requirements that must be met by SET trainees; these requirements vary between specialties and in the most part trivialise the importance of research in surgical training. It was agreed that the minimum requirements for research should be re-examined across all specialties. The Section of Academic Surgery will also seek ways to support the funding of research and increase the corpus of funds available for distribution by the RACS Foundation. To enable this, a representative of the Section is on the Board of Surgical Research.

Finally the Section of Academic Surgery is keen to assist the development of more defined and integrated academic surgery career pathways. It might be useful to document the multiple current 'informal' academic career pathways, publicise them on the RACS website and present recommendations for how we might do this better. This too will require greater collaboration between RACS and universities.

For further information please contact Associate Professor Wendy Babidge, Director Research, Audit and Academic Surgery Division on +618-82190900 or wendy.babidge@surgeons.org

Reference

1. Professor Bruce Barraclough, Professor Chris Christophi, Assoc Professor Norm Eizenberg, Professor Jeff Hamdorf, Professor Guy Maddern, Professor John McCall, Mr Glenn Petrusch, Professor Julian Smith, Professor Michael Solomon, Professor Mark Stringer, Mr Simon Williams, Professor John Windsor

RESEARCH SCHOLARSHIP IN MILITARY SURGERY

Applications are sought for a 12 month Research Scholarship in Military Surgery commencing in January 2012. The position available is Research Instructor at the Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA. The successful applicant will examine "Resuscitation Research for the Combat Mission". The position carries an initial stipend of US$40,000.

To be eligible, applicants must hold Australian or New Zealand citizenship and be either a Fellow of the College or Trainee in the SET program at the time of application. Preference will be given to serving members of the Australian Defence Force

NB: The availability of this scholarship is yet to be confirmed. Please email scholarships@surgeons.org prior to application to confirm that this scholarship is being offered in 2012 and to register your interest.

CPMC National Framework

The College is working to improve and build on actions of the National Aboriginal and Torres Strait Islander Medical Specialist Framework

Kelvin Kong,
Chair Indigenous Health Committee

In November last year the Council of Presidents of Medical Colleges (CPMC), the peak medical specialist body in Australia, endorsed the National Aboriginal and Torres Strait Islander Medical Specialist Framework for Action and Report.

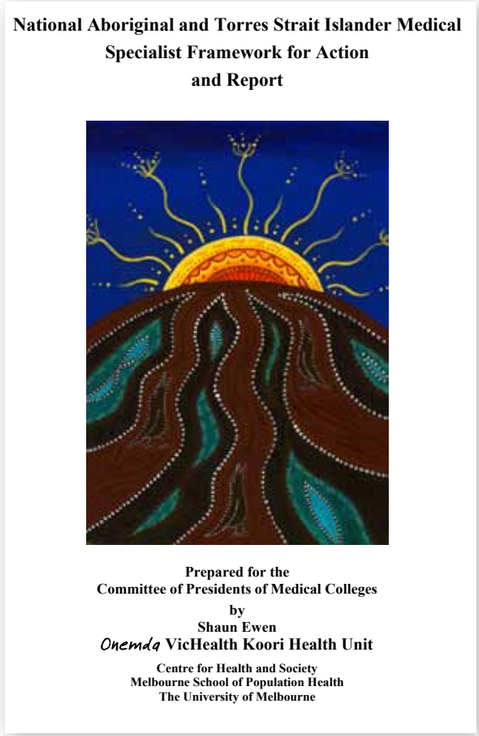
The Framework and report outlines 19 strategies for action and reform in vocational graduate medical education in Aboriginal and Torres Strait Islander (ATSI) health, to give effect to the CPMC's commitment toward closing the gap in health status between Indigenous and non-Indigenous Australians.[1]

This involves the successful recruitment and training of more Indigenous medical graduates as specialists and by reforming the training curriculum to include Indigenous health perspectives, so that Fellows are adequately equipped to work with ATSI people and their communities.

The Medical Specialist Framework complements the Indigenous Health Curriculum Framework developed in 2004, by the Committee of Deans of Australian Medical Schools (CDAMS), to help medical schools develop and deliver Indigenous health content in their core medical curriculum.[2]

In 2006 the CDAMS Framework was incorporated in the Australian Medical Council's standards for accreditation of medical schools. As a consequence medical schools are required to report on its implementation as an integral part of their accreditation process. The CDAMS Framework also led to the establishment of the Leaders in Indigenous Medical Education (LIME), a network of Indigenous and non-Indigenous medical educators to lead and promote curriculum implementation.[3]

How will the new Medical Specialist Framework impact on the College? A review of some of the College's initiatives in ATSI health suggests the College is in a favourable position with respect to the "first priority actions" recommended in the Framework.



Action 2:

Given the variability of national census data, Colleges should collect the Indigenous status data of their members. In 2009 the College added a voluntary question of "Indigineity" to the annual transcript survey of Fellows and Trainees. The data will help inform and support the College's policy and strategies in relation to Indigenous surgical workforce development in Australia and Aeotora/New Zealand.

Action 3:

To develop a learning module or modules in Indigenous health, based upon the principles of vertical integration, using exiting examples from the CDAMS National Indigenous Health Curriculum, College of General Practitioners and College of Psychiatry, and consistent with recommendations from the Med 2009 conference.

In April the Indigenous Health Committee (IHC) will collaborate with the Australian Society for Otolaryngology Head and Neck Surgery (ASOHNS) in the delivery of a session on ATSI ear health at the Society's annual scientific conference in Melbourne. Presenters include ENT surgeons Harvey Coates and Chris Perry, and Shaun Ewen (who developed the CPMC report). They will discuss ear disease in Aboriginal communities and the cultural context of ear treatment, services delivery, research and education.

This forum will progress the recent announcement by the ASOHNS Board of Education and Training that Indigenous health will be incorporated in ear health curriculum for trainees in Australia. The IHC will continue to support ENT Fellows and ASOHNS in their work with ASTI communities to develop curricula which reflect the circumstances and needs of ATSI people. ASOHNS decision is an important step forward in medical specialist education reform and will hopefully encourage other surgical specialties to embed Indigenous health curriculum in their training programs.

