Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **APRIL 2013**

Includes Post Op 12 page Lifestyle section

The College of Surgeons of Australia and New Zealand

ASC - AUCKLAND 2013

Welcome to Auckland

Convenors have an exciting program in store for the 2013 ASC

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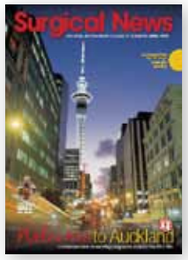


ON THE COVER:
See you in Auckland!
Pic by Keiran Scott
Courtesy New Zealand Tourism

President's Perspective

Culture eats strategy for breakfast

The College maintains important partnership arrangements with the RACP and the Canadian College of Physicians and Surgeons. In mid-March we held a number of workshops on issues like CPD and revalidation, work-based assessment and clinical decision making in conjunction with an open one day seminar on 'Serving the Community: Training Generalists and Extending Specialists'.

This follows on our highly successful seminar last year about 'The Medical Professional in the 21st Century: Competent, Fit and Safe' and again was successful in bringing key educational and regulatory decision makers from Australia, New Zealand and Canada to discuss the important issues that will be impacting on surgeons in the very near future.

Generalism and Specialisation are key strategic issues for our College and affect all branches of surgery. They can be considered from different perspectives, the individual surgeon, the professional organisation and also the views of the community, government and its jurisdictions, and our employers.

The latter stakeholders in particular are keen to promote generalism and are less than enthused about the increasing trend to super specialisation. During the seminar many scenarios were discussed and both the joys and sorrows of programs highlighted.

It is becoming increasingly evident that unless we continue to recognise the importance of our generalist training from an individual and professional perspective, then employers and regulators will step in and enact the outcome they require.

The drive to specialisation is occurring across all of the nine specialties in which the College awards a specialty – not just general surgery and orthopaedic surgery. The gastrointestinal tract seems to be divided into ever decreasing lengths, individual joints now have nominated specialists, otolaryngologists now often specialise in one small component such as voice and plastic and reconstructive surgery have watched the breadth of their practices skewed to an extreme.

But it is not only our recognised specialties where there is concern with Obstetricians and Gynaecologists as well as Ophthalmologists and Radiologists working in smaller and smaller areas of anatomical interest. This has been analysed by health economists as well as health managers. There was an interesting discussion how this drive to sub-specialties is now producing a totally uneconomical model of 'on-call' arrangements in major and metropolitan health services. Not surprisingly some hospitals have now responded in their recruitment processes to a 'commitment' to on-call availability in the 'overall specialty' that cannot be sub-divided or delegated.

In the future, jurisdictions will demand surgeons maintain a commitment to the breadth of their specialty. If a surgeon requires 'back-up' when they are on-call, then that is all possible, but they will need to maintain the role of 'on-call' surgeon, will need to maintain CPD in generalist skills and if necessary 're-skill'. "I do not do those anymore…" will no longer be acceptable.

A particularly valuable presentation was provided by Professor Phil Carson from Darwin Hospital. He undertakes his professional practice in the midst of two large networks of colleagues.

The first is as a general surgeon where he is linked either by mentoring or tele/video conferencing with many sub-specialty surgeons around Australia who provide direct support for the more difficult or technically challenging clinical situations. As he stated so clearly, the best time via air-ambulance to an operating theatre in a major hospital in another region is 14 hours.

His other network is the very large group of medical practitioners – non-surgeons – who undertake surgical procedures throughout the Northern Territory who rely equally on access to Phil and his colleagues to be able to provide the care that is required for the patients they are treating. It was an incredibly powerful, yet pragmatic presentation.

It was not surprising that he was asked, "How would you replicate your model in…" The response highlighted those interpersonal and support in the workplace issues. We all know places where collaboration, communication and teamwork would produce vastly improved services and a much more rewarding professional practice.

It was after Phil tried to explain the key interpersonal issues for success that the facilitator echoed the comment made famous by Peter Drucker: "Culture eats strategy for breakfast". I had heard the remark before – I think we all have. However, it does not just relate to management gurus or the Ford Motor Company where this saying was a clear motto to turn the company around.

It has recently been used in the wake of the Staffordshire review within the NHS as they come to grips with how a culture of compassion, caring and consideration (to which all health-care staff would surely aspire) was replaced by one of callous disregard, fear and disinterest. And here it was again – not in the motor car industry or in the NHS, but applying to hospitals that people in the audience knew so well – too well.

So how do we change culture? Generalism is one aspect of the "culture" the community expects us to espouse and aspire to, and our response to this challenge is one way in which the community will judge us. How do we create models where generalism is desired, respected? This calls for cultural change. To change culture we have to change attitudes by challenging and modelling alternative attitudes that have credence within the same environment.

For surgeons, we sometimes think that culture is a touchy-feely component that belongs with the HR department. However, others will say that "culture" is a key driver that has to be set or adjusted periodically, in response to a changing environment, to maintain our position as a respected and autonomous professional organisation within our community.

Our response to the increasing calls by the community for "generalist" trained and capable surgeons is one way the community will judge whether we can be entrusted with the responsibility for surgical education and standards into the future.

Mike Hollands
President

Important issues for the College

Generalism and Alcohol must be addressed

One of the privileges of being Vice-President is to chair the College's Governance and Advocacy Committee (GAC). Several key initiatives are underway, some being finalised, others in the earlier stages of development. These initiatives reflect internal concerns raised by surgeons, but also proactively address issues related to community need and government processes.

An example of the latter is the well-publicised need for enhanced rural and regional surgical services. After extensive consultation, and working closely with the College's Rural Surgery Section, the committee is finalising a position paper on this particularly challenging issue.

There is increasing awareness that the problem of surgical access outside metropolitan centres stems not from a shortage of surgeons overall, but from the maldistribution of the surgical workforce.

The vast majority of us are drawn to the cities, where partners are more likely to find work, our children have greater educational choice and we are close to major hospitals, universities, the College's conferences and workshops, and a wide network of friends and colleagues. There is also an awareness that continuing to increase surgical numbers overall will not necessarily address the problem of maldistribution.

While surgical practice in rural and regional areas has undeniable attractions, both in terms of lifestyle and professional challenge, they seem too few to entice surgeons away from our major cities.

This is bad news for those communities whose very existence can be threatened by inadequate healthcare provision. It can also result in an unfair burden being placed on those surgeons who choose to rise to the challenge of working in less supported environments – even wanting to take a holiday can engender feelings of guilt!

As a profession of surgeons, we need to identify solutions in the very near future. Otherwise there is the entirely predictable risk that what we would view as the "draconian" solutions currently being contemplated will be imposed.

Another issue being considered by GAC is closely related. Government agencies across both our countries, and in the case of Australia at both levels of government, have made it clear that the trend towards subspecialisation must be offset by a concerted effort to encourage generalism. This is "dangerous territory" for the College, as many surgeons would support this direction and an almost equal number would oppose it. The challenge for GAC is to remain engaged with government in order to achieve an appropriate outcome rather than become isolated and have a solution imposed.

Associate Professor Phillip Carson is a member of GAC and he has accepted the challenge of convening a Generalist Surgery Working Party that will provide advice to GAC. The working party is in the early stages of its brief, identifying where the gaps in surgical services are widest and devising ways in which the College and surgeons can help fill them. To my mind, one of the greatest challenges is how we can restore the prestige of being a generalist.

The working party is initially focusing its efforts on those areas where the College can have real impact: reviewing the training provisions and the role of the specialty training boards and assessing the required scope of practice of generalists.

The working party is also working closely with a working party on an allied issue – GP Proceduralists. It is intended that the two working parties will ultimately deliver a cohesive and coordinated approach to generalist surgical practice which will deliver tangible benefits to patients in rural and regional areas in our two countries.

> *"To my mind, one of the greatest challenges is how we can restore the prestige of being a generalist"*

Finally, I need to tell you that GAC has become very interested in alcohol. Surgeons are ideally placed to take a position with respect to alcohol issues within society – not least because of our reputation for enjoying alcohol or that many of our number produce some very fine wines! We cannot be silenced by being described as "wowsers".

But as surgeons we have to deal with many of the adverse effects of alcohol – road trauma carnage, senseless alcohol fuelled assault, and domestic violence. Many surgeons have contacted me and talked in terms of an epidemic! In our society more than one third of all police time is spent dealing with alcohol related issues – this has to be telling us something!

The College has a well-established tradition of taking informed and principled positions on issues of public health – alcohol harm mitigation is entirely within our remit and our voice must be heard on this issue.

Accordingly the Governance and Advocacy Committee has decided to develop a College policy that will guide our advocacy efforts on this issue. We are fully aware that we will come up against the carefully marshalled forces of the alcohol industry, with experienced lobbyists and seemingly limitless advertising budgets. And we will come up against politicians who are more inclined to listen to constituents than surgeons.

These obstacles notwithstanding, the committee feels that as clinicians we owe it to the community to highlight the extent of the damage being wrought by the abuse of alcohol.

In next month's Surgical News, two committee members, Phil Carson from Darwin and Cathy Ferguson from Wellington, will outline why now is the right time to fight this particular battle, and how we propose to win it.

Michael Grigg
Vice President

Cosmetic risk

Patients complaining after botched cosmetic surgery are just the "tip of the iceberg" according to a senior research fellow at the University of Melbourne. Doctors support the call for greater awareness, with Fellow Hugh Bartholomeusz saying that procedures carried out in risky environments should be outlawed.
"It is too often being done by doctors who are not plastic surgeons and in non-accredited rooms," Dr Bartholomeusz said.
***Sydney Morning Herald*, March 6**

Wii surgery

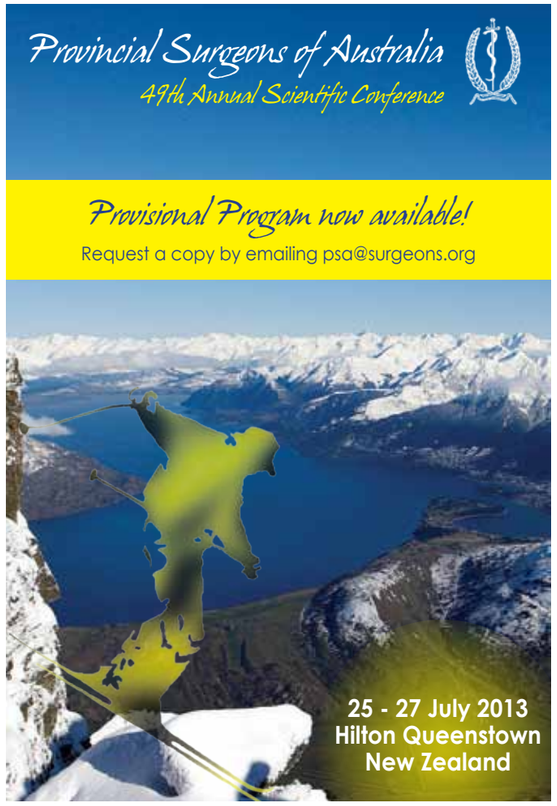
A study from Italy has found that surgeons who regularly play Nintendo Wii computer games perform better surgery than those who do not.
Researchers at the Sapienza University of Rome observed 42 post-graduates in the specialties of general, endoscopy and vascular surgery.
They played games such as table tennis and Battle at High Altitude to improve hand-eye coordination. Despite limited experience in laparoscopic surgery, more of the post-graduates performed better than their colleagues when tested in the theatre. Scientists suggested dedicated training software for surgeons may be helpful.
***Sunday Canberra Times*, March 3**

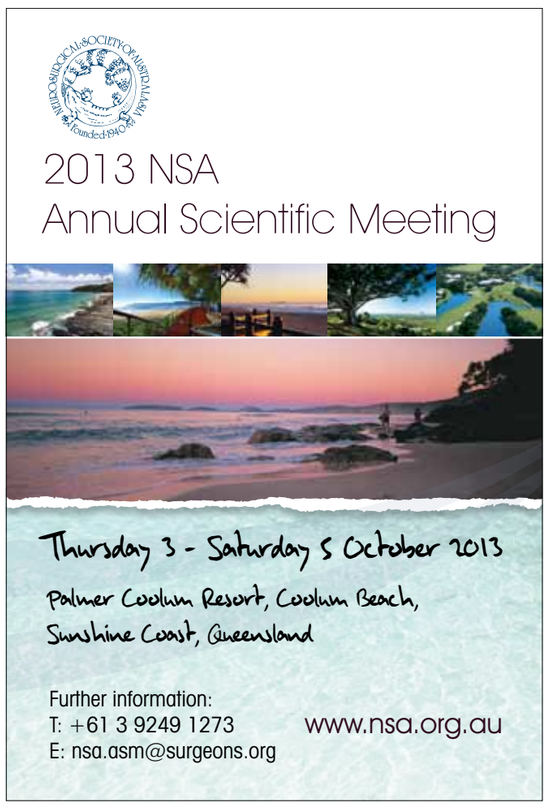
Elective lists rise

Elective surgery lists in Victoria are predicted to rise to 55,000 in June, despite the Federal Government funding reversal. Spokespeople for both the Australian Medical Association and the Australian Nursing Federation have expressed concern, AMA President Stephen Parnis saying the rise was unprecedented and ANF claiming the system is "totally underfunded".
Victorian Chairman of the Royal Australasian College of Surgeons, Robert Stunden said that patient lives were at risk and described the number as "appalling".
***The Age*, March 20**

New clinic for Hobart

A new outpatient clinic of the Royal Hobart Hospital will offer a range of services to patients, including pharmacy, pathology, surgery and specialty clinics. The state-funded facility will become a one-stop shop and make patient care easier and more efficient.
Plastic and reconstructive surgeon Fellow Andrew Castley said that families will appreciate the new facility.
"There's more space within the rooms and you've got access to everything – I think they're great," Mr Castley said.
***Hobart Mercury*, February 27**





Picture: Chris Sisarich. Courtesy New Zealand Tourism

All the programs are finished, section dinners are booked, session chairs appointed – all is ready for the 82nd Annual Scientific Congress to be held at Sky City Convention Centre in Auckland, winner of the latest most liveable city in the world competition. It is not too late to get the dates into your diary, and to decide how many of the family members will be travelling to Auckland with you.

Registration is easily achieved on the Congress website asc.surgeons.org – Register now!!

Convocation and Welcome Reception – Monday 6 May

The official beginning of the meeting is the convocation on the Monday afternoon when new Fellows will formally join the college. During the convocation Sir Peter Gluckman will deliver the Syme Oration, "The challenge of scientific knowns and unknowns; perceiving risk and setting policy".

Honorary Fellowships will be awarded to Beverley Lindley and A.Brent Eastman. The Louis Barnett Medal for service to surgical education will be presented to Professor Mark Edwards and the Sir Hugh Devine Medal to Mr Campbell Miles who recently stepped down after nine years at the helm of the ASC.

Associate Professor Ronald Kaye and Mr Keith Mutimer will receive ESR Hughes medals, Associate Professor Colin Russell and Ms Leslie Dunstall the RACS Medal for Service to the College. Mr Gordon Low AM and Mrs Rosie Low will receive the International Medal. Finally, Professor Russell Gruen will be presented with the 2013 John Mitchell Crouch Fellowship.

Scientific Programs

At this Congress, 23 section and special interest programs have been convened. The convenors are to be congratulated on an outstanding educational program over four days of the meeting. More than 500 abstracts have been submitted and the convenors have selected over 200 for presentation and 250 for electronic posters. The posters can be viewed in the Exhibition Hall – follow the instructions on the screens.

Head and Neck Surgery

This program has been convened by Rajan Patel. He has arranged an extensive program on head and neck malignancy in combination with the Endocrine Surgery program. The international visitor is Professor Neal Futran from the University of Washington Medical Centre in Seattle. Professor Futran's particular areas of interest are complex head and neck oncology and a special interest in micro-vascular reconstruction.

Professor Richard Kefford will deliver a keynote lecture on the systemic treatment of melanoma and a combined session with general surgery and rural surgery will discuss the difficult cutaneous malignancies of the head and neck.

Medico-legal Section

Hamish Crawford has brought together an interesting medico-legal program covering such issues as the medico-legal aspects of implanted devices and chronic regional pain syndrome. The medico-legal section program will be conducted over one day. The day commences with a Masterclass on Implant materials/devices and later the James Pryor Memorial lecture will be given by Professor Ron Patterson, Professor of Health Law and Policy at the University of Auckland.

Vascular Surgery

Andrew A. Hill has convened an outstanding vascular program with four international visitors. The program will be over three days (Wednesday to Friday). The program will cover many of the key areas in vascular surgery and highlights will include the Wednesday Masterclass on TEVAR.

The International invited speakers, Professor Allan Lumsden (USA) and Professor John Robson (SA), Dr. Patrick Peters (Belgium) and Dr Timothy Resch (Sweden) will keep delegates fully informed across a wide range of the latest research and innovations in vascular surgery.

Vascular Trainee papers will be presented on the Friday afternoon and this will be an excellent way to finish what will be an educational, entertaining and informative vascular program. The Vascular Section dinner will be held on Wednesday evening and is booked for the highly regarded 'Sails Restaurant'.

Oncology

For the Surgical Oncology dinner on May 7 I have arranged for Alissa Bates, Winemaker at Brennan Wines, to be present and wines from the Brennan vineyard will be served at this dinner. This vineyard is owned by Murray Brennan the BJS Visitor and his son, Sean, is the head winemaker.

HPB/Upper GI

For the HPB/Upper GI dinner on May 8, Wayne "Buck" Shelford will give an after dinner presentation on Leadership and Team Building. Wayne was All Black captain and undefeated in his time in charge.

