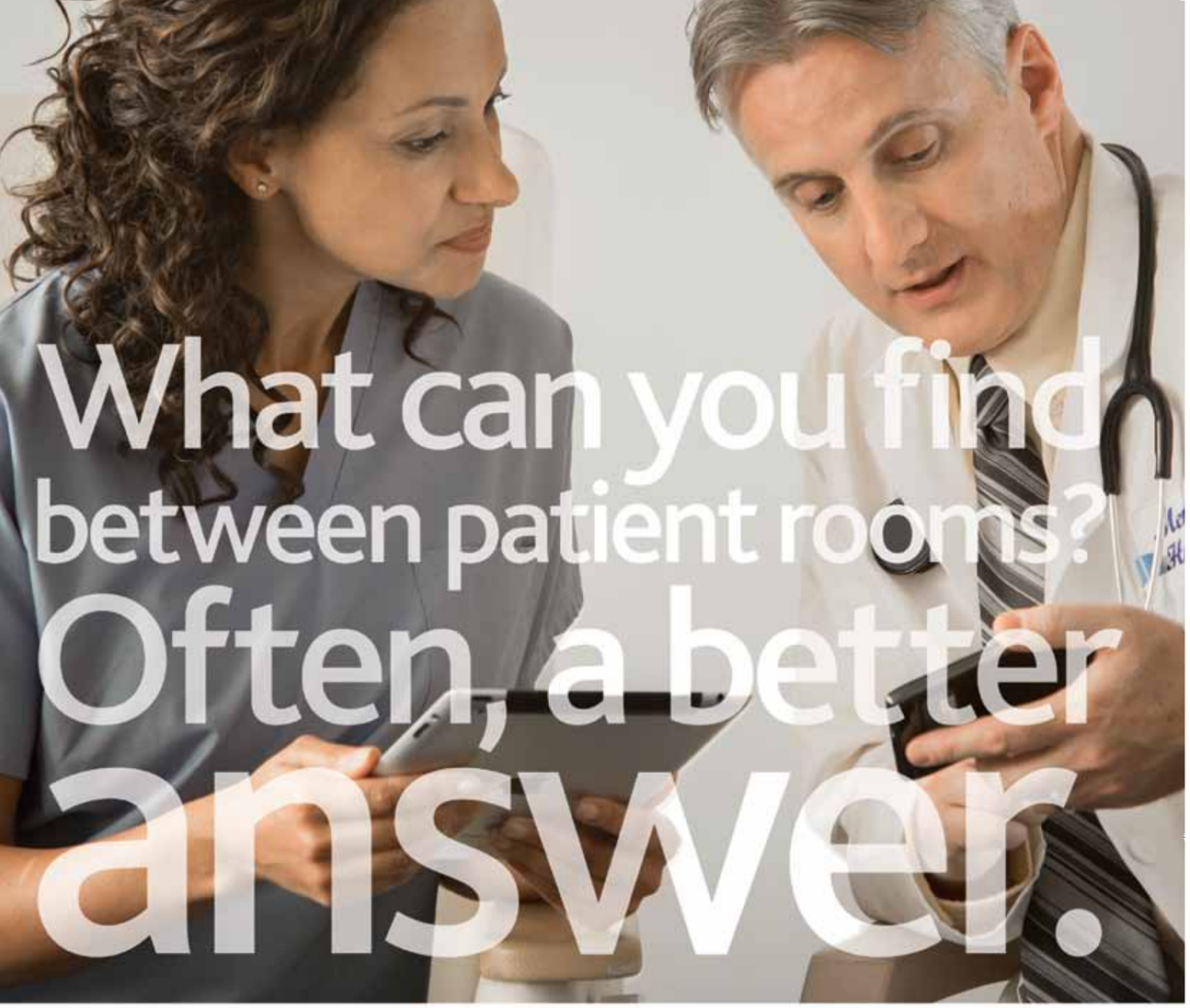
SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **VOL 15 NO 3 / APRIL 2014**

The College of Surgeons of Australia and New Zealand

Annual Scientific Congress 2014 – Singapore

Working Together For Our Patients



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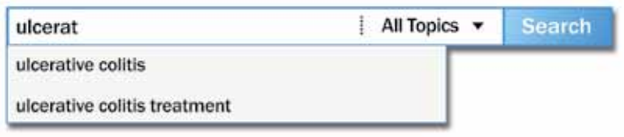

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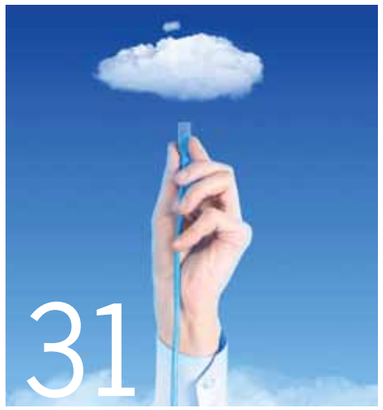

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ON THE COVER:
2014 Annual Scientific Congress, p 12.
Photo Credit Binh Nguyen.

2014 WORKSHOPS & ACTIVITIES

Check the College website for registration details

Non-Technical Skills for Surgeons (NOTSS)

15 April, Melbourne; 5 May, ASC - Singapore

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. This activity is proudly supported by Avant.

Supervisors and Trainers for SET (SAT SET)

29 April, Melbourne; 5 May, ASC – Singapore; 17 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. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. This workshop is also available as an eLearning activity by logging into the RACS website.

Keeping Trainees on Track (KToT)

5 May, ASC – Singapore

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.

Writing Medico Legal Reports

24 July, Brisbane

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. This activity is proudly supported by mlcoa.

Management of Acute Neurotrauma

7 August, Perth (the day before the WA, SA and NT ASM)

You can gain skills to deal with cases of acute neurotrauma in a rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, you can learn these skills using equipment typically available in smaller hospitals, including the Hudson Brace. This activity is proudly supported by RHCE.

Strategy and Risk Management for Surgeons

7 August, Brisbane

This whole day workshop is divided into two parts. Part one gives an overview of basic strategic planning and provides a broad understanding of the link between strategy and financial health or wealth creation. It introduces a set of practical tools to monitor the implementation of strategies to ensure their success. There is also an introduction to a committee's and board's role in risk oversight and monitoring.

Part two of the course focuses on setting strategy; formulating a strategic plan, the strategic planning process, identifying and achieving strategic goals, monitoring performance, and contributing to an analysis of strategic risk. You will have an opportunity to explore risk for an organisation and learn how to monitor and assess risk using practical tools. This activity is proudly supported by Bongiorno National Network.

AMA Impairment Guidelines 5th Edition: Difficult Cases

13 August, Sydney

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. The program uses presentations, case studies and panel discussions to provide surgeons involved in the management of medico-legal cases with a forum to reflect upon their difficult cases, the problems they encountered, and the steps they applied to satisfactorily resolve the issues faced. Please note: Fellows will still need to attend AMA training to be accredited to use AMA guidelines. This activity is proudly supported by eReports.

Surgical Teachers Course

21 - 23 August, Auckland

The Surgical Teachers Course builds upon the concepts and skills developed in the SAT SET and KTOT courses. The most substantial of the RACS' suite of faculty education courses, this new course replaces the previous STC course which was developed and delivered over the period 1999-2011. The two-and-a-half day intensive course covers adult learning, teaching skills, feedback and assessment as applicable to the clinical surgical workplace.

Process Communication (PCM) – Part 2

5 – 7 September, Sydney

The advanced three day program allows you to build on and deepen your knowledge while practicing the skills you learned during PCM Part I. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen. Advanced PCM concentrates more strongly on the failure mechanisms of distress, making it easier to apply PCM in order to resolve conflict and motivate others.

Polishing Presentation Skills

25 September, Sydney

The full-day curriculum demonstrates a step-by-step approach to planning a presentation and tips for delivering your message effectively in a range of settings, from information and teaching sessions in hospitals, to conferences and meetings.

Building Towards Retirement

15 November, Sydney – Video link to Perth

Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. Fellows from a variety of disciplines and their partners join with colleagues and corporate speakers in an interactive discussion format that focuses on three sessions on preparing for retirement, options after retirement and resources to realise options. This activity is proudly supported by mlcoa and Bongiorno National Network.

Global sponsorship of the Royal Australasian College of Surgeons' Professional Development Program has been proudly provided by Avant Mutual Group, Bongiorno National Network and Applied Medical.

WORKSHOPS

May-September 2014

QLD

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

24 July, Brisbane
Writing Medico Legal Reports

SA

24 June, Adelaide
Keeping Trainees on Track (KTOT)

VIC

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

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

6 June, Melbourne
National Simulation Health Educator Training Program (NHET-Sim)

NSW

25 September, Sydney
Polishing Presentation Skills

WA

7 August, Perth
Management of Acute Neurotrauma

NZ

21-23 August, Auckland
Surgical Teachers Course

ASC

5 May, Singapore
KTOT

5 May, Singapore
NOTSS

5 May, Singapore
SAT SET Course

Registrations are taken via Conference and Events for ASC events.

THANK YOU FOR THE PRIVILEGE

It has been a busy, but enjoyable two years and there are many to thank

MIKE HOLLANDS
PRESIDENT

The two years of my Presidency has gone at break-neck speed. It has been an incredible honour being President of our College and I do thank all the Fellows who have been so supportive of me in this role. My thanks particularly to Jane who, as my partner, has watched me go off and do many things important to the College or the profession, often necessitating her staying at home, but all of these have been undertaken with her support and understanding.

Before I sign off there are some clouds on the horizon.

Over the past few months I have had increasing interaction with a number of medical defence insurance companies. The issues are important to recount here. Stuart Boland who is a Fellow of our College, but also Chairman of Avant Mutual, has both written and spoken passionately about his concerns of how the professional bodies need to be more closely involved with the various regulatory authorities. Involving the professional bodies is an incredibly important counter-balance to what is now a harsh legal process. His particular and current concern has been driven by the delays and soul-destroying review process associated with mandatory reporting. Whilst the imposition of mandatory reporting is now with the profession, we must work much more closely with the various State bodies to ensure that delays in the process can be removed.

Mandatory reports that are vexatiously based are fortunately small in number. They are particularly prevalent in sports surgery, cosmetic surgery and bariatric surgery. Unfortunately, an increasing number of them are the result of colleagues who are professional rivals making complaints about each other's practice. Because they reflect on clinical care and thus patient safety, they are taken very seriously by the regulators. The subsequent investigation takes months, even years, is amazingly expensive for the insurers (and indirectly your premiums) and the jurisdictions (your medical registration) and worst of all, they can destroy a surgical practice, a surgical career and a surgeon.

The matter has been discussed by Council and by the Committee of Presidents of Medical Colleges, of which I am Chairman. We will try to work with the insurers and the medical jurisdictions to make the process more transparent and facilitate its completion.