The Australian Medical Council has indicated to medical colleges that training in Indigenous cultural awareness and safety is a priority. The New Zealand Medical Council is bound by legislation to set standards in cultural competence. As consequence training and recertification (CPD) programs in New Zealand must include components which demonstrate an understanding of and respect for cultural competence.

Earlier this year the College was successful in securing funding for two Australian Indigenous health projects under the Commonwealth Government's Rural Health Continuing Education (RHCE) Program. These projects support the Continuing Professional Development (CPD) of individual specialists and multi-disciplinary groups in rural and remote Australia.

The Indigenous Health and Cultural Competency Online Portal is a collaborative project with the Royal Australasian College of Physicians and the Australasian College of Dermatologists.

The project will create a portal to link and/or house and hence provide easy access to available professional development opportunities for the Medical Colleges pertaining to Indigenous specific cultural competency and cultural safety training.

The Australian Indigenous Health eLearning Modules aims to improve surgeons' understanding of Indigenous cultural issues which impact on their Indigenous patients' health care outcomes.

The learning module will build on the Australian Indigenous On-line Health Program delivered by the College in 2006 and 2009.

Both projects will run for three years and will be developed in consultation with the ATSI community to ensure that the resulting Indigenous health resources meet the aims and standards of the CPMC National Aboriginal and Torres Strait islander Curriculum Framework and comply with AMC expectations in regarding to ATSI cultural competency and cultural safety.

Action 4:

(CPMC) develop a cyclical quality review tool, drawing upon the Critical Reflection Tool (CRT) developed by the LIME project, and seeking permission to modify it to ensure relevance for Specialists Colleges.

Representatives from RACS discussing surgery careers with AIDA doctors and medical students at the 2010 AIDA Symposium

The College has an Indigenous Health Position Statement and has incorporated Indigenous health priorities in its strategic plan. Both of these instruments are subject to periodic review and evaluation. The College has an Indigenous Health Committee, supported by an administrative officer, to guide and assist the College achieve its objectives in Indigenous health in both Australia and New Zealand. These existing structures will enable the College to deal confidently with the quality review tool being proposed in the Framework.

Action 5:

CPMC to continue its collaboration with AIDA to develop the Indigenous health workforce, from recruitment to specialisation.

The College is collaborating with the Australian Indigenous Doctors' Association (AIDA) in the development of strategies to promote and recruit ATSI doctors into surgical training. AIDA is a co-opted member of the RACS Indigenous Health Committee (IHC), along with their New Zealand counterpart TeORA, the Maori Medical Practitioners Association.

The College launched its program to promote surgery as a career in Australian Indigenous communities in 2010. Through the program two Aboriginal doctors attended last year's Annual Scientific Congress as guests of the College and a successful surgical career expo was held at AIDA's annual symposium. The IHC is developing a similar program for Maori medical students and doctors in collaboration with TeORA, including a plan to participate in TeORA's scientific symposium later this year.

The College has reason to be proud of its achievements in Indigenous health thus far. Much remains to be done, however, if the College is to realise its strategic and policy commitments to close the gap. The Medical Specialist Framework provides an opportune context in which further strategies and initiatives can be formulated to progress this aim. The IHC is a willing partner with other College stakeholders, the CPMC and Indigenous communities in the implementation of the Framework recognising the needs and strengths of the College and its Fellows.

Please contact indigenoushealth@surgeons.org for further information about the CPMC Specialist Framework and the work of the Indigenous Health Committee.

References

1. The Framework and Report is the result of a project commissioned by the CPMC Indigenous Health Subcommittee and undertaken by Shaun Ewen, Deputy Director of the Onemda VicHealth Koori Health Unit and Senior Lecturer in Aboriginal Health in the School of Population Health, University of Melbourne. The report's 19 strategies for action are grouped in priority of implementation; 6 are designated first priority, 11 second priority and 2 third priority.

2. For further information please visit CDAMS Indigenous Health Curriculum Framework

3. Further information about LIME and the CRT can be found at LIME Network

Process communications model

Learn the tools to help in your communication with others and improve performance

Marianne Vonau
Chair, Professional Development

Research shows that as many as 80 per cent of adverse events and 'human errors' result from human factors breakdown.1 Human factors refer to environmental, organisational and job factors, and human and individual characteristics that influence behaviour at work in a way that can affect health and safety.

A simple way to view human factors is to think about three aspects: the job, the individual and the organisation and how they impact on people's health and safety-related behaviour.2 Behaviour under stress is often identified as the root cause or a contributing factor to these errors occurring. The Process Communication Model (PCM) provides a practical tool that enables you to detect when people are beginning to perform less effectively, and helps you detect the early signs of miscommunication that may lead to problems in performance. It also allows you to reverse the process, improve performance and make communication more effective.

Basically, PCM allows you to detect stress in others and yourself at an early stage and provides you with a tool to re-connect with individuals you are struggling to reach. The most powerful aspect of PCM is that it allows you to step back and recognise that a particular behaviour is often not targeted at you, but is behaviour driven by stress – and you can do something about it! In 2010 the three PCM courses conducted specifically for surgeons were evaluated by the 24 participants; 15 Fellows and nine trainees. The aim was to evaluate the potential impact, value and utility of PCM as a tool for surgeons. Participants were asked to complete the same survey on three occasions: at the start, end and again three to four weeks post completion of the course. The results of the post course outcomes confirm the positive impact that PCM training can have in the short term:

- The pre-course self-assessment of participants' social-emotional skills (self-efficacy: openness, resourcefulness, persistence) showed, in comparison with reference data:
  - (i) Values at the lower end of a normal distribution in the areas of 'At home' and 'In private practice'.
  - (ii) Significantly low values in the area of 'Working with administration staff in public health'.
- The magnitude of change ('effect sizes') achieved across all areas by PCM training was 'dramatic' and beyond expectations.
- The ratings for the item 'My ability to help reduce complaints, lawsuits, mistakes and other unintended outcomes' went up slightly between the immediate post-evaluation and the follow-up evaluation a few weeks later.
- In general, there was a slight decrease in the immediate post to the later follow-up ratings. However, this was a small decrease, particularly given that there was no follow-up coaching, mentoring, instructional or 'share-the-experience' opportunities'. Follow-up opportunities might have had a strong effect in reinforcing the newly acquired skills developed during the initial training.