Evening functions

The Section dinners are on Tuesday and Wednesday nights and a number of leading Auckland venues have been booked to host these dinners.

Thursday night will be the superb Congress dinner at the Langham Hotel. An outstanding banquet is planned with a New Zealand flavour.

Book for each of these events either on the registration site asc.surgeons.org and click on registration or use the registration form.

Transport from Auckland airport to the Conference Hotels

BUSES

Airbus Express is the fastest way to travel to the city.

The service operates 24/7 with buses departing every 10 minutes from both the Domestic and International terminals between 7am and 7pm and every 20 minutes outside of these hours. Stops 3 and 4 are a short walk from SKYCITY and the Congress hotels. Travelling time is approximately 40-50 minutes depending on traffic conditions. Tickets are $16NZD one-way and available online, from airport ticket kiosks or direct from the driver. For more information please visit www.airbus.co.nz.

Auckland has a comprehensive bus network and the main city terminal is at the Britomart Transport Centre situated 15 minutes' walk or 5 minutes on the Green Inner Link bus service from the SKYCITY Auckland Convention Centre.

From Britomart you can get information about public transport and take a bus or ferry to most destinations in Auckland.

TAXIS

Taxi ranks are located outside Door 8 at the International Terminal and outside the luggage collection area – Door 4 at the Domestic Terminal. An indicative fare from the airport into the city is between $60NZD – $80NZD (one-way). All taxis will take you to your destination priced on a meter.

We look forward to seeing you in Auckland.

John Windsor and Andrew G Hill

The ASC on your mobile device

Technology at the ASC

This year, for the first time the ASC will be trialling an online Scientific Program to be available via an app for Android and IOS wireless devices. It is expected that this online Scientific Program made available for the 2013 ASC will be a major resource for delegates for all future ASCs.

Delegates at the ASC to be held in Auckland from May 6 – 10 will be able to use their tablet computers to view the Scientific Program, select the sessions they wish to attend, manage their schedules, get directions and view presentations.

The Digital Producer of the ASC, Mr Dan Thorsland from the event management company KOJO, said the new electronic version of the Congress Program would allow delegates to access information wirelessly on Android and Apple devices such as iPads and iPhones.

He said the new initiative would mean that attendees could walk around the Conference Centre, look at a schedule of events, select those they wished to attend and tap upon the screen to establish a calendar, listing rooms, times and session duration.

Mr Thorsland, who helped design the Virtual Congress of the ASC in 2007, said that with more than 2000 delegates, 1000 individual audio-visual presentations in up to 20 concurrent sessions over five days, the College's ASC was one of the most logistically challenging events held anywhere in the world.

Therefore, he said, the challenge was to make navigation of the event as easy as possible for delegates, presenters and visitors.

Additionally the ASC is also allowing delegates to post any questions they may have during a presentation/session, via Twitter

"In the past, people attending the ASC had to run around and check the details of any presentation or session they wished to attend which required time and effort and if there was a late change there was little to no ability to advise everyone," Mr Thorsland said.

"The program we have developed, however, lets delegates know where they need to be, when they need to be there and will automatically update them when connected to the internet if there are any changes to the program.

Additionally the ASC is also allowing delegates to post any questions they may have during a presentation/session, via Twitter, so that presenters and chairpersons can see in real time what issues are of central interest to the audience."

Mr Thorsland said he believed that between 50 to 70 per cent of ASC delegates will be using mobile devices at this year's ASC and that many attendees were rapidly moving away even from carrying laptop computers.

"All these developments have been designed to both simplify and enhance the experience for presenters and delegates at the ASC, but not to replace social interaction," Mr Thorsland said.

"I think that sitting among your peers and hearing a presentation of interest, listening to the questions posed and answers given is very, very powerful and professionally enriching.

"All our work behind the scenes has been designed to enhance that experience by making it easier to select the presentations of interest, easier to get there, easier to retain the information and easier to engage with presenters."

Mr Thorsland stressed, however, that a printed version of the program would still be available with all information including session times and locations provided throughout the conference centre.

"We have no wish to disenfranchise any Fellow or delegate who does not use mobile technology; we just wish to make it easier for those who do," he said.

With Karen Murphy

Trainees at the ASC

In 2013, the Annual Scientific Congress will return to New Zealand with Auckland hosting this year's event between Monday 6 and Friday, May 10. The Conveners have put together an excellent line-up with much to interest Trainees over 25 general and scientific programs, numerous master classes and several workshops.

The theme of the conference is 'Sustainable Surgery'; plenary sessions will examine sustainable technology, training, research and a sustainable role for the College. Trainees attending the Congress will hear from world-leading surgeons and extraordinary individuals including Sir Peter Gluckman, Chief Science Advisor to the NZ Prime Minister, and Sir Ray Avery, inventor, social entrepreneur and philanthropist.

Monday, the first day of the conference, kicks off with a number of workshops and concludes with the Convocation and Welcome Reception. There are two workshops of particular interest to Trainees: 'Developing an Academic Career' course (DCAS) and the General Surgery Association (GSA) Trainees' Day.

DCAS has been collaboratively developed by the Association of Academic Surgeons and the College Section of Academic Surgery and is an opportunity to hear from enthusiastic, inspiring and highly regarded academic surgeons from the United States and Australasia. It is recommended to all Trainees with an academic interest. Registration is via the ASC website.

General Surgery Trainees from New Zealand and Australia are invited to attend the GSA Trainees' Day. The program aims to provide Trainees with an overview of Surgical Oncology and will include interactive scenarios, case presentations and panel discussions. Registration is via the GSA website, generalsurgeons.com.au.

The scientific programs run from Tuesday to Friday. Each day starts with several master classes, 28 in total. Master classes allow particular focus to be placed on a well-defined topic, be that an area of technical expertise, academic know-how or clinical decision-making. Trainees are strongly encouraged to attend master classes pertinent to their interests and their specialty; registration is required via the ASC website.

The Trainee program also runs from Tuesday to Friday and, through collaboration with numerous other sections, aims to highlight some of the best of what is on offer for Trainees. We highlight master classes and sessions of general interest to Trainees, such as the master class 'Applying for and securing an overseas Fellowship', and those that the Conveners particularly recommend for Trainees coming up to their exams, such as the session on 'Management of advanced skin cancer'.

We particularly encourage Trainees from all specialties to attend the Trainee-specific session, 'Surviving and thriving through surgical training'. We will hear from Fellows and Trainees who have overcome a range of challenges, such as failing exams or combining training with parenthood, to thrive in their surgical careers. Their stories and advice will reassure and inspire all of us as we face trials and tribulations during surgical training.

No Trainee will experience all that the ASC has to offer without attending the Younger Fellows and Trainees Dinner, being held on Tuesday evening. This year the dinner is generously supported by sponsorship from MDA National and Baxter. The evening will feature brilliant food, great wine and a truly extraordinary live act; tickets are strictly limited, so do book early.

We look forward to welcoming you to Auckland and to New Zealand.

Deborah Wright
RACSTA Convenor

Poison'd Chalice

"A stage where every man must play a part"
(Merchant of Venice, Act 1, Scene 1)

As Director of Surgery, one is slowly persuaded that the part one plays can be a mighty one, that only Kryptonite can really produce substantial damage, bring one to one's knees (so to speak). Can you meet with the CEO tomorrow... Sure. Director General of the Health Department the day after... Not a problem. Chief Medical Officer... Always available...his capital city or mine?

It is not that my ego was always getting in the way. My children (still living at home) always deflated that and my beloved wife always made sure that the rubbish bin night was an essential part of my week. However, Directors of Surgery are in demand and as surgeons, well you know the saying about surgeons and opinions...

It started as an innocuous cold – or that is what I thought it was. Some unkind people said it may be man-flu and gave me prognostications of 'near-death'. I hoped that no-one would get what I had – they would surely succumb.

One of my Registrars, knowing my penchant for Shakespeare, quoted Cymbeline: "by medicine life may be prolonged, yet death will seize the doctor too." Very morbid, I thought. I far preferred the more biblical reference (Luke 4:23) on this occasion of "Physician, heal yourself..." So I swallowed more Panadol and battled on.

I eventually succumbed to the domestic pressure and the heavy sighs of my work colleagues who were convinced that I was contaminating their ecosystems... (so they intimated). Maybe I was unwell as I was urgently admitted to hospital for diagnostic tests... the pain in my chest may not just be strained costochondral joints from all that coughing.

It was the cardiologist who reminded me that the famous Scottish Surgeon John Hunter was known to suffer from angina pectoris and frequently stated that his life was "in the hands of any rascal who chooses to annoy and tease me". When he died in 1793, it was just after an acrimonious board meeting at his hospital!

Now I waited, having gone from the Director of Surgery, the Master of my own Universe, to waiting for further tests and procedures... I was a pawn to their diaries... I wondered who they may be meeting...

Professor U.R. Kidding

Case Note Review

Delay To surgery resulted In colonic perforation and death

A patient underwent a colonoscopy for a presumed colo-vesical fistula, but the scope could not transverse a 'tight rectosigmoid junction'. A couple of days later a gastrograffin enema revealed a complete obstruction at the upper sigmoid colon through which no gastrograffin passed.
The patient was discharged with an elective operation being booked for more than two weeks later. Prior to this date the patient presented with an acute abdomen and at laparotomy (undertaken by another surgeon), the transverse colon was found to have perforated secondary to an obstructing sigmoid cancer.
A sub-total colectomy and end ileostomy was undertaken.
Over the next week the patient improved in ICU, but then developed a pleural effusion that was resistant to catheter drainage. The first three tubes did not drain the effusion adequately and during insertion of the fourth catheter the patient had a cardiac arrest and could not be resuscitated.

Comment:

This patient had a complete obstruction to gastrograffin, which will normally get through a pin hole. It seems difficult to defend a delay of nearly three weeks to elective surgery. This resulted in the patient having an emergency operation for a perforated colon (CR-POSSUM predicted mortality >61%) versus an elective operation (CR-POSSUM predicted mortality 9%). The patient should have had an urgent operation during the initial admission.

Guy Maddern
Chair, ANZASM

This can be found as a blog discussion on the website, go to : http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2013/anzasm-case-note-review-april-2013/

Continuing Professional Development

Making it easier to log your CPD

All Fellows will have received a copy of the 2013 Continuing Professional Development (CPD) Guide outlining changes to the program. The program is now simpler and streamlined, with better defined types of practice, fewer categories and greater opportunities for online recording and verification. New to 2013 is the category 'Performance Review' which includes a variety of self-directed learning options and the option of accruing CPD points through participation in a multi-source feedback review.

To support these changes, a new CPD diary is now available for Fellows to enter their 2013 activities and can be accessed by logging into the College website. To access the diary, please log in to the website and click on 'My CPD Program' (see Image 1). On this page you can access both the 2012 CPD diary (until 30 June) and the new 2013 diary. There is also a link to the new CPD 2013 Guide which outlines the core changes to the program.

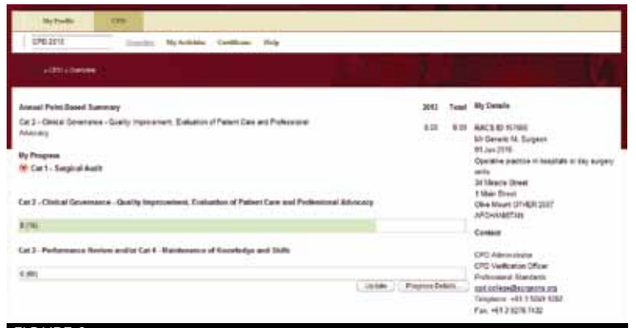
On entering the diary you will see your profile page where you can adjust your practice type (see Image 2). Click on the CPD tab to see an overview of your CPD requirements (based on your practice type) and your progress to date (see Image 3). To view individual activities or to add/update your activities click on the My Activities tab. Here you can enter individual or recurring activities and add evidence of participation (optional) (See Image 4). In 2013 your diary will be automatically updated if you participate in a RACS course or if you attend the College ASC. If you have any difficulty adding activities, the 'Help' tab on your CPD Overview has a user information manual or you can call the Professional Standards office on +61 3 9249 1282 who will be happy to assist.

We would appreciate your feedback regarding the system and suggested improvements, please contact Shirley at cpd.college@surgeons.org or on +61 3 9249 1282. If you do not have a username/password or cannot access the website, please contact the IT Help Desk at (help.desk@surgeons.org).

Graeme Campbell
Chair, Professional Standards Committee

FIGURE 1


FIGURE 2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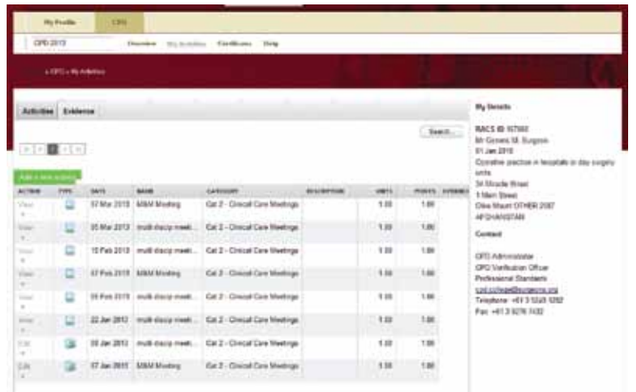
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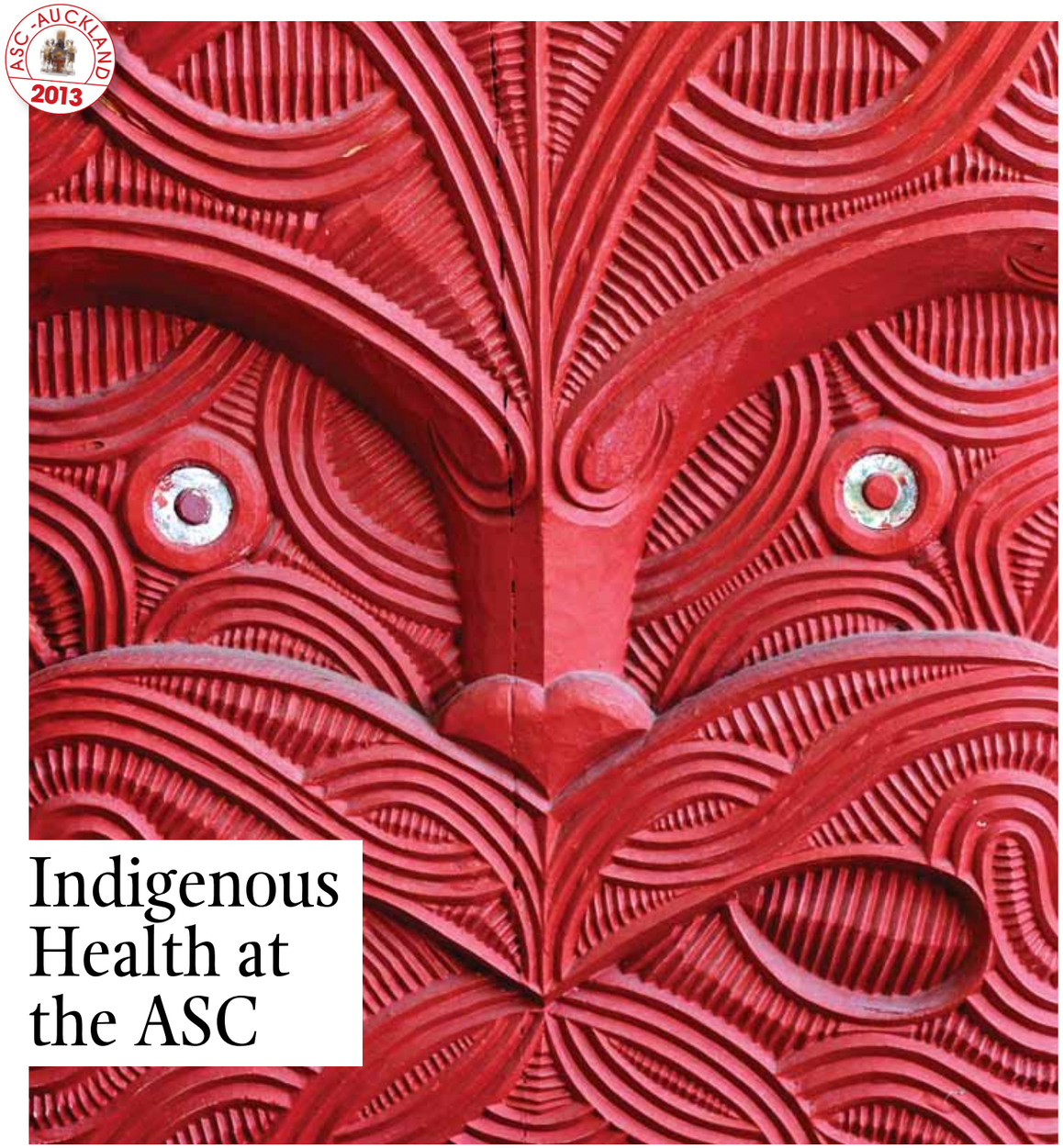


Indigenous Health at the ASC

The Auckland ASC will feature the inaugural Indigenous Health Forum

The steady increase in the number of Māori and Aboriginal and Torres Strait Islander medical graduates in both New Zealand and Australia represents a chance for the College to improve indigenous health indices by actively encouraging more of those graduates to pursue a career in surgery, according to Associate Professor Jonathan Koea.

A member of both the College's Indigenous Health Committee (IHC) and the Māori Medical Practitioners Association, Professor Koea is a general surgeon with a special interest in liver, pancreatic and hepatobiliary disease who works out of the North Shore Hospital in Auckland.