I hope I can contribute in this space. I have recently joined the board of MDA National. Whilst new to this industry as a Board member, my time as President of our College and my role in the passage of tort law reform in NSW whilst Regional Chair have both given me a unique insight into these issues. I have also had the advantage of discussions about the systems in New Zealand, United Kingdom and United States. It will be interesting to see whether the Australian system can be improved.

PRESIDENT'S
PERSPECTIVE

> ***"I have had the opportunity to associate with many individuals of the highest calibre from our profession"***

It is my last President's Perspective within 'Surgical News'. One of the special features of spending so much time on College related activities has been the many friends I have made, not only Fellow surgeons, but also many members of the College staff. I am not sure whether Fellows appreciate what a fantastic team of people work at the College. Many of them work unsung at the College for years, yet become amazingly loyal to our organisation.

I would be wrong to single people out, but I was showing some visitors around the College with Geoff Down our curator. One of the College staff started chatting to the visitors, telling them about the College and what a great place it was. Afterwards the visitor commented on our team and how proud they were of our College and how fortunate we were to have staff such as these. I could relate more such stories – something we can be proud of! So I offer a special thank you to the staff in our College.

As you can imagine I have spent a lot of time away from home. This means time away from my practice and hospital. My public hospital Westmead has been amazingly supportive; my colleagues who have covered me at short notice have been terrific. I would like to thank the Society Presidents with whom I have worked to refresh the MOU's between the College and the Surgical Societies over the last two years. I have appreciated your honesty and friendship. I would like to thank Margaret Rode and Cheryl Wakefield in the President's Office, the two EDSAs John Quinn and Allan Panting, the Dean of Education Stephen Tobin, and the other College Directors. I would particularly like to thank David Hillis, the Chief Executive, who has provided me with advice and support. Although David has not always agreed with my approach, he has either shown me a more appropriate alternative or supported the direction I have embarked upon. The job of President would be impossible without his sage advice.

Lastly the College Council is a team and without that team, most of what is achieved would not happen. Council is working hard to make the College relevant to Fellows and I am sure you will see the fruits of this work over the next year or so. I appreciate having worked with a great team of men and women on Council, especially the Council Executive, who have such a range of skills and talents.

I would like to wish Michael Grigg all the best as President. I hope he enjoys it as much as I have. Once again may I again finish by thanking you all for the privilege of being President of this College over the past two years.

Clockwise from left page: President Michael Hollands at the 2013 ASC Congress Dinner; with Ian Ritchie and partner Jane.
Attending the Younger Fellows Dinner with Richard Martin and Jason Chuen.
At the 2012 College Trauma Seminar, with Trauma Committee Chair Daryl Wall and Hon Catherine King, Shadow Minister for Health.

DEFINING PERCEPTIONS OF SURGERY

Survey shows that general public and surgeons agree on importance of standards

MICHAEL GRIGG
VICE PRESIDENT

As you may have read in the RACS January's Council Highlights email, a significant amount of time was spent by the Executive on defining the key areas for strategic action the College plans to undertake in 2014. One of these actions is to define the perceptions of surgery and the future marketing strategy for surgical services and surgeons.

Surgical training and standards have evolved; so too has the College. Over the years we have broadened our vision to become more politically engaged in upholding surgical standards in the community. To continue to uphold and enhance the surgical profession's community standing into the future, we need to identify what are the key characteristics that are important to the public, and the areas that require better promotion.

The College has already begun work on this target with a pilot study on the general public's perceptions of surgeons conducted last year in Australia. A follow up survey on a sample of our Fellows assessing their self-perception of their key qualities and services was also conducted later in 2013. While I will be presenting the findings of the pilot survey in greater detail at the upcoming RACS Annual Scientific Congress (ASC) in Singapore, I would like to share with you some interesting highlights from the preliminary results so far.

The pilot study results have identified clearly overlapping characteristics that both the general public and surgeons deem important, and it is clear that both of these groups place high importance on professional standards. Possessing high ethical standards was the quality that had the highest proportion of surgeons and the general public deem as an 'essential' quality in a surgeon. While ethical standards are not likely to be easily defined by members of the public, they still remain a highly valued surgical quality – in fact the most highly valued. This is an important message for all of us as individual surgeons.

Communication skills

While many of us struggle to find the right balance of patient care and communication with our exceedingly busy schedules, it appears that we are a bit tough on ourselves when it comes to how we think the general public evaluate our bedside manner. While at least half of our surveyed Fellows reported that they would rate their colleagues' communications skills as 'very good' or 'excellent', few believed the general public would provide an equally high rating. However, our self-assessment appears to be relatively concordant with the general public's, as more than half of our general public respondents gave a rating of 'very good' or 'excellent' to almost all the surgical communication skills we surveyed.

It was also pleasing to find that the quality of surgical training and education and the high level of positive surgical patient outcomes were two qualities that were also rated as being 'very good' or 'excellent' by an overwhelmingly large proportion of Fellows and the general public. It appears the general public also do their homework looking up their surgeon's credentials before a consultation. More than half of the respondents who have had a consultation with a surgeon reported that they have looked up the surgeon's credentials online or asked their referring doctor for further information about them.

When we examined false perceptions of surgeons and their role in the health workplace, it appears that the surgeons surveyed had overestimated the percentage of the general public who believed these misconceptions. The College's dealings with the ACCC appear to have cleared up major public misconceptions regarding the College's influence on surgical workforce numbers. While we are glad to see that public perceptions on this issue is not carried by the majority, there still exists a small proportion of the public that remain to be convinced otherwise.

Terminology loophole

Public knowledge about medical education and training was at a reasonable level; 90 per cent of the general public surveyed agreed with the statement that to be called a surgeon in Australia, one must first have obtained a medical degree. It is disappointing that the term 'surgeon' is not protected i.e., anyone can call themselves a surgeon whether they have a medical degree or not and indeed 'podiatric surgeons' take advantage of this loophole. However, the term 'Specialist Surgeon' is protected and only those holding a FRACS qualification may use this descriptor.

Only 65 per cent of respondents were able to correctly identify that a chiropractor with the title of 'Dr' is not a medical practitioner. This shows the importance of preserving the use of the 'specialist surgeon' title in the health field. Promoting RACS in the media to increase awareness of our College and our health advocacy work will also be a continuing area of focus, with 43 per cent of the general public reporting that they had read or head of RACS in the media over the last 12 months.

I hope that you have found this summary of our key findings so far as interesting as I have. It is heartening to see that surgeons in Australia continue to be held in high regard by the public, and there were certainly several interesting results that have provided us with food for thought. These results will help guide the College as it continues work on this key strategic action area, and I look forward to keeping you updated on this interesting project.

SURGICAL FELLOW IN TRAUMA AND RURAL SURGERY (CLINICAL)

A position exists for a suitably qualified candidate for 12 months commencing late January/early February 2015.

The position is funded by the National Critical Care & Disaster Response Centre (NCCTRC) and there is opportunity for planning and participating in disaster response, and opportunities for trauma research.

The position is based at Royal Darwin Hospital but involves outreach work to regional hospitals in Katherine and Gove, as well as visits to isolated Indigenous communities.

As a 'General Surgeon' you will have the opportunity to definitively manage subspecialty areas such as neurotrauma, burns, vascular, paediatrics, urology and thoracic surgery, both electively and in acute care /trauma.

This position would be of interest to those interested in rural surgery, or working as a surgeon in remote environments such as humanitarian or military situations. There is extensive exposure to indigenous health issues.

Enquiries and further information can be obtained from **DavidJ.Read@nt.gov.au**

NATIONAL CRITICAL CARE AND TRAUMA RESPONSE CENTRE

CLINICAL FELLOW IN PLASTIC AND RECONSTRUCTIVE SURGERY, ROYAL DARWIN HOSPITAL

An exciting and challenging position exists for a Fellow in Plastic and Reconstructive Surgery at the National Critical Care and Trauma Response Centre, Darwin Australia.

This is a unique opportunity to work closely with adult oncology, orthopaedic, otolaryngology and maxillofacial teams and provide extensive exposure to Indigenous health.

The successful applicant will be required to commence in January 2015 and participate in acute service on a rotational oncall bases, research and teaching.

Royal Darwin Hospital is recognised as the National Critical Care and Trauma Response Centre and has two plastic surgeons, one burn surgeons and one visiting craniofacial surgeon.

The Royal Darwin Hospital (RDH) is a 345-bed hospital in the Top End of the Northern Territory servicing a population of 140,000. It is the only tertiary referral centre in the Top End and caters for a wide range of clinical conditions – it is more than 3000 kilometres to the nearest tertiary referral centre. It caters for a diverse young population including high numbers of indigenous patients.

There is a high trauma workload and substantial exposure to patients with sepsis and complex medical illness retrieved from some of the most remote communities in the world.

Candidates must be eligible for general and/or specialist registration with the Medical Board of Australia together with a current Fellowship FRACS (Plastic Surgery) or equivalent.

Further information please contact Mr Shiby Ninan, Director of Plastic Surgery, Royal Darwin Hospital
(08) 8922 8888 *or* **Shiby.Ninan@nt.gov.au**

To apply online please send your current CV, referee details and a covering letter to **Shiby.Ninan@nt.gov.au**

Medical Board releases 'social media' guidelines

The Medical Board of Australia has released its 'Guidelines for advertising regulated health services' effective from March 2014.

Registered health practitioners and students in Board-approved courses should be aware of the implications of using social media and note that the National Law, their National Board's code of ethics and professional conduct (the Code of conduct) and the Guidelines for advertising regulated health services (the Advertising guidelines) apply.

Registered health practitioners should only post on social media information that is not in breach of these obligations and need to be aware that information circulated on social media may end up in the public domain, and remain there, irrespective of the intent at the time of posting.

The Board's definition of 'social media' sources "include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously), WOMO, True Local and microblogs such as Twitter, content-sharing websites such as YouTube and Instagram, and discussion forums and message boards".

The MBA stated, "The use of social media is expanding rapidly. Individuals and organisations are embracing user-generated content, such as social networking, personal websites, discussion forums and message boards, blogs and microblogs.

"In using social media, just as with all aspects of professional behaviour, health practitioners should be aware of their obligations under the National Law, their Board's Code of conduct, the Advertising guidelines and other relevant legislation, such as privacy legislation.

"Whether an online activity is able to be viewed by the public or is limited to a specific group of people, health professionals need to maintain professional standards and be aware of the implications of their actions, as in all professional circumstances."

College lawyer Michael Gorton AM considers 'Doctors, Advertising and Social Media' in his Medico-Legal column on page 42 of this issue.

Search for new EDSA NZ

Allan Panting, the current Executive Director for Surgical Affairs – New Zealand (EDSA-NZ), has indicated he will be retiring from this position towards the end of 2014.

The College wishes to appoint a Fellow to the role before Dr Panting retires to ensure an adequate hand-over period and as his successor may need time to arrange other work commitments before assuming the role.

The College invites expressions of interest from interested Fellows in any specialty for the position of EDSA-NZ.