A number of emails have been received from participants regarding PCM:

Trainee: "I just wanted you to know that I have already received very positive feedback from one of the nurses at work about my being a lot nicer and calmer in my interactions with everyone. I am not all that conscious of this change, but apparently it is very noticeable."

Fellow: "Still referring to notes to 'pick personality' at this stage and will attempt to use PCM as a tool in daily practice. Once again I strongly support the introduction of PCM course for Trainees and Fellows."

Trainee: "It is like my eyes are opened to this mysterious line of communication signals, giving me power beyond belief. It's like I have learnt a new language and can talk to people in their own language."

The College is offering two half day 'Introductory PCM' courses in at the ASC in Adelaide on Monday, 2 May and two full PCM courses (2 ½ day) on 22-24 July in Melbourne and 26-28 August in Sydney. Participants need to complete a diagnostic questionnaire which forms the basis of an individualised report about each person's preferred communication style, so don't miss out and register now!

More information at +61 3 9249 1106 or pdactivities@surgeons.org and www.surgeons.org

References

1. Flin R .Fletcher G Glavin R, Maran N, Patey R. Non technical skills (ANTS) Handbook 2003 UK University of Aberdeen.

2. UK Health and Safety Executive (Reducing error and influencing behaviour, HSG48, 2005, HMSO).

The Younger Fellows Forum

The Younger Fellows Forum can be an excellent opportunity to make friends, and share experiences among peers

Steven Leibman
Chair, Younger Fellows Committee

Left; A group of Younger Fellows at a 2010 Forum; Inset: Fun, friendship and professional experiences are exchanged.

With another Younger Fellows Forum only a few weeks away, I was somewhat surprised recently when I was speaking to a young New Zealand trained Surgeon who had no awareness of the Forum. I thought therefore that it would be timely and important to write about the Forum as well as let you know some of the great achievements of previous Forum delegates.

In fact the first Forum was held in Wellington, New Zealand in 1982 and in the report tabled to College Council, Arthur Beasley commented on close friendships and strong support developed during the seminars.

There were 19 attendees and the topics discussed included surgical training, manpower, quality assurance and the ANZUS of Surgery. There was also, of course, an enjoyable social and bonding program. The Forum was met with great enthusiasm by delegates, attending councillors and the College, so has continued until today.

It is worth knowing and noting that each Forum has provided a report including direct recommendations to Council; each of which has been considered and usually approved with some very significant decisions being directly initiated from the Forum.

In fact the first recommendation from the first Forum was that Council agree to sponsor further meetings each year. Since then regular Forums have been held and it is now a well established College activity, taking place traditionally the weekend before the ASC.

The Forum involves around 20 younger Fellows from Australia and New Zealand with a range of ages, gender and speciality representation. This meeting of minds spends a busy weekend retreat discussing important current issues in surgery as well as College activities.

The focus is not scientific, but rather "it offers a unique opportunity for a group of Fellows to share ideas and experiences and debate issues that affect their professional and personal lives."

The program provides an opportunity for extensive discussion on 'hot College topics' and time to relax, get to know other Younger Fellows and participate in team building activities to challenge the body and mind. Above all, the Forum empowers Fellows to influence the way the College serves its Fellowship and the community, either as individuals or collectively.1

It is no surprise that many attendees have developed a great interest in College activities and have gone on to great achievements within the College. To mention a few (with apologies to those unintentionally left out) our current president, Ian Civil, was an attendee at the second forum in Melbourne in 1984. Also attending this forum were past president Kingsley Faulkner, Spencer Beasley, Anthony Eyers, Christopher Martin, Chris O'Brien, James Toouli plus others.

While reading the list of past presidents, vice presidents and councillors (available on the RACS website) I see only a few who have not attended a Forum as a delegate, councillor in residence or visiting president. As occurred at the first Forum, each year lasting friendships have developed, with links including inter-speciality, interstate, and international.

Each Forum has its own flavour, as determined by the convenor and approved by the Younger Fellows Committee. There are also usually international attendees from locations including Hong Kong, Malaysia, India and the US.

Recently, as part of the leadership exchange program with the American Association of Academic Surgeons, a nominated American Fellow has attended and made great contributions.

The Younger Fellows Committee is very proud of the Forum, and regards it as the standout contribution. There is no disputing the contribution Younger Fellows make to the profession, as well as to the College, and the Forum is for many the starting point of College life. A direct consequence of the recommendations from the Forum at the June 2005 Council meeting was that the Forum representative receives full voting rights at Council.

I encourage all younger Fellows to consider attending a Forum (remember you are eligible for your first 10 years of Fellowship) and all Fellows, particularly those who have been involved in previous Forums, to identify and nominate their 'younger' colleagues for attendance.

See you at the next Forum in Kuala Lumpur in 2012, one which once again is sure to be an enormous success!

Reference
1. www.surgeons.org/racs/fellows/interest-groups-and-sections/younger-fellows/younger-fellows-forum

Blue-printing the Fellowship examination: what does this mean?

Gone are the days where examiners are the only determinants of content

Spencer Beasley
Chair, Court of Examiners

It would be wrong to believe that examiners should determine the curriculum by what they ask in the Fellowship examination. Arguably, that used to happen – to a degree at least – but those days are now long gone.

While it is true that exams dictate learning, it is actually the nine specialty training boards that determine the curriculum, and not the Court of Examiners. The implication of this is that the Fellowship examination must be closely aligned to the curriculum of each specialty. The way this is done is through a process called 'blueprinting'.

Blueprinting is a way of demonstrating that the examination is focused correctly, and adequately covers the scope and depth of the syllabus. But it does even more than that, by clarifying which competencies it tests in relation to the other assessments conducted during SET training, and by making sure that it is conducted at the right level for a true "exit" examination.

It is accepted that the Fellowship examination may not be the best tool to test all the nine surgical competencies (as many are better assessed during SET training). As a consequence, the Fellowship examination concentrates mostly on the assessment of professional judgement and clinical decision-making.

Basic knowledge is assumed, but it expects candidates to be able to demonstrate their ability to apply this knowledge in the clinical setting. Being a true "exit" examination – taken at or near the completion of SET training – it is directed at the higher levels of thought. This means it concentrates on the ability of the candidates to make good clinical and operative decisions, and be able to justify them.