He said both countries now faced a critical period in the development of an Indigenous medical workforce with research indicating that more Indigenous medical graduates could choose surgery if they were assisted in the careful selection of their clinical focus, offered mentoring and support and through a collegial commitment to their success.

In research conducted last year, Professor Koea reported that Australia now has 160 qualified medical practitioners of Aboriginal or Torres Strait Islander descent (0.2 per cent of the total medical workforce) while in New Zealand there are 401 qualified Māori medical practitioners (2.8 per cent of the workforce).

"This to me represents a great opportunity for the College to actively work to attract them into surgery so we can develop a meaningful Indigenous surgical workforce in both countries."

Yet, in Australia there is only one specialist surgeon of Aboriginal descent while there are six in New Zealand; three general surgeons, one plastic surgeon and two orthopaedic surgeons.

Professor Koea found that the increasing numbers of Indigenous medical graduates reflected the success of medical schools in both countries in actively encouraging, supporting and assisting students throughout their studies.

"All medical schools have utilised elements of a pipeline approach encompassing contact with students at secondary school level to encourage aspirational goals and assisting with suitable subject selection," he wrote.

"Bridging courses have been implemented to ensure students leaving school have appropriate skill sets before entering degree courses and extensive practical help and assistance is available during undergraduate study.

"However, by and large, the pipeline has ended at medical school graduation, but the increasing numbers of Indigenous graduates now represent an opportunity to continue the pipeline into postgraduate training, faculty appointment and specialist career success."

Helping to succeed

Professor Koea said research conducted overseas suggested that the keys to increasing the number of Indigenous specialists included mentoring and coaching, identifying suitable candidates, providing a supportive environment and a government and collegial commitment to helping Indigenous candidates succeed.

He said the main issues confronting Indigenous students had changed over time.

"Twenty years ago in New Zealand and even in Australia now, the central problem was getting Indigenous kids to stay in school long enough to do well enough to get into university courses.

"But now, particularly in New Zealand, we are seeing more Māori and Pacific Islander students coming from more aspirational homes and staying in school which has led to a spike in the number of medical graduates, some coming through affirmative entry programs and some making it through on their own," he said.

"This to me represents a great opportunity for the College to actively work to attract them into surgery so we can develop a meaningful Indigenous surgical workforce in both countries.

"In recent years, medical schools have developed the philosophy that the medical community should reflect the general community and given the disparity in health outcomes in both countries, it seems only reasonable that we should have a broad commitment to developing an Indigenous surgical and medical workforce to help address that and improve Indigenous health indices."

Professor Koea said that research now showed that mentoring was the key to improving workforce numbers with graduates being actively encouraged to pursue a surgical career and with that support offered throughout training.

College support essential

A mentor to three Māori general surgery Trainees, he applauded the College for establishing the Indigenous Health Committee and said the College could make a significant contribution to improving the health status of Indigenous peoples in Australia and New Zealand by teaching and training a new generation of Indigenous surgeons.

"Mentoring is crucial because these students not only have to be the best they can possibly be, they also need to stay culturally competent because when they finish their training they will be expected to be experts in all things Māori and Aboriginal," Professor Koea said.

"I think the College has a role to play in both countries in encouraging more of these graduates to become surgeons and in the process make a significant contribution to the health of Indigenous people."

Professor Koea and Professor Pat Alley from North Shore Hospital have organised a 90-minute symposium on Māori and Aboriginal history and the future of Indigenous medicine and health to be held during the forthcoming Annual Scientific Congress in Auckland. Speakers include New Zealander of the Year Dame Anne Salmond and Sir Mason Durie from New Zealand. Australia will be represented by Mr Ollapallil Jacob and Associate Professor Shaun Ewen.

MR WIL HARRISON TALKS WITH KAREN MURPHY ABOUT THE MĀORI EXPERIENCE

The Māori experience

Dr Wil Harrison is an interventional cardiologist at Middlemore Hospital in Auckland and has been the Deputy Chair of the Māori Medical Practitioners Association – known as Te ORA – since 2011. During his tenure he has worked closely with the College Indigenous Health Committee (IHC) to develop a clinically and culturally competent Māori medical workforce to both improve the care of Māori patients and to highlight the specific issues confronting the Māori population in the public health arena. He talks to *Surgical News*.

What is the link between Te ORA and the College?
We collaborate with other like-minded organisations such as the College through the IHC to promote and expand a Māori medical workforce. As such we strongly support initiatives that could produce more Māori surgeons and we also strongly support international efforts to increase the number of Indigenous medical and surgical graduates. Our graduates often go on to become prominent advocates for Māori and Indigenous health which we believe is crucial.

How many Māori surgeons are there now in NZ?
We are proud to have six Māori surgical colleagues.

How many Māori are going through medical school now?
There were 233 Māori medical students in 2012 across the two medical schools in New Zealand, a fantastic number of which we are very proud.

What is Te ORA doing to encourage more doctors and students into surgery?
Te ORA currently runs a senior medical student/junior doctor mentoring scheme called Te Whatu with the aim of fostering support and interest in pursuing specialist careers. Our annual meeting, or Hui-a-Tau, also has a popular careers session where students can meet surgeons and other specialists to discuss and explore career development.

What are the particular problems or barriers that confront Māori pursuing a surgical career?
Hospital practice can appear intimidating to Māori students and junior doctors. Surgery, like internal medicine, is very competitive, demanding long work hours, and many of us have to make sacrifices to lifestyle and family in order to develop a career in these disciplines.

There are also only a handful of Māori SMO's in these positions to be role models or mentors to provide support to aspiring surgeons and physicians. Day to day hospital work can also be devoid of things Māori making it easy for some to feel like a 'cog in the machine' rather than a unique Māori doctor.

Why is it important to have more Māori surgeons and specialists?
Māori specialists can be prominent advocates (clinically and politically) for their discipline in relation to Māori health. We can also offer cultural insights into ways that systems and treatments can be improved while taking cultural needs into consideration. Having a Māori specialist delivering care to a Māori patient is also a unique thing. Many Māori patients are scared, apprehensive and isolated when attending specialist services, particularly when there are serious and complicated medical issues involved. I think most Māori specialists will go the extra mile for their Māori patients, not by delivering different treatment, but by communicating clearly, involving the extended family, informing and empowering.

What are the main health issues confronting the Māori population?
In adult medicine there are a number of important Māori health issues. These include cardiovascular disease, heart disease, cancer, smoking-related diseases, Type 2 diabetes and its complications, obesity and obstructive sleep apnoae. Palliative care is also a culturally important area that has often not been given a lot of attention.

How many Māori surgeons would Te ORA like to see in the near future?
As many as possible! It would be great to have representation among a diverse range of surgical specialties. Personally, I would love to see a Māori cardiothoracic surgeon.

With Karen Murphy

Wild Yam is it a scam?

Wild yam versus today's treatments

A considerable number of my patients sleep poorly, feel chronically tired and every night experience the torture of lying in bed awake, tossing and turning, their mind unable to rest. Recently I was consulted by a menopausal female, Dr H Flashing, who was suffering the full force of 'The Change' despite being a normally calm individual. She was frustrated, forgetful and flushed, at her wits' end, desperate for a good night's sleep; and from her account her family were ducking for cover trying to avoid her irritability and unpredictability. Had she been a singer or a poet, she might well have paraphrased her problem with lyrics from Jeanie Linders' 'Menopause the Musical':

"I'm just so tired of not sleeping,
At first I was afraid I was petrified,
Staring at the ceiling with eyes open wide,
Night sweats, Night sweats...
Spending time just soaking,
Good God you must be joking,
If only I could rehydrate
Night sweats, Night sweats..."

What she came to ask me is what could I give her that would spare her the symptoms, the unpleasantness, but without resorting to hormone replacement therapy (HRT), which she was averse to because of a family history of breast cancer and a DVT after a flight when she was 30. But what she actually asked was whether she should try wild yam, or is wild yam as many suggest merely some form of naturopathic scam?

Yes she could even have sung:

"I'm flashing, just flashing
And the glow is not my jewels,
I didn't know The Change could be so cruel."

Wild yam contains diosgenin, dioscin, phytosterols, and other phytoestrogens. It can be given orally or as a cream. It was used for pain relief including menstrual cramps by the Aztecs and Mayans, and later termed 'colic root' as a result of its use, particularly in the 18th and 19th centuries, for gastrointestinal upset. It was only recently that it earned an undeserved reputation for treatment of menopausal symptoms largely because it was used in the 1950s and 60s to synthesise progesterone from diosogenin, a plant based oestrogen or phyto-oestrogen present in the yam root. It can also be used to synthesise cortisone, and pregnenolone. However, it does not actually contain progesterone despite its use in synthesis.

A placebo controlled trial of wild yam cream for the control of menopausal symptoms found it was free of side-effects, but offered no more improvement than placebo. Another study testing its toxicity and safety in animals showed that although the pure extract could be an irritant, diluted extract was safe, certainly in rats and rabbits, but also as administered in creams for humans. Wild yam would be of uncertain safety in pregnancy, children or patients with diabetes. It should probably be avoided in patients with chronic renal failure.

Other natural remedies for the menopause include soy isoflavones, black cohosh and red clover. These have been well tolerated in clinical trials, but without convincing evidence of being efficacious. Other agents that have been used to alleviate hot flashes include belladonna/ergotamine tartrate/phenobarbital combination, dong quai, evening primrose oil, ginseng, and vitamin E. Unfortunately the evidence is not strong for their effectiveness though they are safe. Most trials have been conducted in patients with breast cancer, understandably as normal women might simply settle for HRT, depending on their assessment of their risk of breast cancer or venous thrombosis.

There have been trials that have supported the use of serotonin reuptake inhibitors, but then one would want to look very closely at all the other potential effects of messing around with one's serotonin or other neurostransmitter pathways. I wouldn't be comfortable tinkering with those.

I stared at Dr H Flashing over the rims of my spectacles. I felt myself start to flush; suddenly I was awfully hot, and I was stopped gasping in my tracks, mid-sentence. What was I saying? Where were we? Then I remembered! I momentarily composed myself, advised that the day of the yam was probably 1000 years ago and that its true role in 2013 is now as a substrate in laboratories manufacturing steroids. The world did not end on 21st December 2012, the Mayans built amazing temples, but they didn't get everything right.

Progesterone might help, but although it can be synthesised in a lab from yam root, unfortunately for yam enthusiasts it cannot be converted by the human body.

There is no Day of the Yam on the horizon. It may not do you much harm, but evidence is lacking that it will obtund the menopause. I think Dr Flashing agreed with me. There is only one problem with this conclusion. Some patients claim their symptoms are so much better taking wild yam that for those of you suffering the same it might be worth a try. Phyto-oestrogens have many other potential benefits, but that is another story though one that is certainly not a scam!

Dr BB G-Loved

New Library resources

For all specialties

Clinical Key is a comprehensive integrated product which includes hundreds of journals, e-books, image libraries, practice guidelines, clinical trials and operative surgery videos from Elsevier. Clinical Key offers fast reliable response to clinical information queries, similar to the Up-to-Date product, and is based on broader knowledge database than any other similar product currently available. Library staff members have been reviewing Clinical Key for the past three months and we are confident that it represents an outstanding scope of relevant information resources for Fellows and Trainees.

Neurosurgery Trainees will appreciate the availability of Youmans Neurological Surgery (latest edition, 4 volume set) included with a comprehensive package of e-books, journals and operative videos.

The Plastic Surgery package includes 20 e-books, 4 journals and 13 operative surgery videos.

Operative surgery videos have often been requested by users of the Library, and this was highlighted in last year's customer satisfaction survey. Clinical Key offers high quality videos ranging from basic to complex surgery, across all specialties, with a higher number available in the larger specialties.

Clinical Key offers a range of products for Trainees, many of which are available for the first time. These include the following core curriculum texts:

– Grey's Anatomy for Students
– Netter's Atlas of Human Anatomy
– The Developing Human by Keith L. Moore
– Epidemiology by Leon Gordis
– Thompson & Thompson Genetics in Medicine
– Wheater's Functional Histology: A Text and Colour Atlas
– McMinn's Clinical Atlas of Human Anatomy
– Medical Microbiology by Murray, Rosenthal and Pfaller
– Rang & Dale's Pharmacology
– Cellular and Molecular Immunology
– Principles of Medical Biochemistry by Meisenberg and Simmons

All surgical specialties are served by the Clinical Key product. Current issues of The Lancet will be available to Fellows and Trainees for the first time. New resources and editions will continue to be added to Clinical Key over the year. This is Elsevier's premium product and they want it to be as compelling as possible.

Comprehensive access

In 2013, Library users will be able to access the entire Clinical Key product, across all areas of medicine and surgery. This will allow users to become familiar with the way the product has been designed and allow users to access all areas of interest without limitation. At the end of the year, the Library will have meaningful usage statistics in order to inform decisions on this offering for 2014.

Additional new specialty journals

In addition to the wealth of Clinical Key resources, the Library has recently added the following new titles, based on requests from Library users –
Clinical Teacher
HPB
Journal of Hepatology
Journal of Surgical Oncology
Microsurgery
Neurourology and Urodynamics
Shoulder and Elbow

Library redesign

The Library web site is being redesigned to provide a better grouping of resources and multiple access points to Clinical Key. The Library pages will be organised in a way that is as intuitive and user friendly as possible. We have been looking forward to offering these improvements to our Fellows and Trainees for a long time, and are now proud to present a new Library interface along with a fantastic collection of new resources.

Cathy Ferguson
Chair, Fellowship Services Committee

YOUR FEEDBACK on any aspect of Clinical Key and the Library redesign is welcome. If you have any questions or would like assistance please don't hesitate to contact the Library at College.Library@surgeons.org or by phone +61 3 9249 1271.

What a few "000"s have done to my thinking!

In the January/February 2013 edition of Surgical News, my astronomical accuracy was rightly called into question. I often dictate these notes with Margaret (dare I be called a dictator?) and if detail is necessary I resort to the Internet for cursory verification of information for the purposes of grammatical, historical or scientific accuracy.

On this particular occasion, following my usual rule, the reference I obtained of the distance from the Sun to the Earth – did I misread it? – came out at 150,000km. The reference I quoted was missing three "000"s. The actual average distance is 150,000,000km from the Sun to the Earth (Ref: Wikipedia, Earth's Orbit).

This led me to ask the significance of three "000"s in scientific language and I could feel another story coming along. We are fully aware that in Babylonian cuneiform script (orthopaedic surgeons note) it was an important part of historical communication.

The 0 symbol in mathematics was introduced in part from the Indian subcontinent in the 7th-8th century, where they separated the symbol and the numeral zero by the 9th century, then adopted by Muslim scholars.

The Indian scholar Pingala and his colleagues earlier in the 2nd century BC had used the Sanskrit word sanya to refer to zero or the void. Decimal-based reckoning followed shortly thereafter. This led me to explore the history of the zero in mathematics, all as a consequence of my initial error. As so often happens, the word zero comes from the French le zéro and the first English use is noted in 1598 (OED).

In conclusion one of my surgical registrars, Andrew Sanderson, offered me a witticism "attributed" to Lincoln (pertinent to the current Lincoln –Spielberg production): "do not believe all the quotes on the internet" - Lincoln 1852.

Felix Behan
Victorian Fellow

Colin Brown looking into a child's ear

Success in Timor Leste

Programs improve the health of the Timorese population with the College's help

Five ENT surgical visits to Timor Leste in 2012 under the Australia Timor Leste Program of Assistance for Secondary Services (ATLASS II) and the Rotary Club of Balwyn Ear Care Project saw more than 94 patients in Dili and Baucau receive vital surgery to restore hearing, treat chronic infections and remove obstructions. More than 900 patients presented for examinations, demonstrating the concrete need for visiting ENT surgical teams.

ATLASS II is funded by AusAID in partnership with the Government of Timor-Leste as part of its support to improving the health of communities in Timor-Leste.

Teams of long-serving volunteers as well as a couple of first-timers made up the volunteers who participated in the ENT surgical visits in 2012. Sydney surgeon Mr John Curotta delivered two visits to Dili in April and October; NZ based surgeon Mr Colin Brown visited Baucau in May for the first time; Mr Michael Dobson, a surgeon from Melbourne, made his fifth trip in July to treat the children of Baucau; and Mr Malcolm Baxter, a surgeon also from Melbourne, also delivered a visit to Baucau in early December. Each of the trips resulted in a large number of patients being screened and treated.

Working alongside anaesthetist Dr Mark Adams and theatre nurse Mrs Katie Nordhausen over the seven days, Mr Dobson performed 14 operations to treat perforated ear drums, Suppurative Otitis Media and cholesteatomas as well as performing a life-saving mastoidectomy.

Mr Dobson said the trip in July followed an earlier visit to Baucau in May by surgeon Mr Colin Brown who had screened over 300 patients and undertook 26 surgeries.

Julie holding a baby with aphrasia

"After his visit it was clear that there was a considerable backlog of surgical ENT patients in Baucau and I was asked to help," Mr Dobson said.

"This meant that our visit was very well organised because all the patients had already been triaged and determined to need surgery and all had been contacted directly to attend the clinic or hospital which made for the efficient use of the time available.

"In addition to performing the theatre cases, a number of clinics were also held and from that a young child with a fistula and active infection received a timely mastoidectomy.

"This patient presented on the Wednesday and received surgery on the Thursday to treat the fistula because such cases are urgent given that some patients can develop meningitis and die.

"Complications associated with ear disease still cause deaths in Timor Leste, particularly for people in the more remote areas.

"This patient had been seen in a regional health clinic and sent down to us in Baucau, but even then it took the family almost two days to arrive."