This position is located in New Zealand and is remunerated at 0.5 FTE. The successful appointee does not need to be Wellington-based but, if not, will need to be prepared to travel to Wellington reasonably regularly. The EDSA (NZ) provides advice to the NZ National Board, NZ Fellows and the NZ Manager on professional surgical matters and represents College Fellows on various national health advisory and planning groups.

The appointee will work with new Fellows and staff and with the EDSA (Australia) and various bi-national College committees to ensure that strategies implemented by the College achieve the best outcomes for the Fellowship.

The ideal appointee will be a Fellow with previous experience on College committees and involvement in College's activities. Experience in research, policy development and/or consultation with professional groups would be advantageous.

Enquiries ahead of the application period can be made to the current incumbent, Allan Panting (allan.panting@surgeons.org), the Chair of the New Zealand National Board, Nigel Willis, or the New Zealand Manager, Justine Peterson (justine.peterson@surgeons.org). Telephone: +64 4 385 8247

ASC
2014

COVER STORY

PICS: Binh Nguyen

Everything set for SINGAPORE

Annual Scientific Congress at Sands Expo Convention Centre, 5 – 9 May, 2014

MARTIN RICHARDSON, ASC 2014 CONVENER
SAYED HASSEN, ASC 2014 SCIENTIFIC COVENER

The programs are finished, section dinners booked, session chairs appointed and all is ready for the 83rd Annual Scientific Congress (ASC) with our ANZCA colleagues at the exceptional Sands Expo Convention Centre. Registration is easily done on the congress website – asc.surgeon.org

The theme of this ASC is 'Working Together For Our Patients'. This ties in with the first collaborative congress with our anaesthetic colleagues in over 25 years and our plenary sessions illustrate this partnership between surgeons and anaesthetists to benefit our patients.

Registration entitles you to attend all sessions – both combined and anaesthetic. This program is the largest ever staged and for the first time ever includes a program for our orthopaedic colleagues.

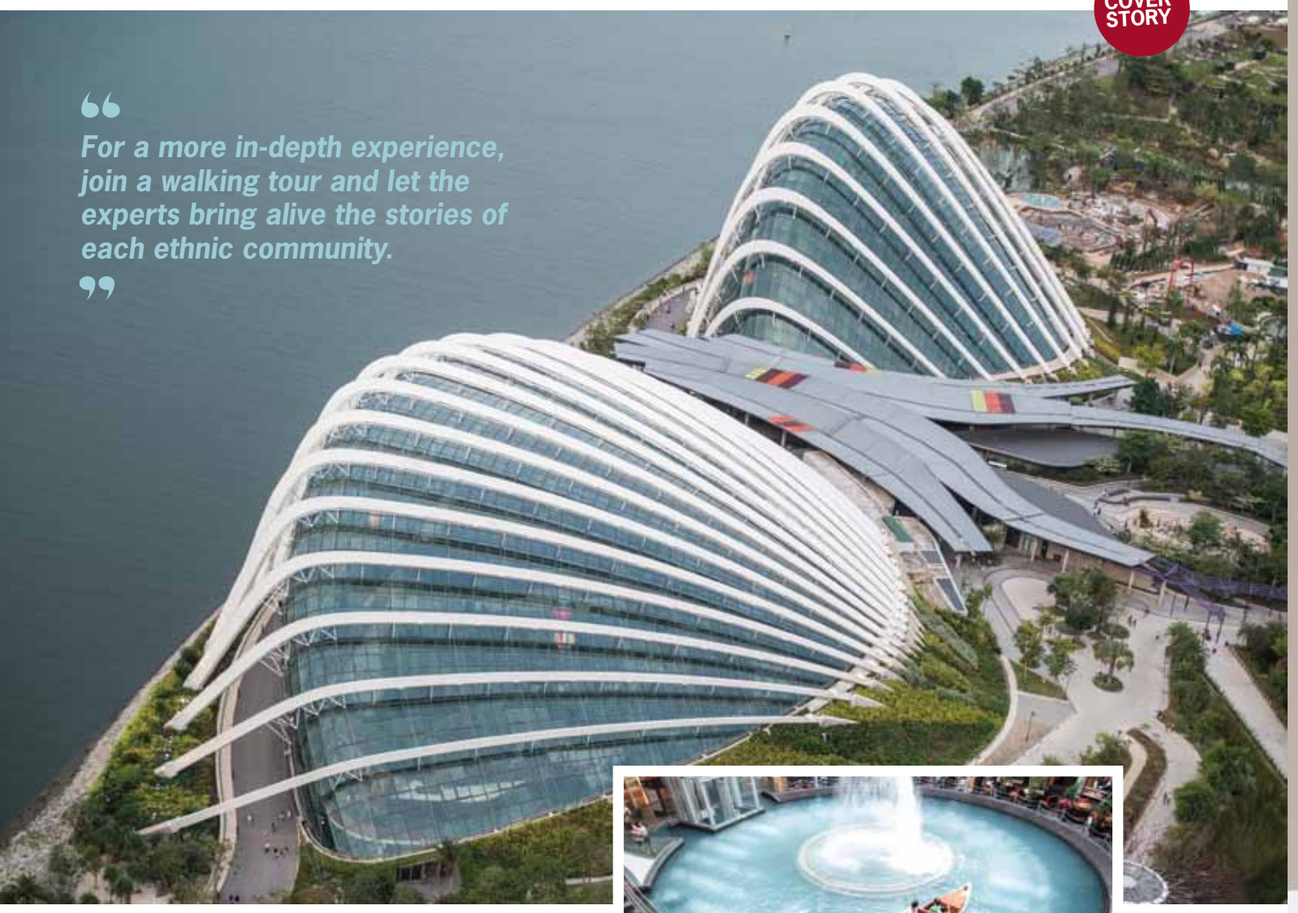
It will be impossible to see each session so remember all these presentations will be uploaded onto the Virtual Congress app for viewing at your leisure.

Convocation & Welcome Reception Monday 5 May

The official start of the meeting is the Convocation on Monday afternoon when over 170 new Fellows will formally join the College. A good friend to our College, Iain Anderson and our CEO, Associate Professor David Hillis will receive Honorary Fellowships, each of whom has contributed so much to the College.

The Louis Barnett medal for services to surgical education will be presented to Professor Guy Maddern who has served, and continues to serve our surgical profession with distinction. Keith Mutimer and John North will receive ESR Hughes medals, Associate Professor Jenepher Martin the RACS medal for service to the College and Gordon and Rosie Low will receive the International medal. Finally, Professor Andrew G. Hill will be presented with the 2014 John Mitchell Crouch Fellowship. The venue for the Convocation is the Orchid 4202 – 4206/ 4302 – 4306 at the Convention Centre.

COVER STORY



> *For a more in-depth experience, join a walking tour and let the experts bring alive the stories of each ethnic community.*

Scientific programs

At this Congress, 32 section and special interest programs have been convened. The conveners are to be congratulated on an outstanding educational program over the four days of the meeting. Well over 907 research abstracts were submitted. Several hundred will have podium presentations and the remainder have been accepted as electronic posters. The posters can be viewed on the screens on level 5; follow the instructions on the screens.

Evening functions

On Monday evening immediately after the Convocation is the RACS and ANZCA Welcome Reception. Guaranteed to be a highlight of this ASC, this is a night not be missed. Spend an entire evening with RACS and ANZCA friends and colleagues enjoying Singapore's finest food and wines. Partners and families warmly welcomed. Bring your camera!

The section dinners are on Tuesday and Wednesday nights at a number of leading Singapore restaurants.

Thursday night will be the superb Congress Gala Dinner. A sumptuous banquet is planned again with a Singaporean flavour and spectacular entertainment.

Book for these events on the registration site 'asc.surgeons.

Cultural Experiences

Immerse yourself in the local culture by joining in the optional activities program. Amongst others they include A Changi Museum War Trail, Breakfast in the Wild at Singapore Zoo, a history tour of the iconic Raffles, lunch with the parrots at Jurong Bird Park, Cheng Ho Cruise with high tea and a Literary Walk of Colonial Singapore.

To experience Singapore's multicultural diversity and charm, explore the various ethnic enclaves such as Chinatown (for Chinese culture), Little India (for Indian culture), Kampong Glam (for Malay culture), Joo Chiat and Katong (for Peranakan culture – a hybrid of Malay and Chinese traditions with a touch of Portuguese, Dutch and Indonesian influences) to immerse yourself in the cultures unique to each ethnicity. Learn about the heritage of each race, shop for traditional crafts and sample their unique cuisines. For a more in-depth experience, join a walking tour and let the experts bring alive the stories of each ethnic community.

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Avant mutual group Your Advantage

Culinary Experiences

Those seeking the pleasures of fine dining can savour the delights of Singapore's culinary establishments. Check out the Singapore outposts of Michelin-starred chefs, which include Bruno Menard, Jason Atherton and Joël Robuchon. Also savour the gastronomic creations of celebrated home-grown chefs at Restaurant Andre and Iggy's. In fact, Restaurant Andre climbed 30 spots on the list of The World's 50 Best Restaurants, coming in at number 38 in 2013.

Speakers' Support

Signage will direct you to the speakers' support room in the convention centre.
All speakers must report to this room at least 24 hours prior to their presentation.

E-Posters

Scientific posters will be displayed electronically on poster stations located throughout the industry exhibition during the congress and will be available for viewing on the ASC Virtual Congress in addition to the abstract. There will be no mounted posters.

Operating Room Skills - Check them out

TUESDAY 6 MAY-FRIDAY 9 MAY 2014
OPERATING ROOM TEAM SIMULATION: HOW DO YOUR SKILLS RATE?

Venue: Sands Expo and Convention Centre

Cost: Complimentary for registered delegates (Registration is essential)

How do your Non-technical skills influence patient outcomes and the team you lead in the Operating Room (OR)?

Step into the Royal Australasian College of Surgeons OR simulator (with a team of nurses and anaesthetist confederates) and participate in live research into this fascinating field. Help in the development of benchmarks for Trainee performance. View your performance on video, receive one on one feedback from a skilled debriefer and assist your College gain valuable data on the skills of experienced surgeons. Set aside forty five minutes to immerse yourself in an engaging OR simulation and it may change the way you practice.

To register for a session please contact
Associate Professor Wendy Babidge at the details below:

Contact: Associate Professor Wendy Babidge, Director of Research, Audit and Academic Surgery, RACS

E: wendy.babidge@surgeons.org

Continuing Professional Development Program

This educational activity has been approved in the College's CPD program. Fellows who participate can claim one point per hour (maximum 34 points) in Category 4: Maintenance of Knowledge and Skills.

Internet facilities

Wireless internet will be available throughout the convention centre. Please refer to the scientific program handbook or visit the registration desk to access this information.

Coach Transfers for Specialty Dinners & Optional Activities Program (Social Tours)

A transport timetable will be included in the scientific program handbook detailing coach transfers for specialty dinners and the optional activities program (social tours). All coach transfers will depart from Sands Expo and Convention Centre porte cochère. Please note there will be no daily coach transfers from congress hotels to the convention centre. Delegates are to make their own arrangements.