The new Examiners' Training course instructs new examiners how to blueprint the examination in relation to scope (coverage of syllabus), surgical competencies being tested, and Bloom's taxonomy level, with a trend towards the higher levels of cognitive function.

As an aside, the introduction of SET has led to review of the format and assessment tools being employed for the specialty-specific surgical science examinations in each specialty. This is happening at a time when the Court of Examiners is gaining increasing expertise in standard setting, exam preparation and conducting summative assessments in each specialty area.

As a consequence, careful consideration needs to be given as to whether there is a role for members of the Court to assist with some of these specialty-specific examinations on behalf of the specialty training boards – this already happens in at least one specialty.

Congratulations on your achievements

NSW Merit awards presented at the NSW Regional Committee End of Year Dinner

As a medical student at Concord Hospital, Martin Jones made it clear he intended to become a surgeon. While his fellow students were in the library, common room or pursuing extracurricular activities, Martin was in the wards or in the operating theatre. As a student he was well known to the consultants. Having received excellent reviews during his intern and residency years, Martin was encouraged to pursue his ambitions.

Martin was far more interested in looking after patients and being in the operating theatres, which meant the necessity to pass the surgical exams was somewhat of a nuisance and interfered with what he enjoyed doing. Ultimately, however, he convinced the examiners of his worthiness as a surgeon.

Martin worked as a senior registrar to the biliary unit at Concord Hospital for approximately three years and was involved with the introduction of laparoscopic gallbladder surgery in 1990.

With a little help and guidance from his in-laws, an opportunity became available for Martin to commence practice in Nowra and after some deliberation, Martin, Denise and their children moved to Nowra, bought the local Catholic Convent and set up home.

As a student and during his training years, Martin was always involved with the many activities within Concord Hospital including the RMO association, organising social functions and the like. During his registrar years, he formed a close working relationship and friendship with Dr John Moulton who at that time was the Australian Rugby Union doctor. Through this relationship, Martin became the club doctor for Eastwood Rugby Club.

He has always given much time to teaching and training, initially as a resident and registrar and once Martin established himself in Nowra, he devoted much time to teaching and training activities. This provided endless hours of tuition, direction and teaching to the students and young doctors attached to the hospital.

Martin has been the driving force for teaching and training at the Shoalhaven District Hospital, chairing the various teaching committees and ultimately becoming head of the Department of Surgery. He was involved with the College training activities, especially as they affected rural surgeons. In more recent years his involvement with the University of Wollongong has culminated in him being appointed as a Clinical Associate Professor in surgery in 2005.

Martin is one of those people who works extremely hard (puts me to shame) and has a knack for attracting difficult and complex cases. When Martin was a registrar and he was rostered on with me, I knew I was in for a tough weekend. When he moved to Nowra his knack for attracting those difficult and complex cases flourished. We got to know many of his cases as he would have no hesitation involving his colleagues to assist him with the management of these patients.

Martin is a truly dedicated surgeon and teacher and even when he developed a nasty medical illness, which made him extremely ill, he pushed on, I suspect against advice and continued with his practice and teaching.

Written by John Hollinshead

Graeme Richardson was born, bred and schooled in regional Victoria before entering the University of Melbourne and gaining MBBS with honours in 1968.

Graeme spent his resident and registrar years at the Royal Melbourne Hospital with a number of memorable rotations, in particular his time in Papua New Guinea. He gained his FRACS General Surgery in 1973.

The years from 1974 through to 1976 were spent with his young family and wife, Di, in the UK gaining an FRCS and post-graduate experience particularly in urology, vascular and general surgery. Graeme returned to Australia in 1976 and settled as a VMO in Wagga Wagga, NSW. This was the beginning of a 30 year illustrious career as a surgeon, teacher and administrator.

Graeme's achievements in Wagga Wagga and indeed as a leader across provincial and regional surgery in Australia are considerable. He became only the second rural-based vascular surgeon in Australia and subsequently developed a strong vascular service in the Riverina.

He has been a pioneer of vascular ultrasound and has gained an international reputation in this field. In particular his interest in the ovarian vein syndrome and its role in pelvic congestion has been internationally published and the basis of a PhD thesis. Graeme has authored a number of chapters in international texts around this interesting subject.

Arguably Graeme's biggest contribution to the Riverina has been his drive and commitment to education, training, surgical innovation and clinical governance. As an educator he has been a driving force behind the Rural Clinical School for the University of NSW. While this has occurred, in recent years he has been instrumental in educating reams of medical students, registrars and mentoring young clinicians.

He has a senior role in IMET NSW. As a surgical trainer he has been rigorously disciplined and all of his registrars have gained great respect for his attention to detail and in particular his anatomy grilling at the time of each case. As an innovator, he has been central to the development and implementation of the EMST program in non-metropolitan areas.

Graeme was a founder of the first privately funded, community-based screening mammography service as well as being a pioneer in tele-radiology. Graeme was also a founding member of a private day surgery in Wagga Wagga, as well as on the steering committee for the first non-metropolitan radiotherapy centre in NSW.

Graeme has always had a strong interest in clinical governance and has spent many years as head of the Department of Surgery in Wagga Wagga. He was a previous chairman of the Medical Staff Council.

He has taken it upon himself to ensure as much of the Garling report can be implemented in Wagga Wagga as possible. He has convened the rural section of an Annual Scientific Congress and has been a prominent member of the Provincial Surgeons of Australia.

Graeme has retired from full-time clinical practice over the past few years. He dedicates much of his time to his farm, his wife, Di, his three beautiful daughters and grandchildren.

It is my pleasure to be able to deliver this citation on Graeme Richardson and he is a worthy recipient of such an honour.

Written by Richard Harrison

JMO Supervision: An Essential Safety Ingredient

This article appeared in the Spring 2010 issue of *Defense Update* from the MDA National Group

Sara Bird
Manager, Medico-Legal and Advisory Services

MDA National Insurance

A recent Coronial Inquest highlighted the need for appropriate staffing and supervision of JMOs in public hospitals.