Mr Dobson said he first went to Timor Leste in 2002 and had made a number of trips in the years following until health authorities decided they had sufficient ENT resources from the Cuban-trained specialists.

However, he said that in 2010 visits resumed when it became apparent that the need for ENT surgery remained significant, particularly in areas outside Dili.

Indeed, according to a recent report which screened children aged five to 14 at two primary schools in Baucau, up to 18.3 per cent suffered some form of hearing loss.

The authors of the report, Ms Tess Bright, Audiologist, and Ms Julie Souness, Primary Ear Care Nurse based in Baucau, said this translated to 2262 children within the tested age group who potentially needed medical/ENT management in the Baucau sub-district alone. ▶

In their report, written in June 2012, they also suggested that the number could even be an under-estimate because children with significant hearing loss may have already been taken out of school and also because the screening was done in the dry season with ear infection rates likely to rise during the wet season.

"There is no local ENT surgeon in Baucau, but the need for such surgery keeps growing, particularly because the population of Timor Leste is so young," Mr Dobson said.

"That is what makes these visits feel so valuable and the visit in July was particularly successful in terms of how it was organised and also the fact that selected patients had their ears treated prior to our arrival so they were suitable for surgery.

"One of the real delights of this trip was to see the high skill levels of the locally-trained primary ear care nurse and the work undertaken by Julie Souness, in particular, was outstanding.

"Her ability to speak Tetun meant that she could clearly communicate with patients, overcome cultural issues related to patient consent and get people where they needed to be to receive treatment.

"We all understand that if the young people of Timor Leste receive timely treatment for hearing loss they stand a much better chance of going on to lead fulfilling, productive lives which is good for the entire country."

Michael Dobson using portable suction machine

inset: Colin Brown looking into a baby's ear

Overcoming difficulties

Mr John Curotta, who along with his team, delivered two week-long visits to Dili in April and October had somewhat more to contend with. In a report on the trip in April, he said that no screening had been done prior to the team's arrival and that a TV ad which aired in the days before the visit had described the trip as Ear, Nose, Throat and Eyes.

As a result, he said that along with the 400 patients seen over the first two days, 92 eye patients also presented who had to be referred to the regular eye clinic at the National Eye Centre in Dili. Mr Curotta's team comprised Dr Jane McDonald, anaesthetist, and Mrs Danielle Doughty, theatre nurse. Over the course of the April visit, they performed seven myringoplasties, five mastoidectomies, three microsuction and ear inspections, one removal of a foreign body, one marsupialisation of branchial cyst, one adenoidectomy and treatments for ear canal skin lesion and thyroglossal cyst.

"The overwhelming number of patients presenting meant that the team worked from arrival to departure without a break," Mr Curotta wrote in his report.

"Even so prioritisation was necessary for surgery with patients with bilateral ear perforations given the highest priority followed by those with cholesteatoma."

Mr Curotta said that in line with recommendations from previous visits to Baucau regarding identification of patient and site of surgery – particularly in an environment where people struggled with communication difficulties – every patient booked for surgery during the Dili ENT visit was given an arm band with name, age and planned surgery written upon it which was not to be removed until discharge.

"This was adhered to very well, but not universally," he wrote in his report.

"Also each patient was photographed with their planned surgery on a placard in front of them, a virtual mug shot, and stored on the anaesthetist's laptop.

"Language barriers were a significant impediment at all stages of the visit and these two means of identification were very helpful to ensure safe surgery."

Mr Curotta said that he strongly recommended the provision of a dedicated interpreter for the duration of each future mission, particularly to work in theatre to guide communication between visiting team members and local hospital staff.

He said such an interpreter needed both good English and Tetun skills as well as some familiarity with Portuguese, Spanish or Bahasa.

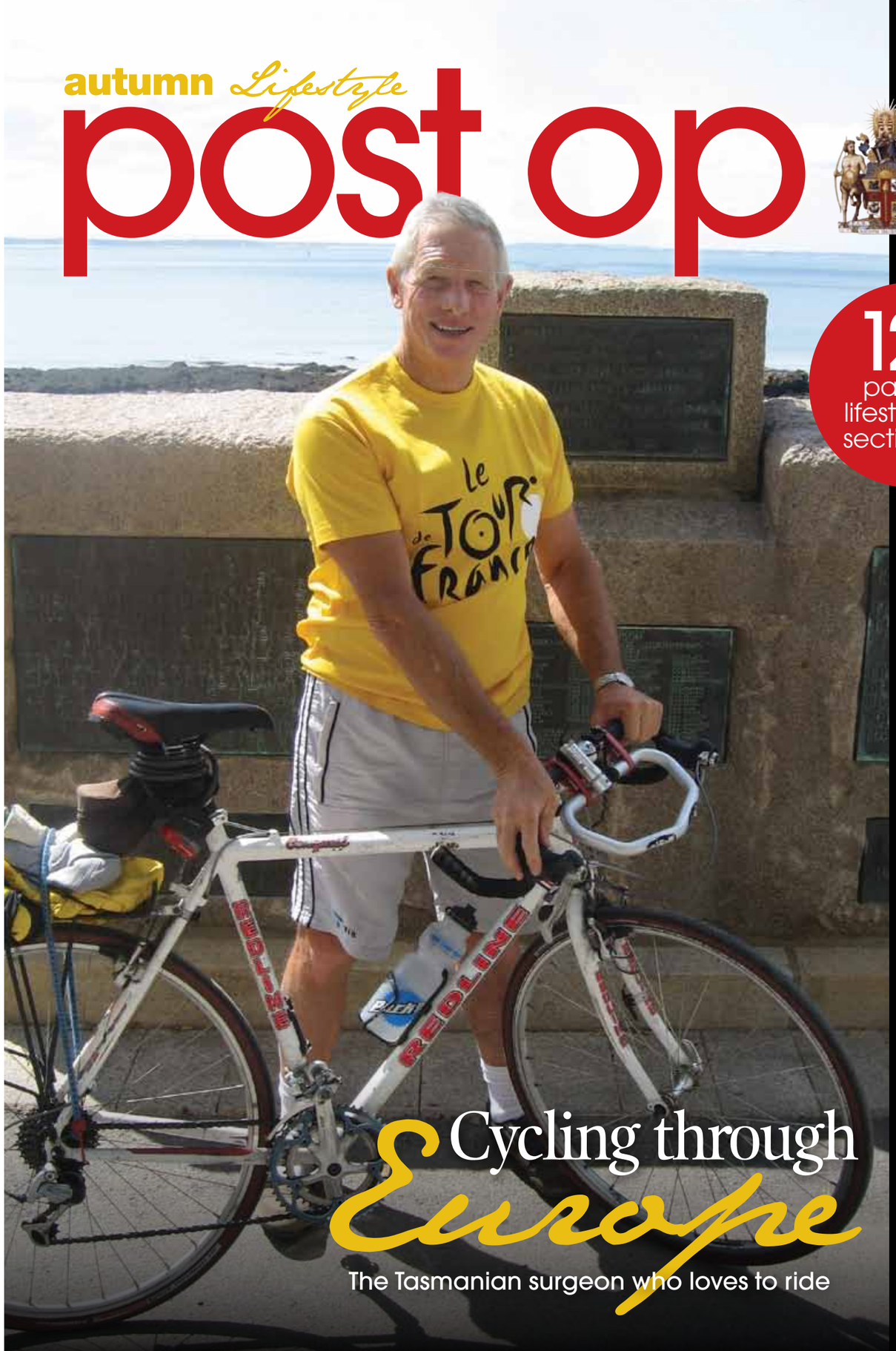
"Some final year medical students attended a few of the operations we conducted which was most welcome," he said.

"However, these were Cuban-trained junior doctors who spoke fluent Spanish, some Tetun and some Portuguese, so even our ability to train and up-skill local staff is hampered without sufficient translation services."

autumn *Lifestyle*

post op

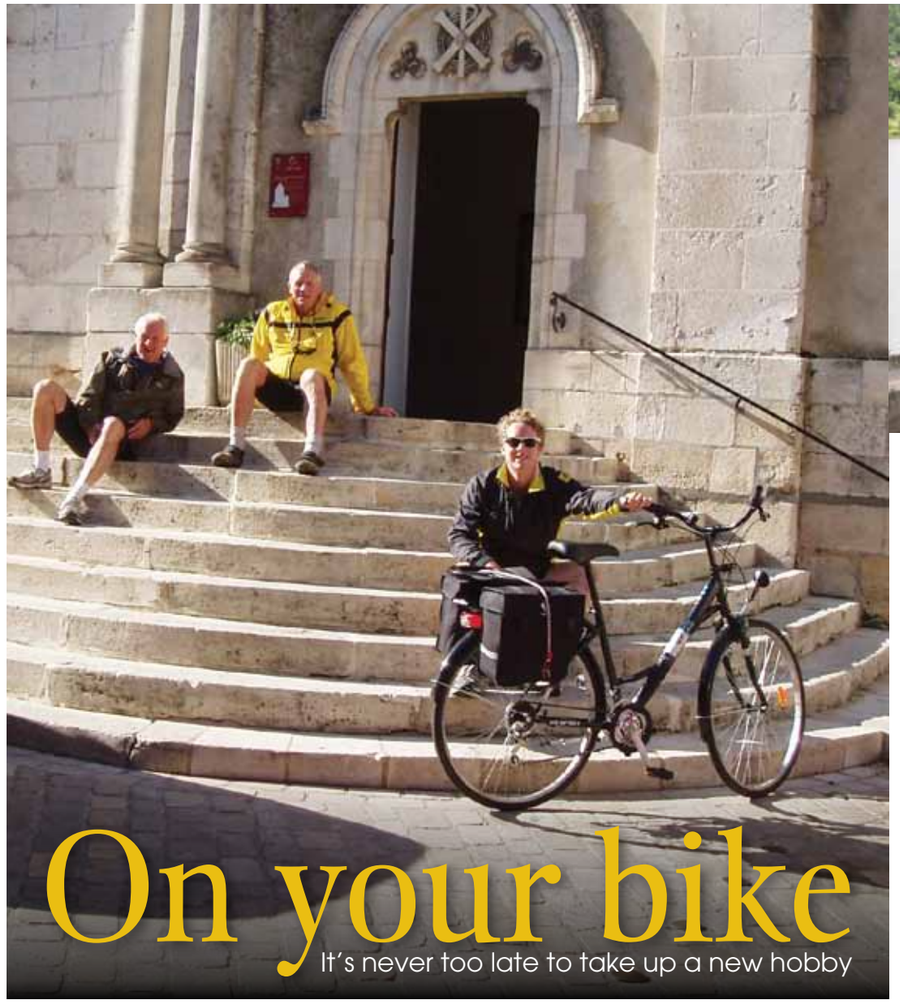
12 page lifestyle section



Cycling through *Europe*

The Tasmanian surgeon who loves to ride

post op appears in *Surgical News* each season



On your bike

It's never too late to take up a new hobby

After spending his youth rowing and playing rugby and his prime years as a rowing coach, Tasmanian general surgeon Mr Barry Edwards decided to devote his middle years to recreational cycling through some of the most beautiful places on earth.

Since taking up the activity some years ago, Mr Edwards has cycled through the mountains of Europe, around the spectacular coast of Ireland, down the Danube valley from Passau in Germany to Vienna and along the Garonne River in France, the Canal Du Midi and onto Sete on the Mediterranean.

Now retired from his public appointment at the Royal Hobart Hospital after 40 years, but still with a private practice working out of the Calvary, St John's and Hobart Private Hospitals, Mr Edwards said he took up tourism cycling as a way to celebrate his 60th birthday.

"In 2000 I coached an Australian rowing crew in the World Championships held in Zagreb, Croatia, and while there I got to know a lot of people from a lot of different countries," he said.

"That year I was 59 and I met a coach from Austria who told me that his father celebrated turning 60 by riding across the Swiss Alps and I thought that was a great idea because I didn't want to race, but I did want to push myself while immersing myself in a different landscape and culture.

"So in 2001, after doing considerable training, I cycled through the Austrian, Swiss and Italian Alps from Landeck in Austria down into Italy and then to Lugano.

"That was a great personal achievement which took eight days and I decided to do such a journey every year, sometimes alone and sometimes with my children and friends."

Mr Edwards followed that original scenic ride with a cycle from Cardiff to Holyhead and then, following a ferry crossing, from Galway to Rosslare in Ireland before returning to Fishguard in Wales and riding through Pembrokeshire to Swansea, a journey made over two weeks.

"That was a great ride, but I think my favourite has been the last one which I did with my son and brother-in-law where we started in Orange, France, and followed the Rhone, climbed the Central Massif and then followed the Loire River from its origin down to the Atlantic Ocean at Saint Nazaire," he said.

"That ride took 19 days to cover 1800 kilometres and it was great fun."

To add to his outside interests, Mr Edwards is also the owner of a highly-regarded vineyard in Tasmania.

Planting his first vines in 1989 on the sunny slopes of his historic property overlooking the Coal River, Mr Edwards' Craigow Vineyard was listed in James Halliday's Australian Wine Companion as a Five Star Winery in 2011.

As such, he said that while he enjoyed the opportunity to taste local wines while biking in Europe, the prime attraction of tourism cycling was the chance to strip life back to its essentials.

"The most stimulating aspect of these rides to me is the chance to survive with very little," he said.

"All you take with you, given that you don't want to be weighed down, is a credit card, a few clothes, some toiletries and a bike repair kit.

"We surround ourselves with so much stuff in modern life and it is very refreshing to live in a minimal way; it's almost unbelievable really to find out what you don't need to survive and survive well.

"Riding like this is also intellectually challenging because you have to find your own way using your maps and it's very easy to get lost and you have to be able to deal with that.

"You also have no idea how far you're likely to get on any given day so you can't book accommodation in advance; you just have to hope you come upon a village with a B&B when the light is closing in.

"I don't rough it like some other riders do, I like a comfortable bed, shower and cooked dinner when I'm riding and so far I've been very lucky and only once came close to having to sleep outdoors.

"This type of tourism cycling also means I get to meet an enormous variety of people from the locals to fellow cyclists of different nationalities, to bushwalkers and climbers and even the occasional band of pilgrims like I met when riding in France on the Loire trip."

Despite his great enthusiasm for cycling holidays, Mr Edwards has been unable to go touring for the past three years after a back injury required surgery, forcing him to cancel a planned cycling trip to Iceland.

Yet he has spent the past two years working hard at the gym to regain his core strength and hopes to go back to Europe on another cycling adventure later this year.

"I do miss it," he said.

"It has taken quite a long time to recover from the injury and the surgery, but the vineyard has been going from strength to strength and that keeps me busy.

"I'm 72 this year and I'd like to keep riding, but I think mountain rides, which I really love, may be too hard on my back – at least for now."

With Karen Murphy

A Surgeon's Guide to *Auckland*

Make the most of the ASC with some inside knowledge

Auckland, New Zealand's largest city with a population of more than 1.3 million people, is also known locally by two other sobriquets, one that exotically conjures its ancient beauty and another that refers to its more modern charms.

In the Maori language it is known as Tamaki-Makau-Rau – "the maiden with a hundred suitors" – for the many tribes that coveted this North Island region that lies on and around a narrow isthmus between Mangere Inlet and the Tamaki River.

Today, it is also popularly known as the "City of Sails", a reference to the hundreds of yachts that dot the harbour, with Auckland now claiming to have more yachts and launches per capita than any other city in the world.

Mr Richard Douglas, an Otolaryngology Surgeon who works out of the Auckland, North Shore and Gillies Hospitals, was raised and educated in Auckland and is clearly proud of the beautiful city of his birth.

A member of the Conference Executive for the ASC to be held in May, Mr Douglas said local surgeons were pleased to be hosting the meeting and looked forward to welcoming delegates and guests.

"The local surgeons have worked hard on the conference program which we believe is scientifically strong, while we have also invited a number of interesting non-surgical speakers," he said.

"Aucklanders are proud of our city and enjoy welcoming visitors.

"Many New Zealander surgeons have worked in Australia and made good friends there who will be coming to the conference and we hope they find the ASC program stimulating and the city as pleasing as we locals do."

The following are Mr Douglas' tips on the best way to enjoy Auckland and its gorgeous environs.

THE CITY

Auckland lies between the Hauraki Gulf of the Pacific Ocean, the low Hunua Ranges, the Manukau Harbour and the Waitakere Ranges and lies on an extinct volcanic field which at one time produced 50 active volcanoes. Today, these take the form of cones, lakes, lagoons, islands and depressions with some cones providing spectacular panoramic views of the city and coastline. Yet while the individual volcanoes are considered extinct, the field is merely dormant with large lava tube caves running from the volcanoes down towards the sea. Home to more than 32 per cent of New Zealand's population, Auckland has the largest Polynesian population of any city in the world while ethnic groups from across the globe have also made their home here, making for a vibrant and cosmopolitan city.