MRT

The Singapore underground train systems, known as the MRT offers a speedy and foolproof way to get around the city. You'll need small change to buy an ezlink card, a contactless smart card for use on the MRT, LRT and the buses. Escalators take you to the platform and train destinations are marked clearly. Trains run frequently..

We look forward to welcoming you to this unique ASC in Singapore.

COVER STORY

A 'SMART' CONGRESS

Smart phones and tablets to aid congress participation

BY **KAREN MURPHY**

For the first time this year, delegates to the Annual Scientific Congress (ASC) will be able to use their smart phones and tablets to submit questions during presentations, take notes and participate in polling or voting.

With about 1000 presentations expected to be delivered over the five day meeting and up to 30 sessions running concurrently at peak times, the mobile apps will also allow delegates to navigate the complex program via an iPhone or Android smart phone.

As with last year, the mobile apps will also allow delegates to view webcasts of presentations via the Virtual Congress website.

This year's ASC is to be a combined meeting with the Australian and New Zealand College of Anaesthetists and the Faculty of Pain Medicine and is to be held from May 5 – 9 at the Sands Expo and Convention Centre in Singapore.

Already considered a logistically complex meeting – even by international standards – this year's combined Congress will see a 25 ▶

> *The webcasts are a great educational tool for delegates and offer vastly increased exposure for presenters*

per cent expansion in the Scientific Program and a 100 per cent increase in registrations.

However, the Executive Producer of Events at KOJO, Mr Andrew Ely, said they had worked with RACS to design systems that make navigating the complex program as easy as possible while on-site staff in Singapore would support presenters through all sessions of the meeting.

He said a team of 20 technicians from Australia would supplement the work and support of approximately 40 local AV crew to ensure all presentations could be delivered smoothly.

"We have spent a great deal of time making sure mobile apps and on-demand webcasts available through the Virtual Congress enhance the experience of both delegates and presenters at such a complex meeting," Mr Ely said.

"This year, the Virtual Congress mobile website and tablet app have the added functionality of allowing delegates to submit questions to the Chair during presentations as well as participate in voting which we hope will increase audience participation and enable presenters to focus on the issues of most interest to the audience.

"As well, delegates will be able to use their tablets to take notes specific to a presentation while presentations can be watched on phones or tablets as webcasts through the Virtual Congress as soon as they become available.

"Both the phone and tablet apps also allow delegates to build their diaries through searching by discipline and add sessions to their MyEvent calendar even when they are not online because all the program information is cached on the device."

The Deputy Manager of the Conferences and Events Department at the RACS, Mr Binh Nguyen, said that while around 20 per cent of delegates used the mobile app last year, he expected that to increase greatly this year given the scale of the combined meeting and greater awareness amongst delegates.

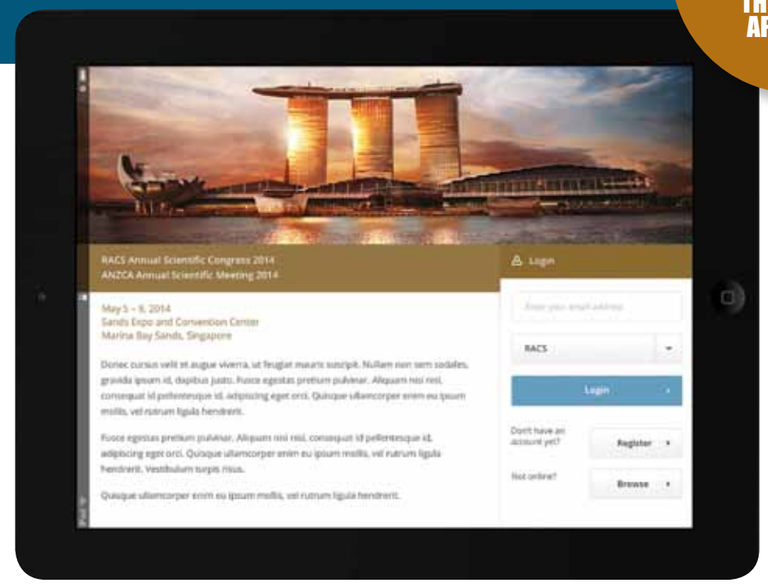
He said the ability to submit questions during presentations and the capacity to watch webcasts on mobile devices could enhance interaction and learning for both delegates and presenters.

"Being able to ask a question mid-presentation could be extremely useful in that it will allow the Chair of each session to vet questions and if they see that one particular question is being asked by many in the audience, that issue can be prioritised," Mr Nguyen said.

"We are also pleased to be able to offer delegates the ability to watch webcasts through the Virtual Congress on their mobile devices.

"The webcasts are a great educational tool for delegates and offer vastly increased exposure for presenters.

"Given that there are up to 29 concurrent streams of presentations and that delegates can only fully immerse themselves in one or two, having the ability to stream presentations that they couldn't get to or to go back and listen again – even on a mobile device – will be of great benefit and one we hope both surgeons and anaesthetists will appreciate this year."



DOWNLOAD THE TABLET APP NOW!

VIRTUAL CONGRESS 2014

Search ANZCA RACS eProgram 2014 on the Apple App Store or for Android tablet users go to h!ps://play.google.com/store/apps.

This year's tablet app has a range of new features to enhance your Virtual ASM or Virtual Congress experience on your iPad or Android tablet:

- ***send questions to the chairperson during a presentation***
- ***participate in votes and polling during sessions***
- ***note taking feature***
- ***receive live updates from the organisers***

The brand new tablet app is rich in content and allows you to browse the program and bookmark sessions and events in your MyEvent calendar.

If you don't have a tablet or prefer to just stick with your phone, the ANZCA Virtual ASM and RACS Virtual Congress are also available online through your smart phone and will have a selection of the same interactive features as the tablet app. Regardless of which device you're using, you'll be able to navigate through the program and watch the presentation webcasts as they become available.

BOOKMARK THE VIRTUAL CONGRESS WEBSITE ON YOUR SMART PHONE NOW

If you're using an iPhone or other smart phone navigate to: asc.surgeons.org/virtual-congress
To make it easy to use it's best to bookmark the website or even put a direct link on your to your home screen.

USING THE APP

Once you've downloaded the app onto your device simply log in using your registered email address. If you haven't already registered go to the ANZCA Virtual ASM or RACS Virtual Congress to register your details.

Once you are logged into the tablet app you can:

- Use the navigation panel on the side bar to navigate.
- Use the +Add Session and +Add Event bu!ons to add sessions into your MyEvents diary.
- Click on More Info to access the in session functionality such Notes, Ask a Question and Vote functions.
- On the Ask a Question page click the New bu!on to activate the Ask a Question dialogue box. Once you save your question it will be received by the chair for the relevant presentation.
- The chairperson will advise if they decide to hold a vote. In which case go the More Info section and select Vote. You will be asked to submit either a simple YES/NO or will be presented with a multiple choice list on the projector screen.

MANAGEMENT OF CONTAMINATED WOUNDS IN DISASTERS

Internationally agreed steps to be launched at ASC

DAVID WATTERS
VICE PRESIDENT ELECT

Wounds should not be primarily closed in the setting of a disaster. Sadly this has often been done by those responsible for the primary assessment and care of wounds in their efforts to help.

These sutured wounds have then become infected, with consequent tissue loss, sometimes also limb loss, considerable morbidity, prolonged disability and some threat to life.

The problem was recognised by surgeons attending a disaster a few days after the initial treatment and misguided closure of contaminated wounds. A/Prof Rob Atkinson FRACS and the Trauma Committee referred the matter to the International Committee to see what could be done.

The result is an internationally agreed consensus on how wounds should be managed in disasters.

A poster for distribution by national surgical societies and colleges will be launched at the Annual Scientific Congress in May 2014.

It highlights the risk of contamination and sets out a step-by-step guide to cleaning, debridement and dressing the wound in preparation for delayed primary closure, or further exploration in complex cases, by skilled surgeons if required.

The consensus was reached during the Global Burden of Surgical Disease Symposium at the College in 2012. It has been subsequently discussed in meetings of surgical colleges worldwide and has resulted in considerable interest, enthusiasm for its message and support for its distribution.

The poster will be co-badged with several international colleges including the American College of Surgeons, College of Surgeons of Indonesia and the Philippines College of Surgeons.

Disaster management

It is hoped that the poster will be a useful tool for promoting education about optimal wound management and for field-based guidance in the acute aftermath of a disaster. It is presented as a simple 'A, B, C, D, E, F, G' aide de memoir for easy reference and to facilitate recollection.

With the support of international colleges and societies, it is intended that the poster will be translated into several languages and modified for local use if necessary, and distributed to hospitals and health clinics in developing countries and disaster prone regions.

It could also be included in disaster management equipment packs and in emergency care facilities during disaster situations.

COVER STORY

Wound Care in Disaster Situations

In a disaster, ALL wounds are contaminated. Do not suture Wounds. Suturing Wounds may cause infection. Follow these steps when managing wounds during disasters to prevent infection and further tissue loss.

A. ABC

1. Scene assessment
2. Primary Survey: airway, breathing, circulation, disability, environment/exposure.
3. Stop bleeding preferably by direct local pressure. Consider use of a tourniquet if direct pressure fails. Record time of tourniquet and remove within 1 – 1.5 hours*
4. (*upper limb: within 1 hour, *lower limb: within 1.5 hours)

B. Baseline Wound Assessment

1. Distal function
2. Associated fractures
3. Underlying structures
4. Need for exploration or extension

C. Control Contamination

1. **Anaesthesia:** Use anaesthesia if available and indicated
2. **Clean:** Wash the wound. Use potable (drinkable) water, saline or antiseptic solution. DO NOT use river water or seawater
3. **Remove foreign matter:** Pick out removable foreign material
4. Scrub the wound to remove embedded foreign material
5. Explore to assess wound and underlying structures. This may require extension of wound margins
6. **Excise:** Debride to remove remaining foreign material and necrotic and devitalised tissue. This may require trimming or excision of wound edges.

D. Dress, Don't close, Document

1. Leave wound open
2. Pack wound loosely with moist gauze. Saline soaked is best.
3. Dress with clean, dry dressing
4. Document on dressing, label or case notes: Place, date & time; Procedure; Proceduralist & Plan.

E. Essential medicine, Explain & Elevate

1. Elevate the limb & minimise wound movement
2. Consider Tetanus status
   – administer Tetanus Toxoid prophylaxis if unimmunised or uncertain
3. Broad spectrum antibiotics
   – Single dose if no established infection
   – IV route if practical
   – Continue if hands, feet or underlying fracture
   – Continue if established infection
4. Elevate or rest an affected limb where possible

F. 48 Hour Follow-up

1. Re-inspect the wound
2. Plan for definitive wound closure if no signs of infection
3. Re-debride and further excise if signs of infection, necrosis or contamination persist

G. Get Specialist Help for:

1. Wounds that can't be closed
2. Complex Orthoplastic reconstruction
3. Complex wounds in children
4. Decisions about amputation and withdrawal of care

SPECIAL CASES

Splinting
Preferably use a splint in cases of suspected or confirmed fractures; Wounds on the limb: test distal function

Definitive fracture management
Soft tissues are best treated by fracture stabilisation

Amputate
Remove devitalised and mangled tissue/limbs in unsalvageable cases; is surgical input to decision-making possible?