Case History

On Sunday 22 January 2006, Ms Olga Krivitch, 81 years of age, presented to Royal Adelaide Hospital (RAH) with a several day history of a cold and painful right foot. A diagnosis of an ischaemic right leg was made. An angiogram and subsequent thrombolytic therapy was performed by a senior radiologist in the Department of Radiology on the afternoon of her presentation to hospital, but this was unsuccessful in improving the perfusion of her leg. The patient was then admitted to the Vascular Surgery Unit at RAH. There was no surgical option available to achieve re-vascularisation of the patient's right leg. In order to try to maintain the viability of her leg, the admitting vascular surgeon decided to commence the patient on an anti-coagulation regime, involving the RAH Heparin Protocol.

At the time of the patient's admission to the Vascular Surgery Unit in January 2006, there were no registrars working in the unit. Instead there were two "relieving" RMOs, working in conjunction with two interns in the unit.

During her admission, the patient's APTT and haemoglobin were checked on 22, 23 and 24 January 2006. On 22 January 2006, her haemoglobin was 119. On 23 January 2006 it was 100 and on 24 January 2006 the haemoglobin was 98. On 24 January 2006, the patient was also diagnosed as suffering from a non-traumatic haematoma of her left shoulder. No haemoglobin was ordered or performed on 25 and 26 January 2006, although her APTT levels were checked on both of these days.

At 10:55am on Friday 27 January 2006, blood tests revealed a haemoglobin of 54 and an APTT of 109. Later that day, the RMO was contacted by the unit intern and informed of these results. The intern explained to the RMO that he had been unable to obtain any further blood for cross-matching. At about 3pm on 27 January 2006, the RMO examined the patient, but the source of bleeding was unable to be identified. The RMO obtained blood for cross-matching and ordered a CT abdomen and pelvis to try to identify if there was an intra-abdominal bleed. The RMO attempted to contact the admitting and also the on-call vascular surgeons, without success.

The RMO left a message for both of the vascular surgeons, outlining his concerns about the patient's deteriorating condition and his plan for a blood transfusion and CT scan. The heparin infusion was also ceased. The RMO went off duty at about 5:30pm and handed over the patient's care to the other unit RMO who was on-call from 5pm until 8am the following morning. The patient's blood transfusion did not commence until about 8:20pm on 27 January 2006. The CT scan revealed a massive haematoma of the right thigh.

The admitting vascular surgeon was eventually contacted and the patient was taken to theatre in the early hours of the morning on Saturday 28 January 2006, where a bleeding point in the right femoral artery was oversewn. Post-operatively, the patient was admitted to the ICU. However, she had developed respiratory failure, renal failure, ischaemic hepatitis and an acute myocardial infarction. Her condition continued to deteriorate over the next 24 hours and eventually treatment was withdrawn. The patient died at 9:30am on 29 January 2006 and her death was reported to the Coroner.

Medico-legal Issues

A Coronial Inquest was held in June 2009 and the Coroner's findings were handed down on 4 February 2010. The Coroner found that the patient had died as a result of hypovolaemic shock following bleeding from the site of a femoral angiogram. Expert evidence was provided at the Inquest by an Intensive Care Specialist, Professor J Cade. The admitting vascular surgeon and the unit RMO also gave evidence at the Inquest.

Professor Cade had two main concerns about the patient's management: Firstly, that the patient's anti-coagulation regime was not stabilised in a timely manner, and she was over anti-coagulated for some period of time. Secondly, he was concerned that the significant bleeding from the site of Ms Krivitch's original thrombolytic therapy had not been identified in a timely manner with the result that the patient experienced severe blood loss, hypovolaemia and significant coagulopathy from which she did not recover.

Professor Cade opined that a number of things urgently should have followed the discovery on 27 January 2006 that the patient's haemoglobin was 54. At the Inquest, he gave the following evidence:

"This is a red flag that needs immediate attention…Firstly it needs to be checked that it is correct, it may have been an erroneous sample…. Then you need to urgently look at the patient, see if they are pale, see if they have got some bleeding and see what their general state is like. If it was believed on all those grounds that the reading is correct then two things have to happen from that: one is urgent repair of the haemoglobin with a blood transfusion; and secondly urgent investigation of the (bleeding) site…. Where is all the bleeding?"

He concluded that Ms Krivitch would have survived if appropriate interventions including an early identification of her haemoglobin levels and a blood transfusion on the morning of 27 January 2006 had been commenced.

The Coroner stated that the fact that the patient's haemoglobin levels had not been checked on 25 or 26 January 2006 "was a significant oversight that was to have a direct bearing on Ms Krivitch's decline and death.

"The fact that no specific instruction was given to junior staff to monitor Ms Krivitch's haemoglobin levels on 25 and 26 January 2006 was to my mind a misjudgement given that there was already in existence evidence of spontaneous bleeding (into the shoulder) that was the product of over anticoagulation".

He went on to state that "I find that there was a significant and unacceptable delay in appropriate action being taken after Ms Krivitch's haemoglobin level was revealed to be 54. The haemoglobin test sampling was undertaken at 10:55am on 27 January 2006. There was no evidence as to when the result of that test would have been available for the first time, but it was not reported to… one of the two RMOs on the ward until shortly before 3pm that day. Even then there was considerable delay in administering the necessary blood transfusion…I conclude that the shortcomings in Ms Krivitch's treatment at the RAH were due to the inexperience of junior practitioners who were staffing the Vascular Surgery Unit at that time and the lack of supervision of those staff members.

"It is hard to imagine experienced registrars, had they been employed within the unit at the time, not ensuring that appropriate monitoring was in place, particularly in relation to Ms Krivitch's haemoglobin levels. Similarly, in my view the delays experienced during the afternoon of 27 January 2006 could have been avoided if more experienced and senior medical staff had been on hand. If appropriate medical expertise had been available within the Vascular Surgery Unit at the relevant time, I find on the balance of probabilities that Ms Krivitch's outcome could have been avoided.

"Having regard to the inexperience of the medical staff who were employed at the Vascular Surgery Unit from 22 to 27 January 2006, there is no evidence to warrant the criticism of any individual junior medical practitioner. They should have been more closely supervised and, in particular, it should have been made clear to them that there was a fundamental need for Ms Krivitch's haemoglobin levels to be closely monitored and evaluated on 25 and 26 January 2006."