AUCKLAND ART GALLERY

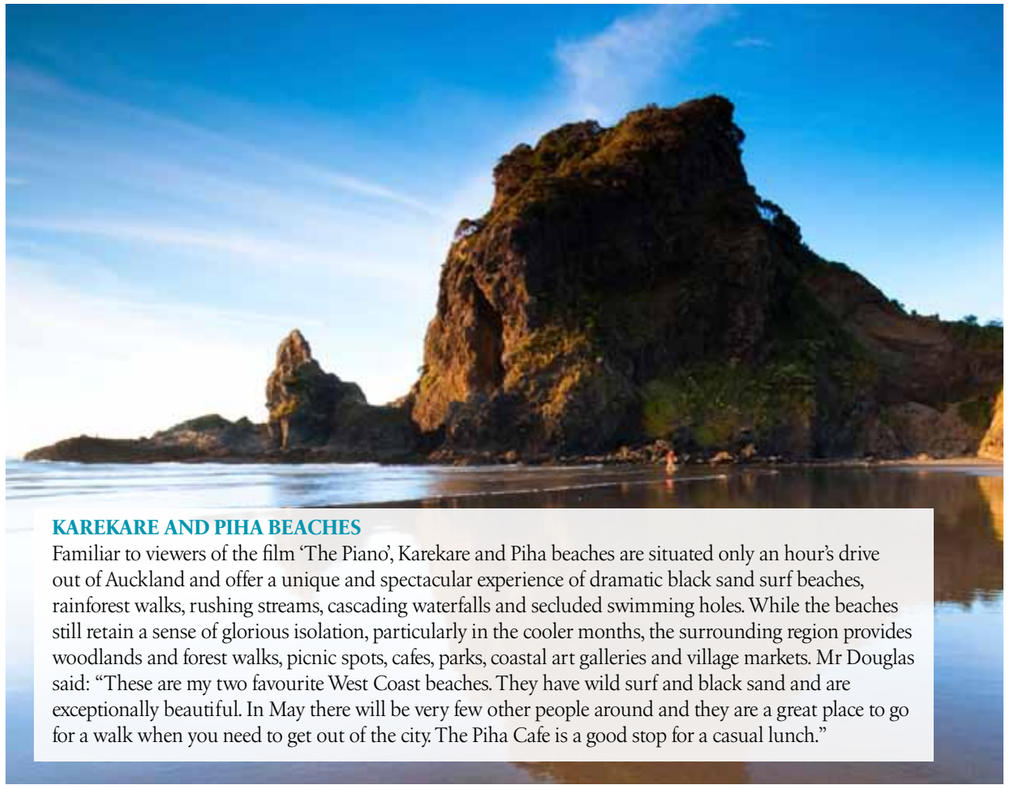
Heralded in 1888 as "the first permanent Art Gallery in the Dominion," Auckland Art Gallery – also known as Toi o Tamaki – remains the largest art institution in New Zealand with a collection numbering over 15,000 works. The Gallery features major holdings of historic, modern and contemporary art and outstanding works by Maori and Pacific Island artists along with European painting, sculpture and print collections with some works dating back to 1376. ▶

WAIHEKE ISLAND

Just 35 minutes from Auckland by ferry is Waiheke Island, situated in the Hauraki Gulf. With a coastline boasting more than 100 beaches and coves, the island is both an adventure playground and the home of some of the region's premier vineyards and restaurants. Mr Douglas said: "The Island has a number of beautiful beaches which become progressively more pristine and remote as you head west. That western end of the island also has a number of great restaurants and vineyards including two of my favourites, Cable Bay Restaurant and Winery and the Mudbrick Vineyard Restaurant. A superb Italian restaurant, Poderi Crisci, offers its famous long lunch if you are in no hurry to return to Auckland."

BRITOMART AND THE VIADUCT PRECINCT

The Auckland waterfront has been extensively redeveloped in the last decade, opening up access to the foreshore once restricted by the activities of the working port. As part of this, two adjacent areas have been developed into restaurant, shopping and transportation hubs: Britomart and the Viaduct Precinct. Reclaimed from the sea in the 1870s as part of a scheme to build improved port facilities for the growing city, Point Britomart fell into decline in the 1970s and was lucky to escape demolition. Now this most historic precinct has become a glamorous hub of designer boutiques, bars and cafes. Mr Douglas recommended a visit to the Chief Post Office, a magnificent old building now converted into a commuter rail terminal, and said several of the best New Zealand designers now have shops in the area including Kate Sylvester, World and Trelise Cooper. He listed Roxy's in Fort Lane as a spot of fine dining while new-comer Ortolana, an Italian-style restaurant serving its own farm produce, was also worth a visit. He said of the Viaduct Precinct: "This is a ten-minute walk from the city centre and was the site of the America's Cup defence. There are many new restaurants there and some of Auckland's more established favourites like Soul and Euro while the Maritime Museum is also definitely worth a visit."



KAREKARE AND PIHA BEACHES

Familiar to viewers of the film 'The Piano', Karekare and Piha beaches are situated only an hour's drive out of Auckland and offer a unique and spectacular experience of dramatic black sand surf beaches, rainforest walks, rushing streams, cascading waterfalls and secluded swimming holes. While the beaches still retain a sense of glorious isolation, particularly in the cooler months, the surrounding region provides woodlands and forest walks, picnic spots, cafes, parks, coastal art galleries and village markets. Mr Douglas said: "These are my two favourite West Coast beaches. They have wild surf and black sand and are exceptionally beautiful. In May there will be very few other people around and they are a great place to go for a walk when you need to get out of the city. The Piha Cafe is a good stop for a casual lunch."

TIRITIRI MATANGI ISLAND

A nature reserve an hour's ferry ride from downtown Auckland, Tiritiri Matangi Island has been converted from working farm to wildlife sanctuary, courtesy of the Department of Conservation. Once stripped of almost all its native bush with the consequent loss of biodiversity, volunteers worked for more than ten years to return the island to its former natural abundance, planting more than 250,000 trees, eliminating non-indigenous predators and restocking the land with threatened and endangered birds and reptiles. "Many of the native birds you can see there are rare on the mainland because of introduced predators," Mr Douglas said. "You can see saddlebacks, kokako, fantails, penguins and takahe and while the round trip from Auckland takes most of the day, it is an unforgettable experience."

AUCKLAND WAR MEMORIAL MUSEUM

Located just a short taxi ride from the city centre, the Museum is housed in a neoclassical style building, perched on a hill overlooking the harbour. Home to millions of objects, the War Memorial Museum tells the story of New Zealand, its place in the Pacific, its people and its wartime history. "This is one of New Zealand's most popular man-made tourist attractions for its unsurpassed collection of Maori and Pacific Island artefacts and displays of New Zealand's natural history," Mr Douglas said.

The perfect brew

Fellow Robin Brown relaxes with a beer, or two, in his spare time

After spending time in the UK in the 1990s, Melbourne cardiothoracic surgeon Mr Robin Brown returned home to Australia not only with increased surgical skills, but a taste for English and European style beers.

So few such brews were imported and stocked here then, however, that he soon realised that if he was to indulge this acquired taste he would not only have to make it himself, but source the components and build the equipment necessary for production.

Drawing on his experience of home-kit brewing from his university days and childhood memories of his physicist father's basement brewing experiments, Mr Brown spent his free time away from the Royal Melbourne Hospital scouring hardware stores and component suppliers in search of the machinery, tubes and pumping equipment needed to create the perfect brew.

Now, that personal endeavour and private passion has grown into a commercially-successful boutique brewery based in a pristine, commercially-equipped, sterile 45-square-metre shed at the back of his Brighton home.

Mr Brown, a former VicBrew Champion and brewing judge, said he began commercial production in 2011 in partnership with perfusionist Brad Schultz whom he met at the Royal Melbourne Hospital.

Called Black Heart Brewery, the enterprise now produces 500 litres of beer each week.

"This all grew out of a basic search for better beer which seems a bit strange when you can buy almost anything in the interconnected world we live in now," he said.

"Yet when I first got involved in this I simply couldn't find the styles of beer I liked, so I had to learn how to make them from scratch.

"But that turned out to be a positive because now Brad and I remain committed to respecting the historical characteristics of the styles of beers we make, meaning that they are all natural with no chemicals or additives.

"All my knowledge of brewing came from reading and early experimentation while my science background gained through medicine was invaluable and that probably is the aspect of brewing that I find most enjoyable, because there's not a huge amount of science involved once you've entered clinical practice.

"Brewing, like surgery, is all about attention to detail and minimisation of contamination, yet at the same time there is something very relaxing about working with machinery and complex procedures that don't involve the human body.

"I love working with the equipment, tinkering with my toys and the microbiology of it, while knowing that if something we try doesn't work, we can just start again.

"The social world you enter as a brewer is also a tonic for the stresses and anxieties of medicine because they are a different breed of people, laidback and easy going with an attitude that not everything has to be done on the instant."

Mr Brown said his brewing interests took up one 12-hour day per week which was most often chosen when both men were free of work commitments while he spent time in the shed most days monitoring fermentation, labelling and bottling or keeping up with the constant cleaning.

So far Mr Brown and Mr Schultz, who now works at the Royal Children's Hospital, have brewed around 65 styles of beer with ten special releases now on the way. The mainstays of production, however, are the more mainstream styles such as English Pale Ale, American Pale Ale, American Brown Ale, Belgian Blond Ale, Bohemian Pilsner, Weizen and Dunkelweizen.

Close to home

Mr Brown said that while at one stage he seriously considered moving his home-based operation to commercial premises such as a brewery-pub, he enjoyed working close to home and involving his three children in the endeavour.

"Even before I began brewing more seriously, I had already cut back my working hours simply from a lifestyle point of view because I felt like my whole life revolved around work with little time for the family," he said.

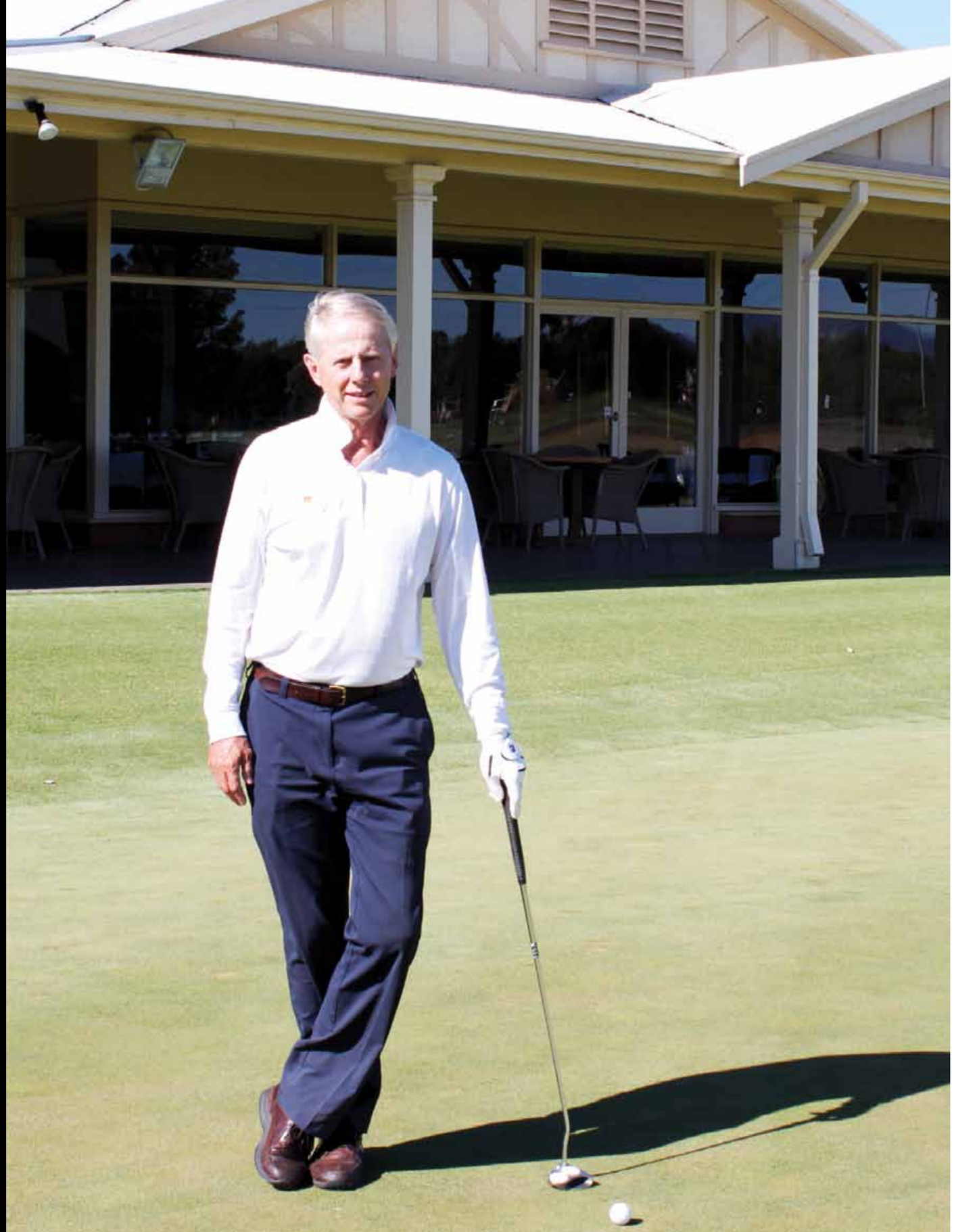
"So I have resisted the urge to make the business bigger because there is something really nice about having it in the back yard, not only because I'm still close to the family, but because it automatically imposes a production capacity and when we reach that, we reach it and don't have to react to outside pressures."

Now, in a little more than 15 months, Mr Brown and Mr Schultz's quality brews are available at scores of bottle shops, on tap at a number of boutique pubs and at restaurants across Melbourne and can also be found at the Local Taphouse in Sydney and at the Freo Doctor in Western Australia.

"There is something extremely rewarding in seeing your beer on tap and watching people enjoy something that you have made, and I doubt that will ever wear off," he said.

"To see our beers in a bottle shop or on a wine list is very personally satisfying and I'd probably give it away if the day ever came that I took that for granted."

With Karen Murphy



A day on the green

Seeing the sustainable angle on golf

When Mr Michael Jay, the immediate past President of the Australian Society for Otolaryngology Head and Neck Surgery (ASOHNS), first took up his golf clubs at the ripe old age of five, the local course in North Adelaide had little greenery of which to boast.

Then, being a golf course in the capital of the driest state in the driest continent, players first had to manage the "scrape" before attempting to sink a putt, that is a thick dirt covering which required scraping before each shot.

Now, however, as the Captain of the Royal Adelaide Golf Club, Mr Jay oversees the workings of a wetland created within the club's boundaries to harvest stormwater runoff from surrounding suburbs which, when cleaned by reed beds, is injected back into an underground aquifer.

It means that the club, widely regarded as ranking with the best in Australia, can not only keep its luscious greens, but do so as a zero net user of aquifer water.

"The wetland has greatly enhanced the appearance of an area of the course that grew only scrubby vegetation in salty soil while it also provides a benefit to the community by reducing the flow of turbid stormwater into the ocean," Mr Jay said.

"We aim to put as much water back from wetlands into the aquifer over winter as we take out over summer which is great for the course and great for the community.

"The scrapes I played on as a boy in the 1950s seem pretty tough upon reflection, but many country courses, in particular, may have to revert to that now that water has become such a precious commodity."

Mr Jay, who describes himself as "transitioning towards retirement", has a one-day per week public appointment at the Royal Adelaide and Lyell McEwin Hospitals and a part-time private practice designed to give him time to enjoy his role as captain of the golf club while also continuing to work within ASOHNS.

With a handicap of nine, he said that while he had always enjoyed playing golf since going out on course as a lad with his father and older brother, who went on to become a state amateur champion, he had only made a regular weekday commitment to play in the 1980s.

"I was getting a lesson from a golf pro one particular day who watched what I was doing and told me that my handicap should have been half of what it was," he said.

"I thought he was then going to pick my game apart, but instead he asked me what I tended to think about when I come on to the course. I explained that it was usually about work, thinking about my patients, hoping all was calm and not wanting to be called back into the hospital.

"He said that was the problem and that if I wanted to improve, I had to leave work at the gate because while golf is relaxing, it also requires great concentration.

"After that, I decided to take one afternoon off per week to play which was actually a very difficult thing to do. I was surprised at the discipline it took to draw a line and say no more consultations, no more work today.

"However, after a few months I became very possessive of that time because it proved to be a great relief against work stress and it actually became a very important part of my working week." ▸

autumn Lifestyle

"We aim to put as much water back from wetlands into the aquifer over winter as we take out over summer which is great for the course and great for the community."

Michael Jay on the Golf Course

Now playing twice a week on average, Mr Jay said he loved the history, traditions and etiquette of golf as well as the social interaction it provides.

"One of the things I most love about golf is that it is so inclusive," he said.

"The handicap system allows people of all standards to compete against each other while you are also always competing against yourself, constantly trying to improve your handicap.

"It is also totally absorbing and exhilarating whereby you can have a totally wretched game, but be overjoyed with one shot in an otherwise horrible match.

"It's also great exercise and at our course, players can walk up to about 10 kilometres a game."

Mr Jay said he found it a great thrill to be elected captain of the Royal Adelaide Golf Club last year, overseeing the maintenance of a course which has been ranked in the top 100 worldwide and a club steeped in tradition.

He said the links course located at Seaton had hosted nine Australian Open Championships and sixteen Australian Amateur Championships as well as the 2008 Eisenhower Cup, the largest amateur golf competition held anywhere in the world.

One of the lesser known – but no less keenly contested - competitions held there, however, is the RACS Golf Day.

Held annually, the event began in 1981 as a competition between surgeons and physicians after physician Dr Leigh Wilson and the late surgeon Mr John Walsh donated a trophy which stands on display in the College of Surgeons Building in Adelaide.

Since its inception, the competition has now been expanded to include members of other medical colleges, pitting surgeons against psychiatrists, physicians and anaesthetists with more than 60 golfers participating most years for the coveted Wilson-Walsh Cup.

That cup is again up for the winning in November.

As Captain of the Royal Adelaide Golf Club, Mr Jay has hosted events against the Royal Sydney and Royal Melbourne Golf Clubs and last year travelled to England with his wife, Penelope Steele, a doctor and keen bird watcher, to play at the Royal West Norfolk Golf Club.