Absence of distal pulses
Or other signs of distal limb ischaemia requires immediate attention

Fasciotomy: (for compartment syndrome)
Should be considered in all limb trauma when pain is out of proportion to injury

Delayed primary closure (2-5 days) where tissue defect
Alternative closure technique with skin graft or flap (local or free); Secondary closure (> 5 days)

Crush injury
Aggressive fluid resuscitation; Alkalinisation with bicarbonate; Serum CPK and electrolyte monitoring at 6-hourly intervals

Blast injury

Extrication
Amputation indicated when alternative retrieval failed, for life-saving purposes only; Amputation by specialised team in coordinated effort; Maximum limb preservation must be considered


Emergency Physician Shona McIntyre with Emergency Medicine Post Grad Diploma trainee Nyein Chan.

Myanmar medical specialists pass WITH FLYING COLOURS

The first cohort of Myanmar medical specialists selected for training in Myanmar Emergency Medicine Development Program (MEMDP) has successfully passed the University of Medicine (1), Yangon's Diploma in EM (October 2013) through the extraordinary efforts of volunteer FACEMs (Fellows of the Australasian College for Emergency Medicine) working as part of an international collaboration

WITH **KAREN MURPHY**

Since the Myanmar Emergency Medicine Development Program (MEMDP) was established in January 2012, more than 80 international clinicians including Emergency Physicians, Surgeons and Anaesthetists from Australia, New Zealand, Hong Kong, Singapore, Malaysia and Thailand have volunteered the equivalent of around 1500 man-days to train the candidates and help develop the program.

This international effort to assist in the building of an EM Service (EMS) in Myanmar has been estimated to equate to a financial contribution of more than $US4 million in voluntary work days and self-funded accommodation and travel costs in the first 18 months. Such dedicated focus and commitment has proved so successful, that all 18 specialists selected for training passed the Diploma Exam and graduwated in March 2014.

With no specialist EMS in Myanmar up to now, the country is in the process of establishing dedicated EM departments at the Yangon, Mandalay and Naypyitaw General Hospitals. A second cohort of specialists commenced the Diploma program in February 2014. As with the first cohort, all candidates are qualified medical specialists (surgeon, anaesthetists, paediatricians or physicians).

Described by the Ministry of Health in Myanmar as an important first step for the establishment of EMS, the Diploma course grew out of collaboration between the Myanmar Ministry of Health, the Myanmar Medical Association, the Australasian College for Emergency Medicine (ACEM), the International Federation for Emergency Medicine (IFEM) and RACS.

Under the joint leadership of Dr James Kong FRACS and Dr Georgina Phillips FACEM, the MEMDP provided candidates with:

- An introductory course in EM;
- Clinical rotations in the core EM specialties of anaesthetics, paediatrics, obstetrics and gynaecology, general and orthopaedic surgery and internal medicine;
- Elective attachments at the Yangon General's Emergency Receiving Centre under the supervision of volunteer international FACEMs (Georgina Phillips, Chris Curry, Michael Augello, Shona McIntyre, Antony Chenhall and Rose Klein);
- A series of international skills training and instructor (train the trainer) courses, such as the ATLS, APLS and ELS courses (see table);
- International observation study visits to Hong Kong and Thailand to allow candidates to familiarise with the workings of mature modern EMS and network with the international community;
- A two-part written and oral Diploma examination in EM.

The development of a syllabus and curriculum for a local Master of Medical Science (EM) course is now being led by an international volunteer (Rose Klein FACEM) and is planned to be delivered at UM(1), Yangon from 2015.

Dr James Kong FRACS, who was born in Myanmar and now works in Hong Kong, travels to the country regularly, several trips each month during the past three years to coordinate the program. He said that although leading the program had been "hard graft", he has been astounded by the support offered to the program by medical colleagues from around the region and the close collaboration and support that the Minister for Health (His Excellency Professor U Pe Thet Khin) and local Myanmar colleagues (Professor Zaw Wai Soe, Myint Thaung and Kyaw Myint Naing) have given.

"When I first suggested this to the Minister in December 2011, I expected working parties and committees to be formed, reports to be written and time lines proposed. However, the fact that an agreement was signed within a few months and the first diploma program initiated and completed within 15 months is incredible," he said. ▶

ABOVE: The 18 Diploma Graduates. Left: Dr Rose Klein (left), Dr Chris Curry (second from left) with Dr Aye Thiri Naing in the foreground – she is one of the new Diploma candidates who commenced the EM PGD in 2014. In the background, centre is Dr Naing Win Aung (one of the 2013 graduates).

"I am both amused and amazed that we have achieved this in such a short time and sometimes when I am stressed out flying back and forth more than a few times each month, I think I should have kept my mouth shut.

"This achievement would not have happened without the cooperation and support that the program has received from colleagues from various countries and the support has been way beyond what I expected. They deserve my heartfelt thank you for giving up so much of their valuable time."

Mr Kong said that the genesis of the MEMDP had been sparked by the crisis following Cyclone Nargis (May 2008). In the aftermath medical colleagues from the region came to the politically isolated country to offer assistance and support for capacity building at an invitation by the Myanmar Medical Association. RACS funded the inaugural Primary Trauma Care program and supported the train the trainers concept. This early and sustained connection has given the College a high level of credibility within the Myanmar medical community and this collaboration will continue as the local medical specialist communities seek international assistance to enhance their future development.

"Modern medical education in Myanmar started under the British Colonial days of the late 1800s and a medical school was established in Yangon before Singapore or Hong Kong," he said.

"However, the disruptions of 1962 and the consequent disconnect with the international community in 1975 meant that the local medical schools have been self-maintaining since. In the international community, the development of EM is a relatively recent event and Myanmar, because of its closed nature of the past five decades missed out on this process of development.

"The aim of all the Colleges involved in MEMDP has never been one of providing aid, but assisting in capacity building. We have been working alongside our Myanmar colleagues to help build their capacity so that they can develop and establish EM as a specialty and they are able to design EMS tailored to the local needs that will improve the quality of care delivered to injured in Myanmar.

"It will take time, but the extraordinary achievements of the past 15 months give everyone involved in this work some confidence that it will happen!"

Mr Kong said that given more than half the costs of the program had been borne by the volunteer specialists themselves, more consideration needed to be given into how the on-going program should be funded to ensure that the next steps are sustainable. A comprehensive, cooperative evaluation of what has been undertaken so far is planned for early this year.

"While the MEMDP has been a great success, the ongoing program needs a formal budget commitment by the Myanmar Government if it is to continue to achieve the best outcomes and avoid the risk of draining the enthusiasm of all the generous volunteer specialists who have given so much of their time and expertise," he said.

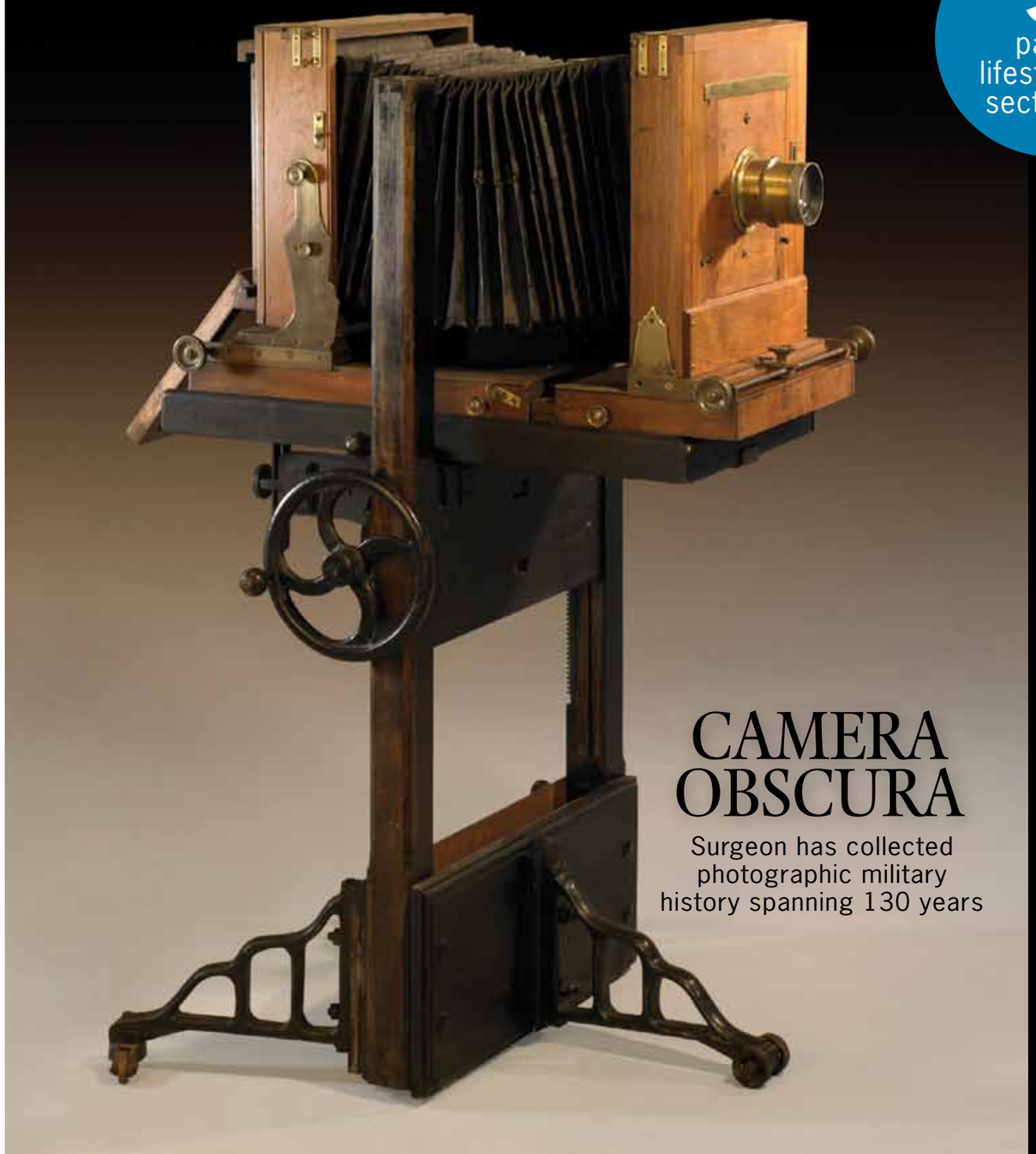
"I congratulate all the successful Myanmar specialists who passed their exams last year for their willingness to put aside their former specialties to take up a new medical career, but I particularly thank the Fellows of the RACS and the ACEM."