Risk Management Strategies

The Coroner's recommendations included the following:

- "That the Minister for Health draw to the attention of the Chief Executive Officers of all public hospitals the desirability of identifying in advance of the commencement of anti-coagulation therapy, the relevant blood grouping of the patient so as to facilitate the more timely delivery of a blood transfusion should the necessity for the same arise;
- That the Minister for Health draw my findings in respect of the necessity to monitor haemoglobin levels in circumstances such as those that pertained to Ms Krivitch to the attention of all the relevant persons at all medical schools in South Australia;
- That the Minister for Health take the necessary steps to ensure that wards in all public hospitals are at all times appropriately staffed."

REFERENCE
Inquest into the death of Ms Olga Krivitch, Coroner's Court of South Australia, Inquest number 13/2009 (0154/2006).

Regent (centre) at the Christ Church Regatta. Below: Regent (Second, left) with Alan Scott (first, right) with Henry and Sheena Lumley enjoying a Sunday lunch.

A helping hand in research

Regent Lee shares his experience in vascular surgery training, research at Oxford and how these were made possible via the support of RACS

Regent Lee
Lumley Exchange Research Fellow 2011

Many people influenced the course of my surgical training. It was truly exciting to meet two of these key figures at the same time. Mr Alan Scott, former Chairman for the Board of Vascular Surgery, was stopping over in London during a trip to Europe. Mr Henry Lumley, the current benefactor of the Lumley Surgical Exchange Research Fellowship, heard of the opportunity and kindly invited Alan and me to join him for a Sunday lunch. It was a highlight of my stay in Oxford so far.

The Lumley's involvement with the College of Surgeons spanned over decades. The Royal College of Surgeons in London needed to be rebuilt after the War. Henry's father, Mr Edward Lumley, contributed heavily through his engagement in the insurance industry. One of the main halls in RCS was named after Edward Lumley in recognition of his contribution. Originally from Australia, the Lumley's subsequently extended their support to the Royal Australasian College of Surgeons and saw the establishment of the Lumley Surgical Exchange Research Fellowship in the 1950s, with the aim to encourage and support capable young surgeons to conduct a period of research training in the UK.

Alan was a keen advocate for vascular trainees to obtain diverse experience and was instrumental in establishing the exchange vascular surgery training program between UK and Australia in 2008. The Australian trainees have the opportunity to spend a year in one of the historic UK campus (Oxford, Cambridge or Edinburgh) as part of the SET program. In return, selected Australian centres would host the UK vascular trainees and offer the unique experience of surgery training in Australia. I have always yearned to visit Oxford and was delighted to be awarded with such an opportunity.

The exchange post in Oxford proved to be a fantastic experience. I was captivated by the rich history of the campus and thrilled to learn of the great Australian heritage in the history of surgery and medicine in Oxford. Walking down the corridor at the Nuffield Department of Surgery, I was greeted by the portrait of Sir Hugh Cairns[1] and Sir Peter Morris[2]; at the Dunn School of Pathology, I was grasped by a plaque that marked the room where Howard Florey's team first purified penicillin[3]!

Life at Oxford is filled with excitement and surprises. There are abundant opportunities to learn from and collaborate with colleagues from all disciplines. Most clinicians at the Oxford Radcliffe Hospital (ORH) have significant interest in academia and there are frequent interactions between the clinical specialties and research groups. I was fortunate to work in such an environment as a vascular surgery trainee and it wasn't long before I decided to explore the potential for doing research at Oxford.

A unique opportunity presented during my vascular surgery training at Oxford. I responded to a research job advertised in the British Medical Journal and was absolutely thrilled to be awarded the job against national competition. After completing my vascular surgery exchange program, I immediately returned to Oxford and took on the role as a clinical research fellow with Professor Keith Channon, a consultant cardiologist at the ORH and Director of the Oxford Biomedical Research Centre.

My research project is focused on identification of novel biomarkers related to atherosclerotic plaque rupture. It is a prospective observation cohort study in patients who present to the ORH for percutaneous coronary intervention (PCI). Using PCI as the model of controlled plaque rupture in-vivo, we aim to investigate the utility of intravascular imaging and plasma biomarkers in the early detection of plaque rupture, an event which predates the "downstream" organ ischaemic injury which may present acutely with symptoms such as transient ischaemic attacks and acute coronary syndromes.

The initial emphasis of my role as a clinical research fellow was to administer every aspect of this clinical study. With recruitment well underway, the focus gradually shifted toward exploring the laboratory and experimental methods in order to address scientific questions of this project. Despite the many potential challenges, I decided to take further time off from clinical training to pursue a Doctorate of Philosophy in Cardiovascular Medicine based on my research in this project.

The timely award of the RACS Lumley Fellowship helped overcome the immediate financial challenge. As a non-EU resident, the Oxford University fees were almost prohibitive without formal funding support. Although only tenured for one year, the Lumley Fellowship nevertheless provided the critical impetus over the initial hurdle and set me in a better position to apply for further funding to support the remainder of my study. After being awarded the Lumley fellowship, I was officially accepted by the University of Oxford and commenced my DPhil with Trinity College in October, 2010.

Without the pioneering efforts of Mr Scott, I would not have fulfilled my dream of coming to Oxford; without the generous support of the Lumley Family, I could not have realised the aspiration to further my academic interest in one of the great institutions for cardiovascular medicine. I remain eternally grateful for their influence in shaping my surgical career and hope to be able to make future contributions to the Australian surgical community.

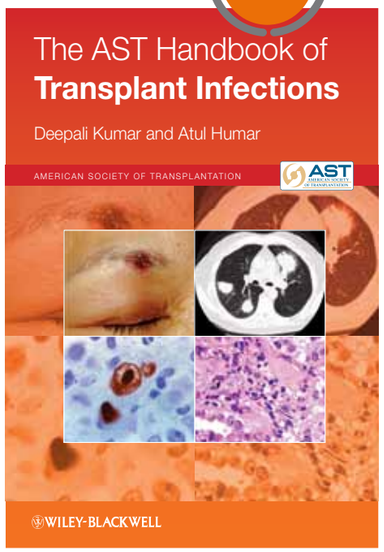
> *"I was captivated by the rich history of the campus and thrilled to learn of the great Australian heritage in the history of surgery and medicine in Oxford."*

Notes
1. Sir Hugh Cairns was one of the founders of Neurosurgery in UK and the medical school in Oxford. The library at ORH is named after him in recognition.
2. Sir Peter Morris was a transplant/vascular surgeon and the Nuffield Professor of Surgery at the University of Oxford for almost two decades. He was subsequently elected the President of Royal College of Surgeons in 2000.
3. Howard Florey won a Nobel Prize in Physiology and Medicine in 1945 for his role in the extraction of penicillin and elected president of the Royal Society in 1959.