As a representative of the Royal Adelaide Golf Club, he has also been invited to play many courses around Australia and the UK and is planning a trip to Canada later this year to play at the centennial celebrations of the Royal Colwood Golf Club, a private club located in Victoria, British Columbia.

"It is wonderful to be invited to play on some of these courses which are among the most beautiful and challenging in the world and when we do go abroad, given that my wife has less interest in golf, we try to combine both of our interests so that after I finish playing we go bird watching," he said.

"Yet I still haven't played at St Andrews in Scotland, the birthplace of the sport.

"I've left that as something to look forward to when my responsibilities have lessened a bit."

With Karen Murphy

Time for family

Dr Pancha took up the chance to spend more time with his family

The College could play a lead role in identifying surgical units around the country that could best adapt to a part-time training position, according to final year Trainee Dr Gowrinanthanan Panchacharavel.

Dr Pancha, as he is known, spent 2011 in a job-share Trainee position with Dr Penelope De Lacavalerie at Liverpool Hospital's Head and Neck Unit.

He said he applied for the part-time position so he could spend more time with his family following the birth of his second son in September 2010 and was also planning to spend the year undertaking a part-time Masters Degree.

"When my first child was born I didn't initially get to spend much time with him at all and I didn't want that to happen a second time," Dr Pancha said.

"I also had plans to study during that year which didn't work out because of both the difficulty in designing a study regime that would fit in with the alternating weekly roster we worked and also because of the unit's heavy workload.

"I did most of the on-call rosters, filled in for other registrars who took leave for their exams and during the second half of the year the unit was understaffed which increased the workload all around.

"I didn't get to do all the things I planned to do and there's no doubt that your income takes a hit, but I did get to spend more time with my wife and children so I am glad I had that part-time year."

A new approach

Dr Pancha was born in Sri Lanka and graduated from the University of Papua New Guinea before going to the US for further medical training. Arriving in Australia in 2001 to take up a short-term position in Alice Springs, he decided to stay after the Twin Towers terrorist attacks and pursue surgical training in Australia.

Now planning to sit his final exams later this year before embarking on post-

Fellowship training in colorectal surgery, Dr Pancha is the first male Trainee in NSW to undertake part-time training.

"Because I was the first, I got a lot of people asking me about the job-sharing arrangement along with suggestions that I was slack and didn't want to work as hard as others," he said.

"But I did a pretty good job there, I had a good reputation and I gained a lot of skills by spending one year in a Head and Neck unit rather than the usual six months on rotation.

"However, this type of stereotyping means that the two Trainees sharing the position have to work very well and very closely with each other to ensure the position works for patients, meets the expectations of senior supervisors and advances our training.

"Yet it does work and could become more common if there was a greater understanding of where such positions could best be accommodated.

"For instance, I think Liverpool Hospital may be one of the busiest – if not the busiest – hospitals in Australia and therefore the workload may make a part-time training position more difficult to manage.

"I think the College could play a pivotal role in this aspect of training by identifying which hospitals and units are appropriate for part-time positions and which are not."

Dr Pancha said he believed more suitable surgical units for part-time training could be colorectal, trauma, acute surgical or breast and endocrine units whereas Upper GI, cardiothoracic and Head and Neck may not, because of the workload and complexity of procedures undertaken in public hospitals.

"That year of part-time training was challenging in terms of meeting everyone's expectations, including my own, but I gained a lot of operating experience," he said.

"I think you gain skills rather than lose out in terms of training in a part-time position because you are spending more time working within a specialty and while I think there is still some degree of negativity towards part-time training, I think many of the problems could be overcome if the right units in the right hospitals were selected in the first place.

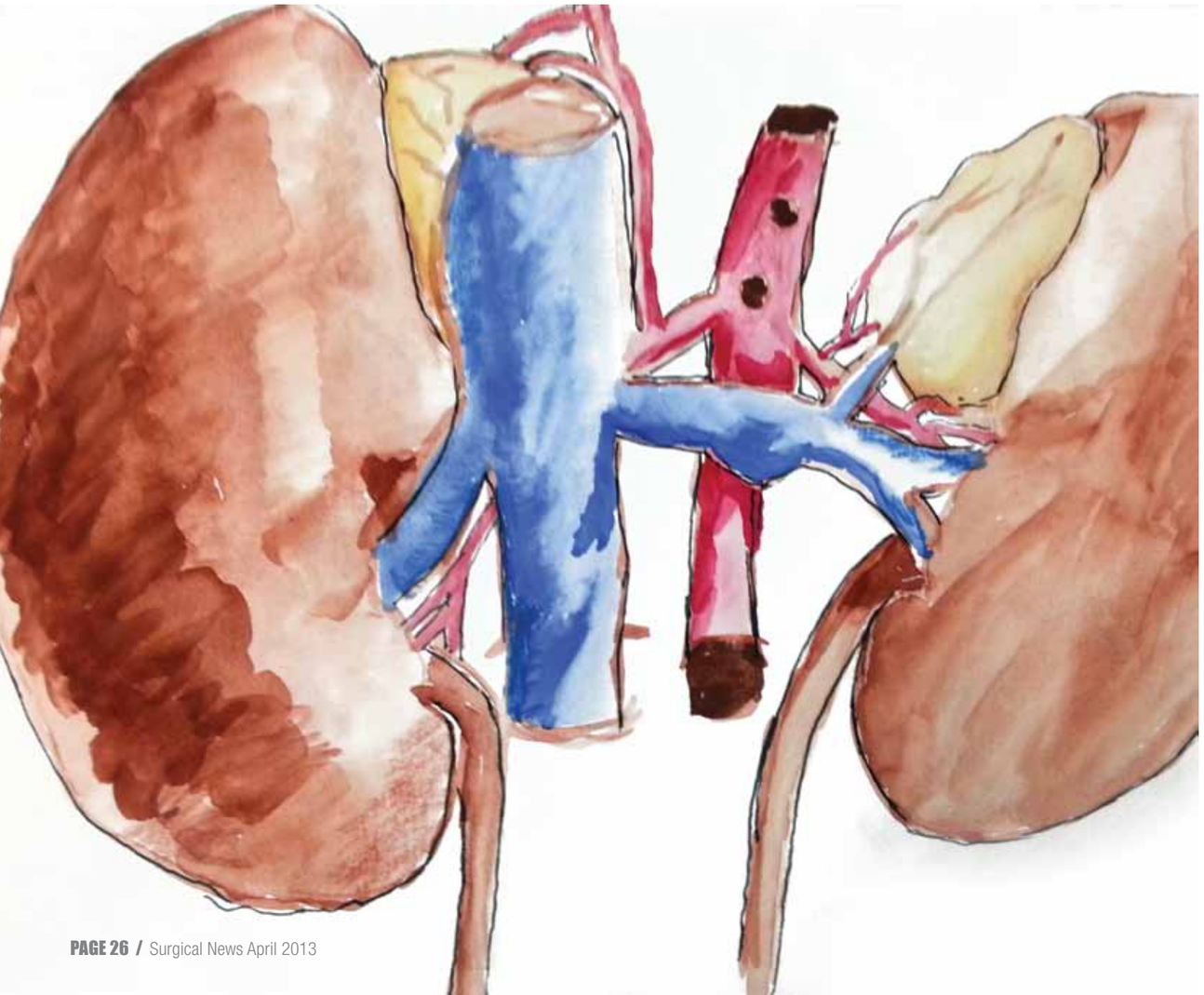
"And while I did not commence my Masters Degree as I had hoped to, I did enjoy spending time with the new baby and sharing more of the family load with my wife."

With Karen Murphy

Drawing for Surgeons

A lesson in art for an Australian surgeon in London

Dr Kellee Slater MBBS (Hons) FRACS, became a Fellow of the Royal Australian College of Surgeons, General Surgery (FRACS) in 2002, then obtained her certificate in Transplantation Surgery in 2006. She is a Hepatobiliary and General Surgeon and specialised Liver Transplant Surgeon at Princess Alexandra Hospital, Greenslopes Private Hospital and Mater Private Hospital. She is also a Senior Lecturer at the University of Queensland, School of Medicine.



As someone who is often looks for conferences and meetings that are a little to the left of centre, a surgeon friend of mine mentioned a course called "Drawing for Surgeons". Held in London at the Royal College of Surgeons twice a year, this wonderful two day program teaches surgeons the basics of art with a view to trying their hand at anatomical drawing.

With my leanings much more toward the sciences, I've always considered myself to be artistically inept. Given that my operative drawings could best be described as stick figures, I wondered if this was the course that might enable me to improve my visual communication skills. I paid the very reasonable registration fee and winged my way to London.

The course is held at the historic College at Lincoln's Inn Fields, somewhat of a tourist attraction all by itself. Sixteen colleagues from all walks of surgical life and from all over Europe were there to keep me company.

Sitting on the table in front of each of us was a sketch book emblazoned with "Drawing for Surgeons". This was filled with sheets of thick, blank pages, ready for us to draw our masterpieces. Alongside it was a beautiful artist's roll, brimming with pencils, erasers and watercolour paints. We were excited to find out that these were ours to keep. They had been especially chosen so we could carry them around and were to be our tool kit to use, any time we were moved to make a sketch in the course of our daily work.

The Drawing for Surgeon's course is a labour of love for the delightful Dr Rowan Pritchard-Jones, a plastic surgeon with a keen interest in surgical drawing. Frustrated by his inability to do this well, he had enlisted the help of art teacher friend Steve Downey and together they formulated this highly instructive class.

They threw us into it straight away by asking us to draw each others faces and other objects in the room. We learned about the 'negative space', light and shade and the principles of 'blind drawing'. It was with great trepidation that we all put pencil to paper. One of the surgeons in the room put into words how we were all feeling. 'Is it OK that I am really nervous'? he said. 'I don't usually like to fail at anything and I know I'm going to be really bad at this'. We all concurred with nervous laughter, clearly feeling way outside our comfort zones.

But, despite our concerns about producing something that even Picasso may not recognise, Rowan and Steve praised and encouraged our efforts. By the end of that first day we were all turning out some reasonably decent drawings.

After we finished sketching each other, we were given some spectacular plaster models made especially for the course, depicting real life surgeon's hands holding surgical instruments in various poses. The detail was so fine, there was even real suture in the needle holders. It was our task to draw them with lead pencil and then move onto shading with colours.

The end of that day culminated in a trip to London's superb National Portrait Gallery where we were taken on a guided tour by our instructors and given a crash course in art appreciation. This was followed by a friendly and informal dinner.

The following morning I awoke, keen to embark on another session of drawing and to see if I could build on my newly acquired artistic skills. The second day was spent in the impressive Wellcome Museum. This newly refurbished room contained an array of dissected pathology specimens from every part of the body.

The choice was ours as to what we would like to sketch. I spent that day turning dissections of livers and pancreas into works of art. By the afternoon, Rowan and Steve had us painting with water colours and with their support I had at least touched on the basics of something that I always thought was very difficult.

On returning home, I have continued to hone my drawing skills in my operative notes and now, if you can't find me after a case, you just have to check the anaesthetic room where I'll have my watercolours out, putting pictures on paper to describe the operation I have just performed.

At just under £400 including lunches and artists materials, this course is great value for money and I couldn't think of a more pleasant way to spend a couple of days and advance my surgical education.

Kellee Slater, Qld Fellow

If you would like the Professional Development Department to explore ways in which we could bring Drawing for Surgeons to you, express your interest via an email to pdactivities@surgeons.org

IMG Assessment Process upheld

Important College processes have been upheld in court

A recent decision of the Supreme Court of Western Australia has upheld the International Medical Graduate (IMG) Assessment process of the Royal Australasian College of Surgeons (Elobadi v. RACS [2013] WASC 29). As part of the College's usual assessment processes, the IMG was assessed as "not comparable" on the basis that he did not meet the assessment criteria to even qualify as "partially comparable".

The IMG had made several applications for assessment, and the decision of the Court was in relation to the most recent IMG Assessment. On previous assessments, the IMG was similarly assessed as "not comparable". The IMG had also sought to appeal the decision of the College through the College's independent Appeal processes and, on previous occasions, was not successful.

Because the recent IMG Assessment was on the same basis, with no further new information, no appeal was allowed in relation to the most recent decision.

It was argued by the IMG that his experience in Australia, for a number of years, in senior roles, now entitled him to a higher level of recognition under IMG Assessment. A central consideration in the IMG Assessment was whether the IMG had undertaken formal training to the equivalent of an Australian trained surgeon.

In previous assessments, and appeal, the conclusion was reached that the IMG had worked in Australia in registrar roles for a reasonable period of time. However, he had not performed at consultant level, and his log books did not indicate that he had operated at the level expected of a fully trained Australian consultant, on an unsupervised basis.

In a previous appeal decision, before the College Appeals Committee, it noted that "years spent simply in a service position do not automatically equate to the number of years that may have been spent in the Surgical Training Program". The Court noted that this basic reason for non-comparability had not changed, and the IMG had not completed a Training Program.

The IMG had previously appealed College decisions twice. On the last appeal, the decision of the College Appeals Committee clearly stated that more work of a similar type (non-consultant) would not provide the basis for comparability, and that the IMG needed to apply to the College Training Program to complete formal training requirements.

The IMG produced a number of referees attesting to his competence, but the Court did not accept that there was sufficient evidence to establish that the IMG had a number of years experience effectively operating as an independent surgeon at the equivalent of consultant level.

In its conclusion, the Court accepted that the College had appropriately followed its procedures for IMG Assessment. The College had applied its criteria appropriately, and there was insufficient additional evidence to suggest that an alternative conclusion should have been reached.

The Court noted that the IMG "has never completed a comparable Specialist Training Program to the College Programs. He will never be regarded as "partially comparable" until he does. The policy has not been rigidly applied, but properly applied".

The decision is therefore a helpful decision confirming that the medical colleges IMG processes are legally supportable, and the criteria used, as authorised by the Australian Medical Council and the Medical Board of Australia, are defensible. It also confirms that, so long as medical colleges properly follow the procedures established for IMG Assessment, then successful legal challenge is unlikely.

Implicit for medical colleges, arising from this case, are the need for:

- clear criteria to determine comparability, substantial comparability or non-comparability;
- clear processes by which the IMG Assessment process will be undertaken;
- transparent and documented processes in each individual case;
- documented discussions, meetings and even incidental contact with the IMG, referees or others involved in the process.

Important in this decision was the ability of the College to substantiate its processes, including with documents and notes of telephone conversations and other meetings, to demonstrate that it had transparently followed its own processes. Accordingly, well documented processes of all aspects of IMG Assessment will greatly assist medical colleges to defend challenges in the future.

The College representatives, who gave evidence in the case before the Supreme Court, were considered credible, and gave comprehensive evidence from memory and in documentation as to the manner in which the IMG process had been undertaken in this particular case.

Russell Kennedy, Solicitors, acted for the College in this case before the Supreme Court of Western Australia.

Michael Gorton,
College Solicitor

In Memoriam

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

Vincent Ooi,
South Australian Fellow

David Warnock,
New Zealand Fellow

Graham Hill,
New Zealand Fellow

Marius Fahrer,
Victorian Fellow

Wilton Carter,
Victorian Fellow

James Lewis Jardine,
New Zealand Fellow

William Chin,
Victorian Fellow

Anthony Bookallil,
New South Wales Fellow

Wilton Carter,
Victorian Fellow

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they 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. They are

ACT: Eve.edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Daniela.Ciccarello@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

Workshop success

The Acute Neurotrauma workshop has become a popular and successful event

From 2007 until last year the College has offered nine Acute Neurotrauma workshops in total. Three of these were offered in Adelaide, two each in Melbourne and Brisbane and one each in Perth and Townsville. They provided training in performing burr-holes, craniectomy and craniotomy for head trauma emergencies and provided a foundation for improved head injury management.

The workshops were primarily for rural surgeons, but also other health care professionals, such as retrieval emergency physicians, found the course very valuable. Over 150 participants gained the skills to deal with neurotrauma cases in the rural setting.

Due to the urgency of the case or difficulties with patient transport, there are occasions when rural surgeons need to perform emergency procedures to relieve raised intracranial pressure to save the patient's life or reduce neurological morbidity.

These skills are taught using relatively inexpensive equipment, such as the Hudson Brace, which can easily be available in smaller hospitals. Participants learned to correctly evaluate whether treatment on-the-spot was needed and how to proceed after contact with a neurosurgeon. Adequate time was spent operating on cadavers until participants were comfortable with performing the procedures.

Pleasingly, all the workshops received excellent feedback from the participants and there have been waiting lists for workshop attendance. Some of the major concerns the participants had about dealing with neurotrauma before the workshops were; unavailability of staff to perform or assist in rural hospitals, no confidence in performing the procedures, and communication issues with some neurosurgical units, in the emergency situation.

All participants thought their concerns had been addressed and that they were more confident in dealing with emergencies in the future. One participant wrote: "Certainly, feel like I could perform this procedure given guidance over the phone from the neurosurgery specialist."

I am very grateful for the support I have received from my colleagues around Australia in facilitating these workshops and take this opportunity to thank Teresa Withers, Eric Guazzo, Larry Marshman, Glenn McCulloch, Marguerite Harding, Stephen Santoreneos, Amal Abou-Hamden and Ellison Stephenson for their great contribution. They have also commented on how they have enjoyed imparting skills to their rural colleagues.

This project has been funded by the Department of Health and Ageing under the Rural Health Continuing Education Sub-program (RHCE) Stream One which is managed by the Committee of Presidents of Medical Colleges. The Royal Australasian College of Surgeons is solely responsible for the content of, and views expressed in any material associated with this Project.