Mr Kong said other than the volunteers, he particularly wished also to thank the College for the support provided to the program and to his RACS colleagues who had travelled to Myanmar in support, including Mr Phil Truskett, Mr Richard Perry, Ms Christine Castle, Mr Max Esser and also to Michael Hollands and David Watters for their inveterate support, guidance and leadership.

autumn *lifestyle*

post op

5 page lifestyle section



CAMERA OBSCURA

Surgeon has collected photographic military history spanning 130 years

post op appears in *Surgical News* each season

PICTORIAL RECORDS OF WAR

Perth surgeon Professor Robert Pearce has gathered a remarkable collection of cameras and photographs taken by service men and women in the fields of war

BY **PROFESSOR ROBERT PEARCE**

As a former military surgeon and a current military historian, Professor Robert Pearce of Perth has spent a considerable portion of his working life treating Australian war veterans, including a number from such long ago conflicts as Gallipoli.

Knowing of his interest in Australia's wartime history, many of his patients shared their stories and photos from various theatres of conflict. Over the years, some of these patients gave him their photographs knowing they would be treasured and respected. In recent times their families have contributed their old cameras as well.

In just two years, Professor Pearce has gathered together a mini-museum of 200 cameras, a collection which spans more than 130 years of photographic history.

Professor Pearce said that as a Plastic and Reconstructive Surgeon he had always worked with cameras, had taken a photography course as a medical student and had long had an interest in the evolution of camera technology.

However, he said it was his interest in his war-service patients and military history that sparked the accumulation of his present collection, with aging veterans or their families generously donating their cameras.

"In 1975 I was appointed consultant Plastic Surgeon to the Department of Veterans Affairs at Hollywood Repatriation Hospital and was also consultant surgeon to the Australian Defence Force so I've been treating ex-servicemen and women for most of my career," he said.

"I'd estimate that in that time, I've seen about 20,000 veterans, and in earlier days I would have about 200 Gallipoli veterans on my patient lists. They were always prepared to talk about the war to someone who might listen and over the years some of them brought in photos to show me.

"Officially they were not supposed to take photographs or write journals, but a great many slipped cameras and dairies through so they could document their time abroad. A great many of us who are interested in military history are very glad they did of course, because those stories and images now form part of our historical record, and a great many of them are now preserved in the archive of the Australian War Museum in Canberra."

With his interest sparked by the Kodak 'Vest Pocket' cameras used by the young men fighting in WW1, Professor Pearce then began to collect cameras that told not only a story about history, but about the history of cameras and photography. While 80 per cent of the collection was donated as gifts, Professor Pearce has also purchased others at camera fairs and markets to fill in the gaps of that story.

Now his collection ranges from old hooded cameras on tripods, to micro or sub-miniature spy cameras from the Cold War era, and from the dependable Box Brownie to the glamorous Minolta.

He has 8mm movie cameras from the 1930s and 1940s, early Polaroid Land cameras, a small video camera used by cinematographers to document WW11 and intricate wind-up cameras that resemble first generation brick-like mobile phones. He even has an old camera, mahogany with bellows and brass fittings, that dates from the US Civil War era which is known as a 'View Camera'.

"This is a beautiful piece of equipment that actually produced very clear images," Professor Pearce said.

"It has an open shutter in the front and frosted glass at the back and the photographer had to get under the hood, slide in the plate and open and close the shutter to take a picture while the subject had to stand still for 30 seconds without blinking. These cameras were used extensively during the American Civil War and with some improvements during the next 50 years.

"Later, sensitised collodion on glass plates gave way to roll film when George Eastman produced the first commercial Kodak 'box camera' in 1888.

"Yet, I think all the cameras I have acquired are lovely instruments with technology that you can observe evolving over time.

"I have cameras that can be folded, a small 35 mm camera that a soldier took to the Vietnam War and a spy camera that is the size of a box of matches like you would see in a James Bond film.

"Some even tell a story of economic history. For instance, after WW11 when Japan was trying to rebuild its economy, they developed the Hit Camera which was very affordable and very popular and which began Japan's rise as a world leader not only in technology but photographic technology in particular resulting, in later years, in the Minolta, Nikon, Pentax, Olympus, Canon and Yashica brands.

"Some cameras in my collection are worth only $3, while the most expensive would cost up to $1000; but I don't see them in dollar terms, I see them as historical artefacts, as examples of technological development and even in terms of who used them and when and for what purpose."

Professor Pearce, who now uses a basic digital camera for work and art, said his personal favourite is a German Voigtlander.

"The name comes from an instrument maker called Johann Christoph Voigtlander who worked in Vienna making scientific instruments such as compasses and quadrants in 1756," he said.

"His son started making optical lenses for spectacles and the grandson worked with a mathematician to design the first mathematically computed lens in 1840. This was only a decade after the invention of photography by French scientists Niepce and Daguerre.

"Carl Zeiss subsequently acquired Voigtlander in 1956 and production of this brand has continued under different owners since then. But especially through the 35mm single lens reflex (SLR) era, modern Voigtlander cameras have continued with excellent lenses and automatic focus and efficient shutter mechanisms."

Professor Pearce's interest in history is no mere hobby. He completed a BA in History at Murdoch University after his surgical training and has written many papers and articles on the effects of WW1 on Australia as a newly emerging nation.

"Australia had such a small population at that time and we were still coming to terms with Federation and that sense of Australia as an independent nation and not just an outpost of the Empire," he said.

"Yet when Australia was called upon to go to Britain's aid, a great many young men answered the call. The patriotism these volunteers showed has always moved me greatly and while there was a prospect of adventure on enlistment they quickly came to understand the cost of war, but carried on and did their duty. My camera collection allows me to honour their experience. I think it would be nice if a museum or university might wish to display them. And of course the collection will continue to grow as I acquire some of the missing pieces.

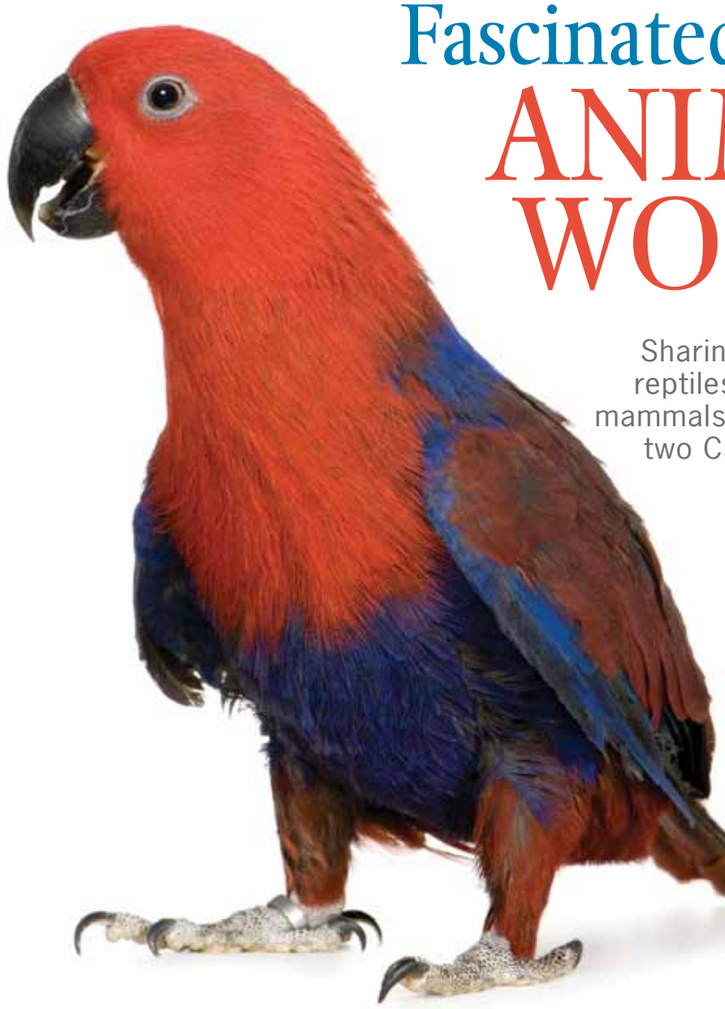
"Some of the photographs also belong in a museum. I have one photograph of an incredible moment at Gallipoli when the two opposing armies agreed on a brief ceasefire to allow both sides to reclaim their dead. In this tiny image, you can see a blind-folded Turkish officer being led down the beach to meet the English officers to arrange the temporary armistice.

"This was taken by a Digger and given to me some years ago, yet every time I look at it I am still greatly moved. It's easy to understand why Gallipoli holds a special place in the history of our nation for all Australians."

With Karen Murphy

Fascinated by the ANIMAL WORLD

Sharing your home with reptiles, birds and small mammals comes easily for two Canberra surgeons



Professor David Hardman's interest in biology is obvious in his professional role as vascular surgeon at the Canberra Hospital and in his academic appointments as Professor of Surgery at ANU and Associate Professor of Anatomy and Surgery at the University of Canberra.

Yet his work with the human body is merely one aspect of a far greater interest in biology, for he has also spent the past 15 years putting together a thriving home-based menagerie comprising gorgeous exotic birds, amphibians, reptiles and small mammals.

With a licence to collect and breed exotic fauna, Professor Hardman houses the hundreds of creatures that comprise his menagerie in zoo-like conditions in a purpose built room attached to the house and in aviaries and a bright pink chook shed outside.

He said the animal room had separate air-conditioning to the rest of the house to avoid smells or the transfer of germs and was so discretely connected that human visitors who did not have an interest in natural history could remain oblivious to the other occupants of the suburban Canberra home.

Collecting creatures since he was a boy, Professor Hardman said his interest lay not in a desire for sentimental anthropomorphic attachment, but because of his passion for scientific knowledge.

"It has always been, to me, a fascinating endeavour to learn everything I need to know about how to keep and raise and breed different species," he said.

"I have always been interested in science, but chemistry and physics didn't really grab my attention to the same degree that biology did, which is what drew me to surgery in the first place.

"Whenever I travel I visit the local zoo to find out what animals are there and how they are kept, I read constantly and talk to other collectors because the great, most rewarding, challenge is to give the creatures in the menagerie all they need to allow them to thrive.

"All the facilities have been purpose built at a zoo-like level, both inside the house and outside, because it is a fascinating exercise designing the perfect environments that allow them to breed.

"That's because if they are breeding, they're thriving and you know you've done a good job."

Professor Hardman said his equipment and systems were so sophisticated that while every creature was "eye-balled" every day, he and his wife, breast surgeon Carolyn Cho, often only spent less than half an hour each day making sure all was well with all.

Yet while he doesn't list his creatures in terms of favourites and rarely names them, it does appear that Arabella (a blue and gold Macaw) and Babette (an African Grey Parrot) might hold a secret pride of place.

"We acquired both these birds before they were fully weaned, so hand-fed both which creates a very strong bond," Professor Hardman said.