Welcome to the Surgeons' BOOKCLUB

Highlighted in this month's issue are recent and new titles from across the spectrum of books available from John Wiley & Sons.

BOOK OF THE MONTH 20% Discount



AST Handbook of Transplant Infections

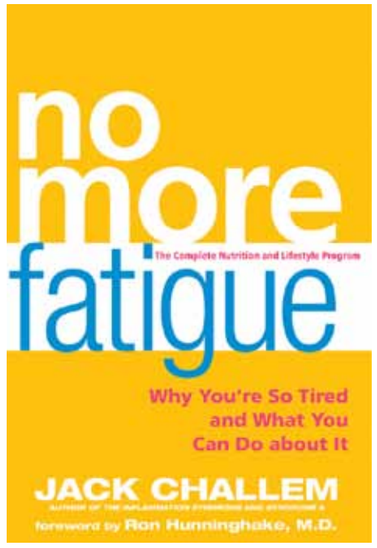
Deepali Kumar, Atul Humar
9780470658277 | Pbk | 144 pages | May 2011
~~AU$64.95~~ **/ AU$51.96**

Whether you need to manage a post-transplant infection or reduce the possibility of infection, you will find effective guidance in this handbook. The work of the American Society of Transplantation Infectious Diseases Community of Practice, this reference exclusively uses tables and flowcharts to speed up decision making.

This distinguished group of investigators and teachers provide point of care information on optimum management of infection in adult and paediatric organ and stem cell transplant patients. The unique tables and flowcharts are devised by the authors, backed up with extensive references, making the book a fully researched yet easy to use guide.

Increasing numbers of successful procedures mean transplant teams have to be ever more alert to the possibility of and need for action in the event of ensuing infection.

15% Discount



No More Fatigue: Why You're So Tired and What You Can Do About It

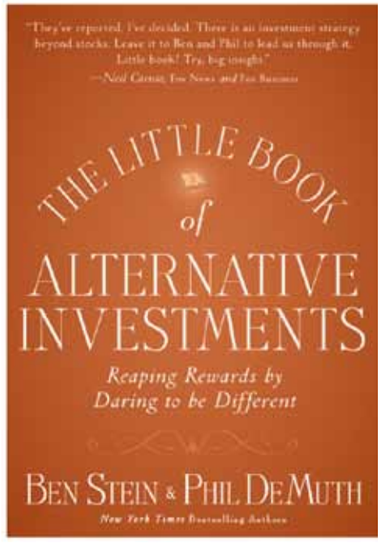
Jack Challem
9780470525456 | Hbk | 288 pages | Feb 2011
~~AU$32.95~~ **/ AU$28.00**

A complete program to overcome a new epidemic-The Fatigue Syndrome. Do you feel exhausted, rundown, and stressed-out all the time? Do you have trouble sleeping well at night and wake up feeling exhausted? More and more of us have these problems. In this groundbreaking new book, bestselling Inflammation Syndrome author Jack Challem will help you combat fatigue and feel better.

- Uncovers the role that eating habits, hormones, illness, aging, and other factors play in fatigue
- Discusses the growing problems of adrenal fatigue and low thyroid hormone
- Presents a complete nutrition and lifestyle program to conquer fatigue and re-energise your body and life
- Includes energy-enhancing recipes and meal plans to help you combat fatigue and stress

With No More Fatigue, you will rediscover the joy of feeling well rested, re-energised, and ready to take charge of your health.

15% Discount



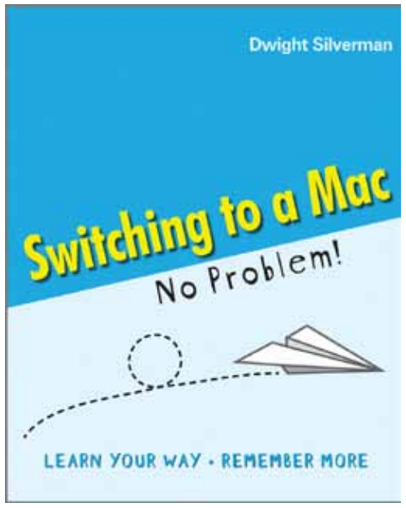
The Little Book of Alternative Investments: Reaping Rewards by Daring to be Different

Ben Stein and Phil DeMuth
9780470920046 | Hbk | 288 pages | March 2011
~~AU$27.95~~ **/ AU$23.76**

Bestselling authors Ben Stein and Phil DeMuth know that investors are bored with their typical 60/40 stock and bond portfolios and curious about whether some of the new variations going around might be right for them. At the same time, many alternative strategies are going down-market and opening to the retail investor. Stein and DeMuth recommend that investors look outside of the box to hedge funds, real estate, gold, commodities, and even art as sources of investment income.

Stein and DeMuth interview the leading experts in the industry, take you on a guided tour of this Ripley's museum of new and strange offerings, explain in simple language how they work (or don't work), and tell you how you can use them to manage risk and boost returns.

15% Discount



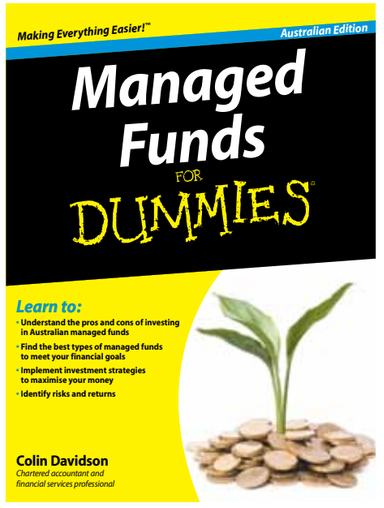
Switching to a Mac – No Problem!