New funding is crucial to be able to offer further practical workshops. Following the success of the workshops a series of online modules have been developed, and in this I am very grateful to Professor Peter Reilly who has taken the lead in developing this complementary resource.

Marianne Vonau

2013 Workshops & Activities

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

Keeping Trainees on Track (KToT)

6 May, Auckland – ASC; 18 June, Adelaide

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Supervisors and Trainers for SET (SAT SET)

6 May, Auckland – ASC; 18 June, Brisbane

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can 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. This workshop is also available as an eLearning activity by logging into the RACS website.

Non-Technical Skills for Surgeons (NOTSS)

6 May, Auckland – ASC; 9 August, Sydney

This workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues.

AMA Impairment Guidelines 5th Edition: Difficult Cases

29 May, Brisbane

The American Medical Association (AMA) Impairment Guidelines inform medico-legal practitioners as to the level of impairment suffered by patients and assist with their decision as to the suitability of a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time. This 3 hour evening seminar compliments the accredited AMA Guideline training courses. Please note: Fellows will still need to attend AMA training to be accredited to use AMA guidelines.

Writing Medicolegal Reports

15 July, Sydney

This 3 hour evening workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This ability is one of the most important roles of an expert adviser.

Finance for Surgeons

19 July, Melbourne

This whole day course establishes a basic understanding of how to assess a company's performance using a range of analytical methods and financial and non-financial indicators. It reviews the three key parts of a financial statement; balance sheet, income (profit and loss) and cash flow. Participants learn how these statements are used to monitor financial performance.

Process Communication Model

2 - 4 August, Melbourne

PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach.

NSW

15 July, Sydney
Writing Medicolegal Reports,

9 August, Sydney
Non-Technical Skills for Surgeons (NOTSS)

NZ

6 May, Auckland – ASC
Keeping Trainees on Track (KToT)

6 May, Auckland - ASC
Supervisors and Trainers for SET (SAT SET)

6 May, Auckland - ASC
Non-Technical Skills for Surgeons (NOTSS)

QLD

29 May, Brisbane
AMA Impairment Guidelines 5th Edition: Difficult Cases

18 June, Brisbane
Supervisors and Trainers for SET (SAT SET)

31 July, Brisbane
Keeping Trainees on Track (KToT)

SA

18 June, Adelaide
Keeping Trainees on Track (KToT)

29 - 31 August, Adelaide
Surgical Teachers Course

VIC

16 April, Melbourne
Supervisors and Trainers for SET (SAT SET)

19 April, Melbourne
Non-Technical Skills for Surgeons (NOTSS)

19 July, Melbourne
Finance for Surgeons

2 - 4 August, Melbourne
Process Communication Model

24 - 25 August,Melbourne
Preparation for Practice

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

profile

HIGHLIGHTS

2011: Commonwealth Scholarship; Royal Australasian College of Surgeons Foundation for Surgery Research Scholarship; Award from the New Zealand Orthopaedic Association Wishbone Trust

2007: Douglas Robb Prize for the best academic performance throughout the clinical phase (MBChB degree); J D K North Prize in Clinical Medicine for the best performance in the clinical assessment; Flavell Exchange Scholarship to undertake an elective at Barts and The London Hospital in London

2006: Year 5 Annual Award for best academic performance

Relieving back pain

This scholar is working towards a pain free future for patients

With the financial support of the College, NZ Orthopaedics Trainee Dr Anand Segar is now investigating the pathophysiology of intervertebral disc degeneration and its link with obesity as part of a PhD at Oxford University.

Dr Segar, from Auckland, was awarded both a Foundation for Surgery Scholarship for 2012 by the College and a Commonwealth Scholarship by the British Government to fund his place at Oxford, the latter prize awarded to only three New Zealanders each year.

He is conducting his research at the Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences (NDORMS), situated on the site of the Nuffield Orthopaedic Centre, the largest dedicated orthopaedics hospital in the UK.

Under the supervision of Dr Jill Urban, an internationally regarded expert in cartilage and intervertebral disc biology, and Professor Jeremy Fairbank, head of spine research, Dr Segar is investigating the role of adipose tissue in the disc degeneration process.

"An article published in the Lancet last year highlighted the burden of low back pain, ranking it as the foremost cause of worldwide disability, ahead of ischemic heart disease and diabetes. However, our understanding of the disease process leading to disability is unclear." Dr Segar said.

"Obesity is a significant contributing factor to low back pain and disc degeneration; however, the mechanism underlying the link between the two is unclear.

"It is very exciting because we all once thought fat was quiescent. However, this view has shifted recently and we now know fat directly contributes to the chronic low-grade inflammation of obesity via specific cytokines called adipokines.

"Of these, two important adipokines are leptin and adiponectin, both of which can be pro-inflammatory in cartilage. Researchers have now drawn a link between intra-articular fat, which produces local adipokines, and osteoarthritis.

"In osteoarthritics, the degenerating bone and cartilage even produces these adipokines, further feeding back on the degradative process.

"My research aim is to determine if leptin and adiponectin, produced by fat, are involved in the pathogenesis of low back pain and intervertebral disc degeneration."

Dr Segar said that his work during 2012 had shown that both leptin and adiponectin reduce cellular function in the intervertebral disc, down-regulate matrix production and up-regulate degradative enzymes.

Focusing research

During this year and next, he said he would refine his research to attempt to identify the cellular signalling processes which mediate the response and has already received ethics committee approval to conduct a cross-sectional clinical study to investigate the relationship of the adipokines in symptomatic patients.

Dr Segar said he hoped that his work would advance global research efforts into the development of cell-based biological therapies to treat disc degeneration.

Dr Segar graduated from the University of Auckland in 2007 and was selected onto the New Zealand Orthopaedic Association (NZOA) and RACS SET orthopaedic program in 2010, completing his first year of training in Wellington before heading to Oxford.

He said it took 18 months of contact and negotiation to win his place at the prestigious university, a success he could not have achieved without the support of the New Zealand Orthopaedic Association (NZOA) and the College.

"My interest in surgical research was initially fostered and supported by Professor John Windsor and I am very grateful to him for helping me get here," he said.

"I wanted an international experience to my research and was lucky enough to be working for a surgeon, Mr Richard Nicol, who had contacts at Oxford.

"Now I feel incredibly lucky to be working at NDORMS, which is a world-class centre of excellence.

"It is an integrated department housing researchers from many backgrounds including clinical orthopaedics, immunology, genetics, rheumatology, oncology, engineering and statistics. All of this provides great opportunities for discussion across different research areas and ideas for translation of the research.

"Another reason I wanted to come here was to work under my supervisors, both of whom are internationally regarded for their work in this field. As a surgical Trainee conducting basic science research, I think it is very important to be supervised by both a clinician and scientist."

Dr Segar said he felt proud to be able to return to New Zealand upon completion of his PhD with the skills in, and knowledge of, mesenchymal cell biology to advance research work conducted in Australasia into the development of cell-based therapies for treating musculoskeletal conditions.

"There is a small research community with this focus in New Zealand and Australia, but both obesity and degenerative musculoskeletal conditions are becoming an ever increasing problem. On my return, I hope to combine science with my future surgical practice to promote translational musculoskeletal research to improve patient outcomes."

Essential support

Dr Segar's Foundation for Surgery Scholarship provided a $45,000 stipend and the Commonwealth Scholarship provided a small living allowance and covered the international student fees at Oxford University. His laboratory costs have been funded by the Wishbone Trust of New Zealand.

"It was a great honour to receive the Commonwealth Scholarship, but still I would not be here without the support and funding from New Zealand and the College while the NZOA was very supportive of me taking a break from my clinical training to undertake this research work," he said.

"Oxford is an amazing place and even after living here for a year, I am still taken aback.

"I am based at Christ Church, an Oxford college founded in 1546.

"Christchurch, New Zealand, was founded by a graduate of this college and it is amazing for me to see all these links with New Zealand.

"I also enjoy the fact that you cannot immerse yourself in any more orthopaedics than you can in Oxford – particularly when your work is associated with the Nuffield Orthopaedic Centre."

With Karen Murphy

Was Graham Coupland ahead of his time?

This is the first half of a lecture presented at the NSW Regional Committee End of Year Dinner, 14 December 2012

I am honoured and flattered to be asked to give the 2012 Graham Coupland Lecture because I believe there are many surgeons in NSW, and certainly in the rest of Australasia, who are more qualified and more eloquent than I. However, I shall try to hold your interest at this time of day when somnolence is the rule.

Born in Manilla in 1934, he (Graham Coupland) graduated from Sydney University in 1959, obtaining his Fellowship in 1964 and an MS in 1975. He was primarily a general surgeon, but also trained in paediatric surgery at the Alder Hey Hospital in Liverpool, an aspect of his practice that continued for the rest of his life.

My personal contact with Graham was through his involvement in paediatric surgery. In the 1970s he used to come quite often to the Thursday lunchtime surgical meetings at the Kids Hospital, then at Camperdown. Doug Cohen and Arch Middleton were the senior members of the group with Martin Glasson as the young gun. Graham was there not so much as an expert as his practice did not involve the sort of complex cases that were usually discussed at this meeting (although his opinion was always valued), but he was there to maintain his knowledge.

I think it speaks a lot about the man that even with his high level of expertise in the main area of his practice, he took the trouble to ensure that all areas of his professional life were at a high level of expertise.

My recollections, and those that others who knew him better have shared with me, are that he was a most complete surgeon. I am particularly indebted to the eulogy that Tom Reeve wrote. Graham's knowledge and technical skills were enormous, supported by excellent judgement. He was a kind, gentle person, communicated well, highly professional in his dealings with patients and colleagues, an outstanding team player and a leader such that his nursing staff were utterly devoted to him.

Those who passed through his hands as junior members tell us that he was a wonderful teacher. The recollections of his son, given to us only a few years ago in this address, show that if there was any area of life in which he did not excel it was as a family man. Like so many of us, he seems to have struggled with work/life balance and health advocacy as far as his own health was concerned, but this was long before those terms were coined.

Those of you who are still awake may realise that I have just gone through the nine College competencies. Graham would never have heard of them. Indeed, even if he had, I doubt if he would have spent much time worrying about them, as individuals who excel rarely waste time trying to measure how good they are.

This is not to say that we shouldn't write down what we expect of surgeons. We should have some explicit standards. But writing down a lowest common denominator does not mean that some individuals, such as Graham, will not exceed the codified standard.

This is so of human behaviour in general: laws are a lowest common denominator that the society will accept of its members, but most honourable people would have a code of behaviour well above that, a code we could call ethics or simply being a decent, honourable human being. For example, you and I would hope that our word was binding when we give it even though legally we can abandon an agreement that isn't in writing. To be excellent, either as a citizen or a surgeon, one must function well above the minimum standard, the written code.

This is not to say that I believe the College's standards, as codified in the Code of Conduct and the Competence and Performance Guide, are too low. It is more that they are standards that are in some degree measurable, such as is outlined in the Competence and Performance Guide.

But we all know that a huge part of a human's life is concerned with that which is not measurable, including their response to contact with a medical practitioner, and, more specifically, a surgeon. It is this that I want to address tonight.

The fixer

As surgeons, we fix things. Operating is what makes us different from non-procedural specialists. We should take pride in doing it well, and doing it well should give us pleasure. What we can do is expanding at an amazing rate: when you think of what we can do now compared with only 50 years ago when I was a student, one cannot but be amazed, and there is little sign that the rate of change is slowing.

The downside of this is that we are bedazzled by the technical wonders at our command. In the past we couldn't "fix" many things, but, perhaps surprisingly and certainly paradoxically, this didn't mean that medical practitioners were held in low esteem. Indeed, just the opposite. In all cultures throughout history, healers have been held in high esteem.

I think the clue to this apparent contradiction lies in the last phrase of that well known saying "...to comfort always". It is this that makes an individual surgeon a healer, not simply a technician.

I believe it is this aspect of patient care that made many of the greats of our profession, like Graham, stand out, but I fear that it is this aspect of patient care that we are at risk of losing, agape in the wonderland of technology like kids in a sweet shop, and at the same time, constrained by a fiscally driven bureaucracy.

If this part of patient care is so important we need to know something about it. In the past this non-technical aspect of healing was either innate within the individual or learned by osmosis and example from a mentor who possessed it. Now we have considerable literature to help us understand it, much of it coming from work done with cancer patients,[1,3] but more widely applicable because it deals with one of the core aspects of everybody's life, that of suffering.

Suffering is a universal human experience. It is hard to define. Coulehan[2] described it as "the experience of distress or disharmony caused by the loss, or threatened loss, of what we most cherish", but I think we all have some understanding of what the word means. Suffering separates the sufferer from the society and their personal supports such as family and friends. It destroys daily routines, belief systems and core values such as the meaning and purpose of life.

Hugh Martin,
NSW Fellow

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3. Wilson KG, Chochinov HM, McPherson CJ, LeMay K, Allard P, Chary S, *et al.* Suffering with advanced cancer. *J Clin Oncol.* 2007; 25:1691-1697

This lecture is to be continued in the next issue of *Surgical News*.

CONGRATULATIONS on your achievements

Presented at the NSW End of Year Dinner, held on 14 December 2012

Kerin Fielding

Kerin Fielding has been an essential part of the surgical service in Wagga Wagga since 1992, having graduated from Sydney University in 1982 and been awarded FRACS in 1991. She is a highly accomplished Orthopaedic and Trauma Surgeon.

Tonight we want to recognise and celebrate her contribution to our College's activities in NSW and, in particular, her very significant contribution to Surgical Education.

So what are some of Kerin's particular achievements?

She was a member of NSW Australian Orthopaedic Association Board of Studies for registrar training and term supervisor for accredited and unaccredited registrar Trainees 2001 -2005

She was a member of AOA NSW state executive committee 2003-2009

She is currently a Course Director and Instructor trainer for the Early Management of Severe Trauma programme, Royal Australasian College of Surgeons.

She is Associate Professor, University of Notre Dame Australia, School of Medicine Sydney and clinical discipline lead for Speciality Surgery, Wagga Wagga Sub-school.

However, perhaps her most significant contribution has been and continues to be to various institutions that have succeeded the former NSW Post Graduate Medical Foundation. She was a member of the NSW Medical Education and Training Council MTEC 2003 – 2007 and Chair of the procedural stream (Basic Surgical Training Project) 2005 – 2007.

MTEC evolved into the Clinical Education and Training Institute in 2007 and Kerin became Chair NSW Surgical Training Council which continues under the new Health Education and Training Institute formed in 2011.

In this position her responsibilities cover all of NSW through several surgical skill networks covering all hospitals in NSW that provide prevocational training in Surgery for Resident Medical Officers. She has been responsible for the implementation of training programs either developed on site in hospitals; e.g. skills laboratories or instructional lectures, seminars or workshops or state wide programmes such as surgical science courses preparing for the College Surgical Science Exam or courses to develop non clinical skills.

Kerin is a wife, married to Dr Joe McGirr, a mother of four children, an enthusiast of all things French, being fluent and also a Cordon Bleu Chef, having been successful in Le Certificat de Patisserie de Base de l'Ecole Le Cordon Bleu, Paris 2012

Kerin's parents were both schoolteachers who answered an advertisement to teach in Canada when Kerin was 7-years-old. Kerin was educated in Ontario gaining her School Certificate at Laura Secord Secondary School, St Catherines. At this stage her father returned to Wollongong University as the Professor of Education and Kerin attended Dapto High School for her HSC. She describes the culture shock she experienced. There was a totally different approach to education with only 47 students in years 11 and 12 in a High School which was one of the largest in the state. Told by the school counsellor she should do nursing made her doubly determined to do Medicine and then become a Surgeon. She became the first pupil to ever enter a Medical Faculty from Dapto High School and there is in the Headmasters office a small wall plaque commemorating her achievement.

Kerin, thank you for all you have given to our College and to Surgical Education in NSW.

Citation provided by Robert Rae

Patrick Cregan

There is no more deserving recipient of the Michael Donnellan Award for 2012 than Patrick Cregan. He has demonstrated over the years his commitment to surgery and most particularly surgical leadership. Patrick has, as all real surgical leaders do, extended his influence outside of conventional surgical fields and thus enhanced the role of surgeons in guiding our Health Care System in Australia.

Following his surgical training at Concord Repatriation General Hospital he heeded the advice to "go west young man" rather than heading overseas to obtain his B.A. (Being Abroad). His clinical work has remained based at Nepean from 1983 until the present and he has been the catalyst for the expansion of surgical and subsequently many other clinical services at Nepean Hospital and he is now the Chairman of the Board of the Nepean Blue Mountains Local Health Network.

As a surgeon he was an early and enthusiastic uptaker of laparoscopy and is now a leader in advanced laparoscopic surgery. He has been involved in the development of surgical robotics and tele-surgery; Patrick has assessed and implemented a Virtual Critical Care Unit Programme at a remote hospital.

Through the University of Western Sydney, Department of Mechatronics in the faculty of engineering, Patrick was involved in the development of a touch sensor to develop data in-vivo for in-vitro haptic feedback use.

Patrick's interest in training surgeons is legendary and most particularly assessing the use of virtual reality and other simulation tools, and he was Medical Director and Chairman of the Board of Directors at MedicVision which has developed effective simulators which are used in Australia and internationally. Patrick initiated the Medical Simulation Group within the Royal Australasian College of Surgeons and has played a significant role in SIMTEC and ASERNIP-S assessments.

In this field Patrick was a Visiting Professor to Stanford University in 2009 in their centre of Immersive and Simulative Learning.