"Carolyn hand-fed Arabella who now follows her around the house, but given that she is the size of a dog, with a beak the size of a fist, I don't go too near because I need all my ten fingers as a surgeon.

"But I raised Babette who follows me around and Carolyn keeps her distance because she too is quite attached to all her fingers.

"The whole family raised our Eclectus Parrot who has become so relaxed with everyone and everything, it just lies around on its back with its feet in the air waiting for a scratch.

The rest of his extensive bird collection includes Silver, Chinese and Japanese quails, three different species of Australian finches, exotic finches including the Cuban Cutthroat, the Red Ruddy and the Bengalese finch, Masked pigeons, budgerigars, White doves, Golden pheasants and a Chukkar partridge.

His parrot collection includes the Sun, Nanjay and Green Cheek Conures, Bourke's Parrots, Alexandrian Parrots and Kakariki Parrots, some of which can cost up to $10,000 per breeding pair.

Exotic chooks strut around the eye-catching shed known as "the Pink Emporium" while in his miscellaneous division, Professor Hardman has two tanks of tropical fish, guinea pigs and a rabbit named Toffee.

Inside, Professor Hardman's reptile collection comprises adult and newly hatched Alpine lizards, Eastern blue tongue lizards, Bearded Dragons and Shingle Back lizards while his amphibians include three species of tree frogs and three Eastern snake neck tortoises.

"The trick with reptiles is to get the heat and the light right and I have all those mechanisms on automatic timers so I don't have to do much," he said.

"They are also opportunistic feeders, meaning that in nature it is quite common for them to go for longish periods without eating, so they are fairly low maintenance.

"That's good for us because we travel quite regularly to the snow country in winter and I'm also very lucky to have a mother-in-law who is also a bird lover who doesn't mind taking care of our feathered friends while we are away."

Professor Hardman said he was currently between snakes following the death of a large carpet snake from old age, but was planning to buy a new one, possibly a diamond python, upon the urgings of his daughter.

"My daughter is very keen on reptiles and often sits watching TV with a lizard on her lap," he said.

"Carolyn is somewhat more ambivalent after she found me putting down sticky tape all over the carpet which is how you catch an errant snake.

"I looked and looked for it but then had to travel interstate and she rang me rather cross during that trip to tell me she found it in her handbag.

"She got a bit judgemental about the whole thing and told me that not only did I need to return home with a nice gift, but that there was a new house rule that whatever snake I buy can only escape once."

Professor Hardman said he found his creatures large and small scientifically interesting and an antidote to the stresses and limitations of a life in surgery.

"We all know that our day jobs won't go on forever, but our outside interests can last much longer," he said.

"This interest gives me great intellectual stimulation, artistic stimulation through my collection of 19th century colour-plate natural history books and I get great pleasure talking to other people with great expertise about subjects other than surgery.

"Carolyn and I are also quite happy to invite over people who have an interest in natural history or the children of people we know, such as the kids of GPs around Canberra, to have a look at the menagerie.

"Their eyes almost pop out of their heads when they see Arabella, but she's not the only star of the show. We let the children hold the frogs and lizards and feed the tortoises and birds and they love that."

With Karen Murphy

THE HYPE ON HYPO

Or how to tackle those mood swings

DR BB G-LOVED

Many of my patients suffer from the very common symptoms of depression and anxiety. You may be surprised to know that doctors and surgeons are not much different from the general population, which is why you all need your own GP. Yes, doctors [including surgeons] report depression and anxiety at rates that exceed the average.

The recent Australian 'Beyond Blue' [October 2012] survey of the medical profession found that doctors experience even higher rates of depression and psychological distress than the normal populace. When taking a fuller history from those so afflicted, one finds they often complain of insomnia, irritability, fatigue and headaches as well. There are many possible causes, some of which may be related to the workplace, but let me tell you about one of the more preventable that is related to an individual's physiology and diet.

Some months ago Dr Hype O'Gly Seemus consulted me. I listened to the unveiling of the various stressors that were contributory – a heavy workload, challenging personalities, too busy, a sense of helplessness and hopelessness, with no vision of how to cope without giving up or getting out. There were also the usual work-life balance issues, and some sense of unease about not spending enough time with the family, but then when Hype O'Gly Seemus could, family time was spoiled by irritability and being over demanding.

A careful history aimed to match mood to time of day was revealing. Dr Hype O'Gly Seemus considered things started to deteriorate mid morning. The typical pattern was 7am breakfast of toast or muesli [mood good, though tired], 8am morning rounds [mood good, but time pressured], mid-morning [mood irritable or anxious, sometimes with headaches or sweating]. This was normally the moment for a strong coffee with two sugars [mood better, but without any sense of ease, on edge], then deterioration through late morning [mood irritable and getting more frustrated]. Lunch was usually carbohydrate heavy [mood better], then afternoon similar to morning [mood worse mid to late afternoon].

It continues...

On arriving home ... hungry, frustrated by traffic, irritable until dinner, before which often argue with or annoy kids or partner, after dinner [mood more relaxed], often collapse with glass of wine [or three] in front of TV. Wake up or woken up, off to bed, but around 2am wide awake, difficulty getting back to sleep, mind filling up and racing, but eventually some more sleep, before early rise, and another unfulfilling and irritating new day.

Hype O' has hypoglycaemic syndrome with many of the typical mood, anxiety or energy problems. About 4-5 per cent of the population suffer it severely, others more marginally. The underlying mechanism is a hypoglycaemic dip, resulting in low blood sugar (<3.4mmol/L fasting or on GTT). The lack of glucose for brain cellular metabolism stimulates a hypothalamic and adrenergic response to mobilise glucose, increase heart rate, blood pressure and sweating. The symptoms are both those of hypoglycaemia – the 'alarm' – and then the catecholamine response. Coping with hypoglycaemia by consuming sugar, soft drinks or cookies only buys another 30-60 minutes before the next insulin response induces the next sugar low. The worst mid-morning snack is that muffin or jam and cream scone [professional development course participants beware].

Too much sugar and carbohydrate make us fat and fatty, and more prone to type II diabetes later in life. A much better habit is to take protein, which is metabolised into amino acids and then glucose, but more slowly to avoid precipitous 'lows'. Beware of the alcohol 'energy burst'. This is all the worse in the zinc depleted in which alcohol is metabolised to acetaldehyde and acetyl – CoA, bypassing the zinc dependent glucose – pyruvate – acetyl CoA pathway. That does not deliver glucose to the cells that are desperate, particularly the brain. Behaviour and self control are prone to suffer.

Hypoglycaemic syndrome is likely if three of the four following are present: depression or moodiness; lethargy; forgetfulness or poor concentration; sucrophilia – a history of preference for sugar, sweet food and sugary drinks. The accompanying adrenergic symptoms are nervousness, sweating, becoming shaky, dry mouth, palpitations. The condition can't be treated with drugs and is of no interest to pharmaceutical companies. They've nothing to sell. Affected individuals need to be self aware, and take the right food at the right time.

Dr Hype O'Gly Seemus correlated diet and mood in a chart for a month, agreed to restrict carbohydrate and sugar, take protein [eggs, salmon or tofu] for breakfast, and consume protein snacks between meals, eating small amounts often. Three months later, the depression had lifted, there was less angst, some much desired weight loss and an improvement in blood pressure. Sleeping pattern was improved. Alcohol consumption was less and the rest of the family felt very much safer during the hour or so that led up to dinner.

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is new technology. Well, not all new technology, but more the way that some of the devices function. Now don't get me wrong, I love computers and smart phones, but they sure can be annoying.

Take my smart phone for example. It does all sorts of things that are great, but I take exception to the 'cloud' thing. Apparently I can store my photos and documents on some sort of cloud in the sky. However, where we live (and it is not the boon docks) the cloud has evaporated and the system will not work. It is something to do with the poor mobile phone reception (that is a topic for another day!). If that is not bad enough, I need the cloud, or at least a good Wi-Fi connection, to upgrade my system and get new programmes. If you see me in a place such as the Qantas Club, where there is free and good Wi-Fi, using the phone frenetically, I am trying to use the cloud for all these essential functions. I have even tried various coffee places, but then you have to have some of their 'coffee' (and, yes, there is yet another topic for another day).

Many people, not just curmudgeons, have pointed out that modern technology is always changing. Please note that I did not use the word 'improving'. How can you describe something as an improvement if it makes something, which your grandson has spent an hour showing and explaining how it should be used, suddenly unusable because some techno-fool has changed the whole thing? No longer do the icons on the desktop take you to the correct place, but it gives a dialogue box saying that the short cut cannot be found and asks would you like the computer to find it for you (it can't – which does give a bit of satisfaction that we curmudgeons may be smarter than the technology).

Mrs Curmudgeon and I bought new smart phones within a month of each other. They look the same and seem to work the same, but are different models so the cable connecting to the phone is different and we must have different rechargers. Now how smart is that? Furthermore her protective case does not fit my phone, but on second thoughts we curmudgeons don't do pink all that well.

As for new computers – that is another story! If you simply want to send emails and do some typing, why do you want a computer that promises the super highest speed that one would only ever need for serious gaming. Hasn't anyone told the gurus of Silicone Valley that we curmudgeons don't 'game'? Why do you need system 7 or 8 or whatever when the system that you have is already frustrating enough? Why buy a new version of frustration? Join me and don't buy a new computer, but spend your money, as I have recently, on an excellent book, 'A Complete Idiot's Guide to System 3.1'.

IN MEMORIAM

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

David Lees
Tasmanian Fellow

Neil Openshaw
West Australian Fellow

Barbara Heslop
New Zealand Fellow

Lindo Ferguson
New Zealand Fellow

William Egerton
Queensland Fellow

Richard Horton
Victorian Fellow

James Escott Church
New Zealand Fellow

James Findlater
New South Wales 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

GSA ANNUAL SCIENTIFIC MEETING

Perfect weather, amazing beaches, a cosmopolitan, vibrant city and stunning nature are just some of the characteristics of Perth, Western Australia – the host city of the sixth GSA Annual Scientific Meeting (ASM). Taking place from 26-28 September 2014, we are excited to be heading west for the first time since the ASM's inception.

The Perth Convention and Exhibition Centre will be our base for the three days – Friday 26 through to Sunday 27 September – and this is where all areas of 'Emergency General Surgery – a New Paradigm' will be investigated.

Scientific Conveners Dr Amanda Foster and Dr Andrew Thompson are in the midst of finalising an exciting and diverse program, relevant to all Consultant and Trainee General Surgeons, and medical personnel, whether they are based at large teaching hospitals, metropolitan or provincial hospitals, both nationally and internationally.

Emergency Surgery has always been part of the practice of General Surgeons. In the past, emergency cases had to be fitted around the Surgeon's elective workload and were often done after hours. In more recent years, many units have made the conscious decision that Emergency General Surgery is now core business of their Hospitals and Practices. Emergency can no longer be the poor cousin to elective work if good outcomes are expected. Appropriate rostering and resourcing are necessary, and time to treat and determine outcomes need measuring. New models of care have been introduced in many hospitals across Australia, and Surgeons and their patients have realised the benefits.