Dwight Silverman
9780470710159 | Pbk | 344 pages | June 2010
~~AU$29.95~~ **/ AU$25.46**

Switch from a PC to Mac with no problem!

- Experienced using Microsoft but now switching over to a Mac? No Problem! With this book you can build upon the knowledge you have
- In a rush to get going on a Mac? No Problem! For a quick path, you can choose to read only the highlighted text for just what you need to know
- Prefer to take notes while you learn? No Problem! We've sprinkled loads of notes and quick tips throughout the book, and left you plenty of room to take your own
- Need a detailed step-by-step guide to switching from Microsoft to Apple software? No Problem! Combine all the learning paths for a comprehensive workshop

15% Discount



Managed Funds For Dummies, Australian Edition

Colin Davidson
9781742169422 | Pbk | 376 pages | January 2011
~~AU$39.95~~ **/ AU$33.96**

Multi-sector Equities? Concentrated Funds? What about index funds? If you are lost in the maze of possible investment options, Managed Funds for Dummies will show you the way! Packed with insider tips on finding the best funds for your needs, this accessible and informative guide demystifies managed funds and shows you how to make smart investment decisions that will pave your way to financial success.

Also available at 15% off in our best selling How To series at this special price:

How to Display Data 9781405139748
How to Present at Meetings 2E 9781405139854
How to Read a Paper 4E 9781444334364
How to Succeed at the Medical Interview 9781405167291
How to Succeed at Medical School 9781405151399
How to Survive a Medical Malpractice Lawsuit 9781444331301
How to Survive a Peer Review 9780727916860
How to Survive in Medicine 9781405192712
How to Teach Continuing Medical Education 9781405153980
How to Write a Grant Application 9781405197557

WILEY-BLACKWELL

To Order

Contact Customer Service by phone on 1800 777 474
Provide your name, contact details and payment details.

Wiley accepts Visa, MasterCard and Amex only
Postage is charged on all orders: AU$7.50 within Australia and AU$25.00 to New Zealand

To read more about these titles please go to www.wiley.com

RACS Discounts

Wiley-Blackwell offers College Fellows discounts on All Wiley-Blackwell titles.

20% discount is offered on the Book of the Month.

15% discount is offered on all other books.

You must quote Promo Code
RCS11

Foundation for Surgery
Passion. Skill. Legacy.

thank-you

for donating to the Foundation for Surgery

Victoria
Assoc. Prof. Joseph Epstein, AM
Mr Keith Henderson
Mr Paul Kierce
Mr Raymond King
Mr Ian McInnes
Mr John O'Brien
Assoc. Prof. Richard Page
Prof. John Royle
Mr Alan Saunder
Dr Jennifer Wheatley

New South Wales
Prof. Bruce Barraclough, AO
Dr Lisa Cottee
Dr Ian Francis, OAM
Mr Min Lai
Mr David Millons, AM

ACT
Dr Peter Brown, AM

Queensland
Professor Glen Gole
Mr Jacobus Malan

South Australia
Mr Djin Ghan
Mr Paul Leong

New Zealand
Mr Richard Coutts
Mr Michael Klaassen
Mr John McDonald
Mr Mark Wright

USA
Mr George Fielding
Mr Michael Rutter

Singapore
Mr Siew Cheah

Pakistan
Mr Muhammad Shaffi

Total $11,250

Your passion.
Your skill.
Your legacy.

Your Foundation.

YES, I would like to donate to our Foundation for Surgery.

With every donation over $1000, the College is able to support Research & International Outreach Programs.

Name: Speciality:

Address:

Telephone: Facsimile:

My cheque or Bank Draft (payable to Royal Australasian College of Surgeons) for $ ☐☐☐☐☐.☐☐

Please debit my credit card account for $ ☐☐☐☐☐.☐☐

☐ Mastercard ☐ Visa ☐ AMEX ☐ Diners Club ☐ NZ Bankcard

Credit Card No: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry ☐☐/☐☐

Card Holder's Name - Block Letters Card Holder's Signature Date

I would like my donation to go to:

☐ General College Bequests ☐ International Development Program
☐ Scholarship and Fellowship program ☐ International Scholarship Program
☐ I have a potential contribution to the Cultural Gifts Program
☐ I do not give permission for acknowledgement of my gift in any College Publication

Please send your donations to:
Foundation for Surgery

AUSTRALIA & OTHER COUNTRIES
Royal Australasian College of Surgeons
College of Surgeons Gardens
250 - 290 Spring Street
EAST MELBOURNE VIC 3002

NEW ZEALAND
PO Box 7451
Wellington South New Zealand
Tel: +61 4 385 8247
Fax: +64 4 385 8873

Foundation for Surgery
Passion. Skill. Legacy.

GAMMEX®
Powder-Free

AMT®
Antimicrobial Technology

Antimicrobial technology for surgical gloves.

When the Outside Gets Inside

The first surgical glove that fights back: GAMMEX® Powder-Free Glove with AMT™. It is the surgical glove that gives you a new level of protection in the event of a glove breach.* Available only from Ansell, the glove's unique internal coating contains chlorhexidine gluconate for ongoing action against invading viruses and bacteria.

For further information please contact:

Telephone 1800 337 041
Facsimile 1800 803 578
protection@ap.ansell.com
www.gammexpfamt.com

During in vitro laboratory testing, GAMMEX Powder-Free with AMT:

- Kills >99% of an HCV surrogate and 99% of HIV-1 strain Mn as early as one minute following exposure.
- Kills >99.7% to >99.999% of eight common healthcare facility associated infection bacteria, comprising gram-positive, gram-negative, and drug-resistant bacteria as early as one and two minutes following exposure.

In vivo laboratory testing confirms that the internal antimicrobial coating remains active against *S. aureus* after two hours of wear.

GAMMEX Powder-Free with AMT contains natural rubber latex, which may cause allergic reactions.
* GAMMEX Powder-Free with AMT is not proven to protect against blood-borne infections where the skin is broken, cut, or punctured.
Australia Patent No. 703926 and New Zealand Patent No. 556353. AU and worldwide patents pending.

Ansell