Outside the operating theatre Patrick instigated a communication video ("technically brilliant") which was completed with others including Prof Richard West, with the video winning international acclaim in the training of advanced surgical Trainees in communication skills.

Patrick was always a leader – the Year Representative at the Sydney University Medical Society for three consecutive years, 1973-1975, New South Wales Trainee Representative on the Royal Australasian College of Surgeons, 1980-1981, President of the Concord Hospital Residents Association from 1980-1982 before a series of positions at Nepean Hospital and the previous Wentworth Area Health Services, including the Clinical Director of Surgery from 2000-2004.

Patrick served on the New South Wales State Committee of the RACS from 1987-1996 including Chairman of the Continuing Medical Education Committee, Chairman of the Standards Committee and was the Secretary from 1993-1996.

His leadership and innovative skills were recognised when he was appointed the Inaugural Chair of the New South Wales Surgical Services Task Force and proceeded to revolutionise the process of elective surgical services in New South Wales Hospitals. This will be one of his major legacies.

Although considered by some to be Nepean-centric, Patrick has been a major player in the development of clinical services and teaching at Nepean Hospital, moving it from a semi-rural district hospital when he first accepted an appointment there to a major teaching hospital of Sydney as it is now recognised.

Patrick has been recognised for his academic pursuits with Professorial titles at both the University of Sydney and the University of Western Sydney.

Patrick Cregan is a true surgical leader and we all congratulate him on his most recent recognition – that of the Michael Donnellan Award, an award that I am sure will give Patrick much pleasure in receiving.

Citation provided by Brian McCaughan

Bryan Wheaton Yeo

25 April 1938 – 5 May 2012

Bryan graduated from Sydney University in 1961. He completed internship at Royal North Shore Hospital in that year. In 1962 he accepted his first appointment at Prince Henry, Prince of Wales Hospitals. These hospitals were to become his clinical home for his professional life.

Like so many at that time, he went to England in 1968 to complete his surgical training. He held positions at Essex Hospital, Colchester; Guy's Hospital, London and St. Marks where he worked with Lloyd-Davies.

He returned to Prince Henry Hospital in 1970 as Senior Registrar and was appointed to the consultant staff the following year. He was awarded Fellowships of the College of Surgeons England in 1967 and the Royal Australasian College of Surgeons in 1971.

Bryan's clinical interest was Upper Gastrointestinal Surgery with particular interest in surgical diseases of the pancreas. He loved all things surgical. He was a consummate clinician who provided a great deal of support to his colleagues both clinically and emotionally. It was always good to see Bryan and share his enthusiasm for life.

A true persevering advocate; there was nothing he would not do to help a patient in need, no matter how menial.

He had an unfettered fervour for teaching. Teaching was his greatest professional passion. He had style that was humble, but engaging where his enthusiasm for what he did and how he did it was infectious to all who were privileged to be part of it.

He was the professional yard stick against whom many of us measured our own performance.

He would have been brimming with pride the day he died. He was in transit to attend the convocation of his son, David, at the Annual Scientific Congress in Kuala Lumpur. He probably died the way he wished; fully in harness and in good health.

His legacy will be the hands that he has trained and the hearts and minds he has touched of hundreds of surgeons and thousands of medical students. His influence will be limitless and timeless.

He was a loving father to Paul, David, Belinda and Anna and devoted husband to Paula.

We have lost a teacher, coach, mentor, friend and colleague. The art of surgery has been enriched by his contribution.

Citation provided by Phil Trusket

Royal Australasian College of Surgeons

2014 Rowan Nicks Australian & New Zealand Exchange Fellowship

The Rowan Nicks Australian and New Zealand Exchange Fellowship is intended to promote international surgical interchange at the levels of practice and research, raise and maintain the profile of surgery in Australia and New Zealand and increase interaction between Australian and New Zealand surgical communities.

The Fellowship provides funding to assist a New Zealander to work in an Australian unit, or an Australian to work in a New Zealand unit, judged by the College to be of national excellence for a period of up to one year.

Applicants must have gained Fellowship of the RACS within the previous ten years on the closing date for applications.

Selection Criteria
The Committee will
– consider the potential of the applicant to become a surgical leader and ability to provide a particular service that may be deficient in their chosen surgical discipline.
– assess the applicants in the areas of surgical ability, ethical integrity, scholarship and leadership.

The Fellowship is not available for the purpose of extending a candidate's current position in Australia or New Zealand.

Value: Up to $75,000 pro-rata, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand.

Tenure: 3 - 12 months

FURTHER INFORMATION
Application and instructions will be available from the College website from December 2012: www.surgeons.org
Closing date: 5pm Monday 6 May, 2013.
Applicants will be notified of the outcome by 30 October 2013.

Please contact:
Secretariat, Rowan Nicks Committee
Royal Australasian College of Surgeons
250 - 290 Spring Street,
East Melbourne VIC 3002
Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211
Fax: + 61 3 9276 7431

Lion Hearts

An accomplished addition to the list

Henry R. (Harry) Lew is a quiet, unassuming senior ophthalmologist, with a wry smile and a mischievous sense of humour. One would not guess that behind this lies an author of considerable skill. His previous, highly successful books have included an historical novel and two biographies of little known early Australian modernist artists whose work he has assiduously collected.

These books were followed by a brilliant, collaboratively translated first-hand account of a Holocaust survivor originally written in Yiddish, 'The Stories Our Parents Found Too Painful To Tell', which subsequently was made the subject of an ABC telemovie.

In his new book, 'Lion Hearts', he has outdone himself. The book is fascinating. It basically tells the life story of his father, Lonek (or Leo), who was born in Bialystok in 1907. At that time Bialystok was in Czarist Russia; later it was German, then Polish, then Russian, then German and finally Polish again after 1945. Lonek grew up and lived through all this turmoil.

However, Harry has not simply told the story of a man who lived through extraordinary times, although that story clearly comes through. We learn of his father's childhood and being a lawyer before the war, surviving the war in Southern Russia, emigrating to Australia in 1947, setting up a successful small business here, and living to 95.

But this story which Harry weaves is also brilliantly told by relating the stories of more than 20 other people with whom his father interacted at different stages of his life. This wonderful device brings in a host of intimate details and texture about life in Poland before and after the war and the struggles and triumphs of survivors of those terrible times.

The result is a fascinating and informative book, well written, extensively researched and a great read. As Sir Michael Holroyd, one of Britain's leading biographers has said about it, "...the story embraces us all. It deserves a wide readership".

Hugh R Taylor,
Victorian Fellow

Professor Hugh R Taylor AC, Melbourne Laureate Professor, Harold Mitchell Chair of Indigenous Eye Health, Melbourne School of Population and Global Health, University of Melbourne, 207 Bouverie Street, Carlton, 3053. www.iehu.unimelb.edu.au

No phone home?

Mobile, but not easy

There is one thing that really annoys me and that is marketing, and in particular the marketing of mobile phones. I recently bought an iPhone 5. Yes, we curmudgeons are tech-savvy! I was aware that they were about $800 in the US and I thought that I could simply call in to my local Telstra shop and buy one. However, that lovely sales assistant said they were not selling them. This seemed to be a disaster for a phone shop to not sell phones as I would have thought that was their core business.

They will allow you to enter a two year contract with one of their iPhones for $67 per month which includes a fee of $17 per month for "MRO" or mobile repayment option. Now I assume that is the cost of the phone. $17 for 24 months is $408 so that is a cheap iPhone. However, the generous people at Telstra also give you a $10 per month MRO bonus discount so over 24 months you pay $168 – now that is a really cheap phone.

As I left the shop I asked what happens after 24 months and that is where it gets complicated. You can change to another carrier (or "port" your number as they say) or take out a new plan with Telstra. You can be sure that new plan will be more expensive. What happens to your MRO? That will cease, but the MRO bonus will also cease and so your new plan, if you do nothing, is $60 per month. Now that means that they have sold you a really cheap phone, but sold you a contract for on-going charges that are artificially inflated. Most people will simply continue the contract by default after the 24 months.

So there you go, Mr Telstra wins the day – but you can always go to see Mr Optus who no doubt will have a special deal if you "port" to them, which no doubt will have an "MRO" or a "BBRO" charge. In case you don't know, BBRO is technical language for blasted big rip off.

Surgical News welcomes letters from readers.

Please write to The Editor, Surgical News, Royal Australasian College of Surgeons, 250-290 Spring St, E ast Melbourne. Vic 3002 or **letters.editor@surgeons.org**

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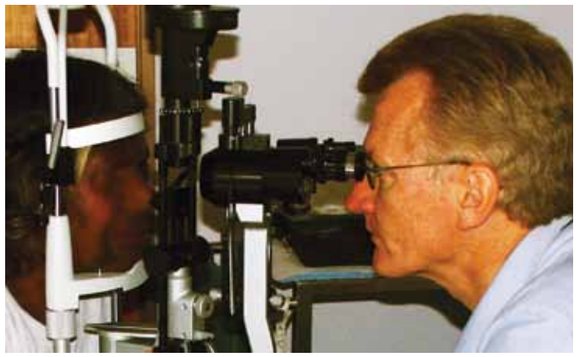

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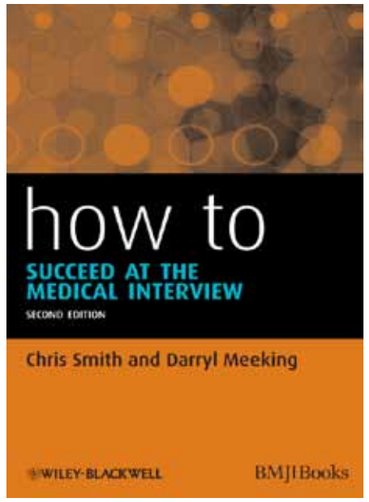

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Chris Smith, Darryl Meeking
9781118393833 | Pbk | 144 pages
April 2013, BMJ Books

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How to Succeed at the Medical Interview provides candidates with a competitive edge. It reduces the likelihood of unexpected questions or situations and helps improve confidence before and during the medical interview.

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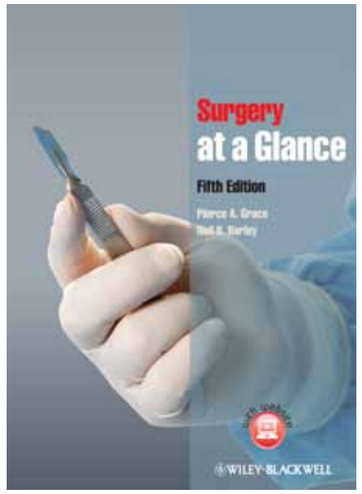

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Pierce A. Grace, Neil R. Borley
9781118272206 | Pbk | 208 pages
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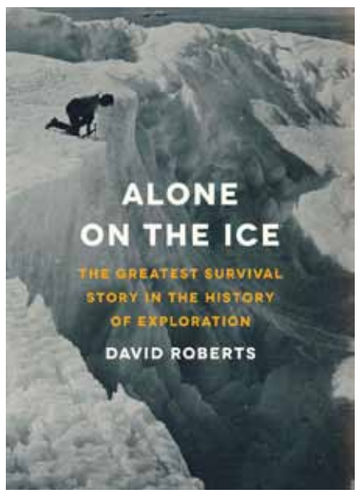

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David Roberts
9780393083712 | PB | 304 pages
April 2013, Norton

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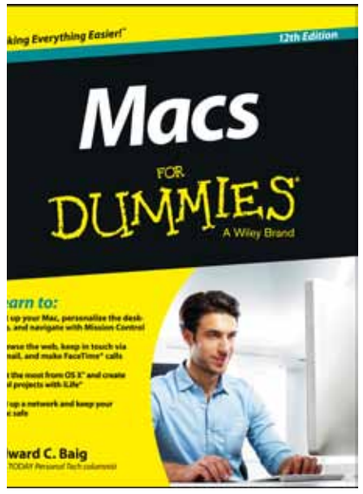

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Edward C. Baig
9781118517192 | Pbk | 456 pages
April 2013

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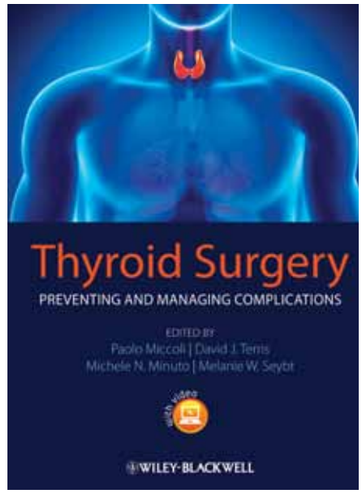

Thyroid Surgery: Preventing and Managing Complications

Paolo Miccoli, David J. Terris, Michele N. Minuto, Melanie W. Seybt (Editors)
9780470659502 | Hbk |336 pages
February 2013

~~AU$305~~ | **AU$228.75**
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This highly practical, full color teaching tool is focused on best surgical practice in thyroid surgery, including the key issue of prevention and management of surgical complications. An accompanying website contains twenty step-by-step surgical videos of thyroid surgery in action. Several chapters are included on brand new surgical techniques, such as robotic and image-localized surgery.

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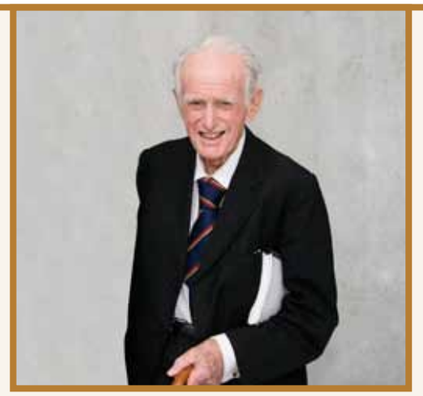

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Please contact:

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Developing a Career in Academic Surgery

Monday 6 May 2013, 7.00am – 4.00pm

SKYCITY CONVENTION CENTRE AUCKLAND, NEW ZEALAND

Provisional Program

7:00am Registration and Breakfast
7:15am Welcome . . . . . *Michael Hollands (RACS President)*
Introduction . . . . . *Andrew Hill (Auckland)*

SESSION 1: GENERAL PRINCIPLES

Chairs: Mark Smithers (Brisbane) and Julie Ann Sosa (Durham, USA)

7:30am What is a career in academic surgery? . . . . . *John Windsor (Auckland)*
7:50am Research - How to get research started - ideas, grants, ethics and collaboration. . . . . *Russell Gruen (Melbourne)*
8:15am Academic surgery - the essentials - teaching, leadership and administration . . . . . *Timothy Pawlik (Baltimore, USA)*
8:40am Discussion

9:00am MORNING TEA

SESSION 2: TOOLS OF THE TRADE

Chairs: Eric Kimchi (Hershey, USA) and Richard Hanney (Sydney)

9:15am **HOT TOPIC IN ACADEMIC SURGERY - Stem Cells** . . . . . *Julie Ann Sosa (Durham, USA)*
9:35am Bedside to bench to bedside . . . . . *Lillian Kao (Houston, USA)*
9:55am Basic science . . . . . *Carlton Barnett (Denver, USA)*
10:15am Randomised clinical trials. . . . . *Andrew Hill (Auckland)*
10:35am Comparative effectiveness research . . . . . *Justin Dimick (Ann Arbor, USA)*
10:55am Surgical education/simulation . . . . . *Jeffrey Hamdorf (Perth)*
11:15am Discussion

11:30am LUNCH

12:30pm **KEYNOTE PRESENTATION - An Antipodean academic odyssey - between the siren call and the rocks** *Charles McGhee (Auckland)*

SESSION 3: CONCURRENT ACADEMIC WORKSHOPS:

Workshop 1: Interactive Workshop on Issues in Research

Chairs: Mark Smithers (Brisbane) and Julie Howle (Sydney)

1:00pm Getting the most out of a team
Justin Dimick (Ann Arbor, USA)
1:20pm Multiple Faculty
Justin Dimick (Ann Arbor, USA)
Michael Edye (Sydney)
Jeffrey Hamdorf (Perth)
Timothy Pawlik (Baltimore, USA)
Julie Ann Sosa (Durham, USA)

Workshop 2: Career Development

Chairs: Russell Gruen (Melbourne) and David Watson (Adelaide)

I want to be an academic surgeon.
What can I do as a:

1:00pm Medical Student
Deborah Wright (Auckland)
1:15pm Intern
Marc Gladman (Sydney)
1:30pm SET Trainee
Gregory O'Grady (Sydney)
1:45pm Fellow
Win Meyer-Rochow (Hamilton)
2:00pm Consultant
Susan Neuhaus (Adelaide)
2:20pm Discussion

Workshop 3: Presenting Your Work

Chairs: Lillian Kao (Houston, USA) and Arthur Richardson (Sydney)

1:00pm Writing an abstract
Eric Kimchi (Hershey, USA)
1:15pm Writing a paper
Rebecca Sippel (Madison, USA)
1:45pm Presenting a talk
Carlton Barnett (Denver, USA)
2:00pm Producing a poster
Eric Kimchi (Hershey, USA)
2:15pm Discussion

2:40pm AFTERNOON TEA

SESSION 4: A CAREER IN ACADEMIC SURGERY

Chairs: Andrew Hill (Auckland) and Timothy Pawlik (Baltimore, USA)

3:00pm Choosing and being a mentor . . . . . *Mark Smithers (Brisbane)*
3:20pm Work-life balance . . . . . *Julie Howle (Sydney)*
3:40pm On the shoulders of giants - The legacy of the Otago University Department of Surgery . . . . . *Andre van Rij (Dunedin)*

Registrants receive a complimentary copy of Success in Academic Surgery (Part 1) edited by Herbert Chen and Lillian Kao.

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