This is the new paradigm in which we operate.

Much of the program will cover clinical topics of relevance to General Surgeons with an emergency practice. There will be a focus on conditions and circumstances that challenge (read scare) us in our own practice, and to examine some of the techniques we can use to avoid trouble and keep our patients safe. A component will be devoted to models of Emergency Surgical Care around Australia and the resourcing required, and it is into this framework that we have selected the very best national and international speakers including Mr Iain Anderson of Salford Royal Hospital, Manchester, and Mr Leslie Nathanson of Royal Brisbane and Women's Hospital.

This year we also have on offer a number of fantastic workshops running prior to, and during the ASM, including Bile Duct Exploration, Controlling of Intra-operative Bleeds: Two Effective Solutions, Advances in Ventral Hernia Repair, Managing Risk for New Surgical, and some great financial breakfast sessions.

While the ASM is a chance for professionals to come together to learn, impart new knowledge, and explore a common interest, it also offers the opportunity for you to mix with your colleagues and peers in a social environment that will showcase our host city. Our Social Progra m for the Saturday afternoon includes the Golf Championship at Joondalup Resort, High Tea at the historic five star hotel – The Terrace Hotel Perth – and a Swan Valley Food and Wine Tour.

The ASM Official Functions will showcase the spirit of Perth – an eclectic mix of city culture and stunning nature. The Welcome Reception will take place at the famous Royal Perth Yacht Club and will include a relaxed barbecue overlooking the Swan River, while taking in the smooth sounds of jazz and swing. The Gala Dinner will take place in a luxury marquee at the Cottesloe Civic Centre Gardens – the Sunken Lawn. This spectacular event will have all the ingredients for a great night out – fantastic food and wine, great company and sensational entertainment – with views of the Indian Ocean as a backdrop.

We hope you will join us in beautiful Perth this September, for the Sixth GSA Annual Scientific Meeting.

Please visit http://asm.generalsurgeons.com.au/ to find out more.

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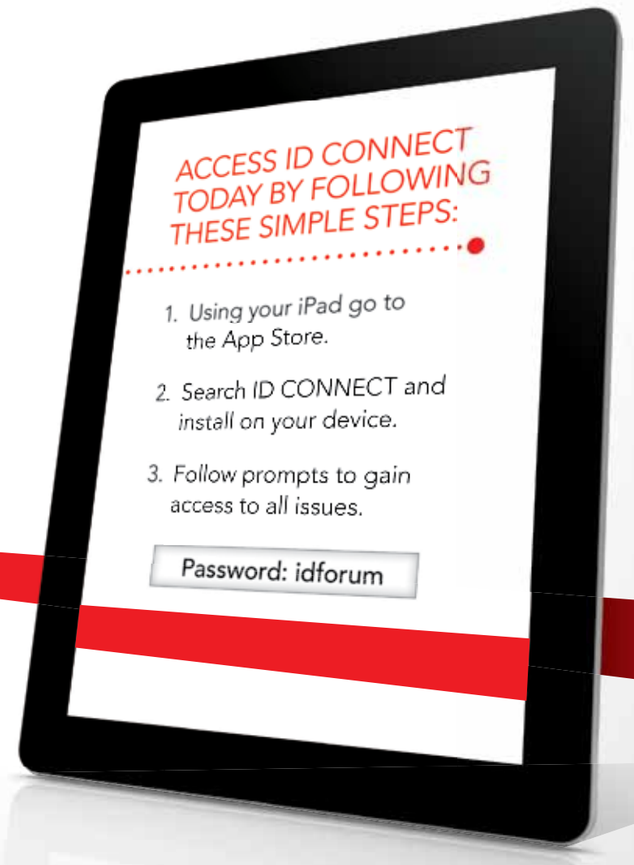

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"Ulysses, come home…" I still hear those voices. My dreams have become an ongoing nightmare. Hamlet has so clearly stated: "this above all; to thine own self be true, and it must follow as the night the day, Thoust cannot then be false to any man"
(Hamlet Act 1, Scene 3).

POISON'D CHALICE

Am I home? (not likely!)

I am now an 'experienced' surgeon – I much prefer that descriptive term to 'old'! Yet that is how others probably perceive me – too polite to point out that my hair is conducting its own race between baldness and greyness. As far as I can tell, both are striving for dominance in an ever increasing fashion. And yet on the inside, I still see myself closer to the fresh faced, enthusiastic registrar I once was rather than an elder statesman type figure.

For some reason, I had always assumed that with time and experience would come increasing certitude of one's thoughts and actions. Alas it is not so, only perhaps an increasing ability to portray certitude of thought and action. But I do have experience which means that I have seen many things that are re-invented in the guise of being new. I have watched and encouraged younger surgeons assuming greater leadership roles and observed their frustration as they confront the inherent inertia of bureaucratic organisations – so different from surgical thinking. But many have endured and wrought changes through determination and persistence. Revolutions are rare and often short-lived, but incremental, embedded improvements endure.

At a recent clinical management workshop, I was asked about the things that I thought was important that mangers concentrate upon. As you may have guessed, I had a ready-made answer.

"'There are two things," I replied. "Standards, and by that I mean the standards that you walk past are the standards that you accept; and frustrations. Try to identify the frustrations that confront those who you manage as they attempt to fulfil the roles that they are employed to perform and work to eliminate them." I would like to think that these might become known as Kidding's Laws!

But back to my dreams – dreams of waves crashing onto those shores not seen for many years now becoming so much clearer: "but, for my own part, it was Greek to me" ('Julius Caesar', Act III, Scene I). Professor Kidding's journey is at an end. Perhaps this is indeed home… But as so clearly stated in 'As You Like It' (Act II, Scene VII): "All the world's a stage and all the men and women merely players. They have their exits and their entrances; and one man in his time plays many parts".

For me a new part, a new role has emerged. I am often asked if I have a hobby to take my mind off the constant trials, tribulations and challenges of being a surgeon. The answer is, of course, yes – over the last few years that 'hobby' being the College Council. It has been a time consuming hobby, but one that has its rewards, not least of which is getting to know inspiring surgeons from every specialty, every State and from New Zealand. Imagine my surprise when Council, in something of a departure from its usual wisdom, chose to elect Professor Kidding to be the next College President. What a headline that would make!

Indeed, time to be true to oneself, to leave behind my Shakespearean wit, my thinking man and to no longer be Professor U.R. Kidding. The next part I need to play is that of the President of the College, a role that I will be taking over from the May Annual General Meeting. However, no more Shakespeare, I promise.

Professor Kidding was "born" in 2009 – five years ago. He has appeared every month without fail – on each occasion has attempted to provide a modicum of advice, insight or just plain empathy. To those around me who have provided the inspiration for many of the articles within 'Surgical News' over the past, my endless thanks. You may not know who you are, but your impressions have now been left on thousands of surgeons who have flicked through the pages, the pages of our transience. To the many surgeons who have taken the trouble to write to Professor Kidding expressing understanding and empathy and even to those who have corrected my grammar – thank you.

To my wonderful surgeon-wife, thank you for your endless support and inspiration. To the Editor of 'Surgical News', many thanks for Shakespearean witticisms, encouragement, cajoling, ideas and friendship.

Professor Kidding is no more, he has breathed his last. But I hope his existence has meant something to some. I for one will miss him.

Professor Michael Grigg
President-elect

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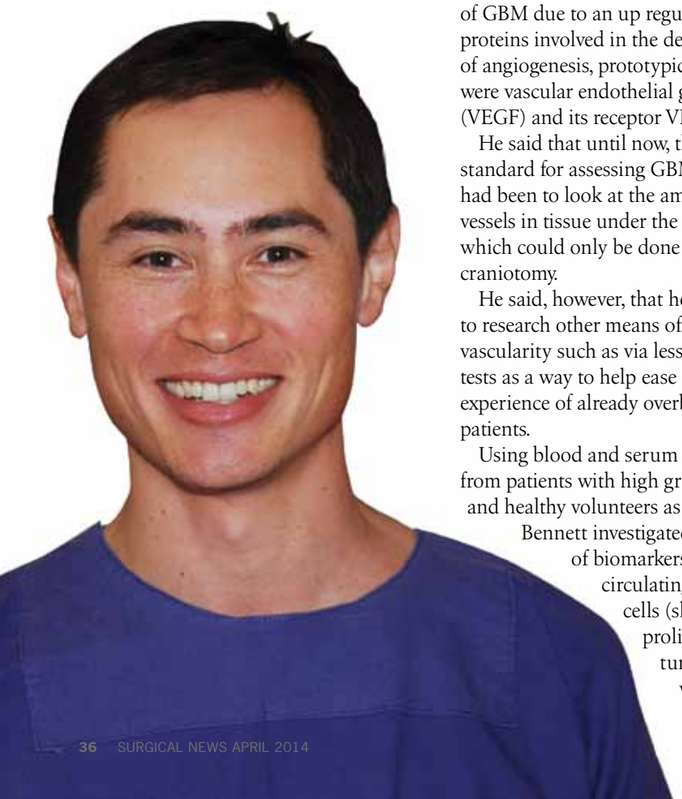
EASING PATIENT EXPERIENCE

This Trainee's research is working towards better treatment of one of the most malignant and incurable of cancers.

WITH **KAREN MURPHY**

Neurosurgery Trainee Dr Iwan Bennett has spent the past three years conducting research to identify vascular biomarkers in glioblastoma multiforme (GBM), one of the most malignant and incurable of cancers, which causes half of all patients to die within little more than a year of diagnosis.

Known to be one of the most vascular cancers found in humans, Dr Bennett has been working to design minimally-invasive vascularity testing protocols which could allow clinicians to understand which patients would be most likely to benefit from the use of novel anti-angiogenic therapies.



First developed in the mid-2000s, anti-angiogenic drug therapies target the blood supply to tumours and are now either approved for use or under investigation for a range of malignancies in Australia and around the world.

Yet, while anti-angiogenic therapies such as Bevacizumab (Avastin) have been approved for use in the US for the treatment of recurrent GBM, such agents have yet to receive approval for use in GMB in Australia.

Dr Bennett said that vascular proliferation was one of the hallmarks of GBM due to an up regulation of proteins involved in the development of angiogenesis, prototypical of which were vascular endothelial growth factor (VEGF) and its receptor VEGFR-2.

He said that until now, the gold standard for assessing GBM vascularity had been to look at the amount of blood vessels in tissue under the microscope which could only be done via a craniotomy.

He said, however, that he had set out to research other means of studying vascularity such as via less invasive blood tests as a way to help ease the treatment experience of already overburdened patients.

Using blood and serum samples taken from patients with high grade glioma and healthy volunteers as controls, Dr Bennett investigated a range of biomarkers including circulating endothelial cells (shed from proliferating tumour vasculature), circulating endothelial progenitors (mobilised from bone marrow) and serum VEGF.

He also conducted Perfusion MRI tests, an advanced MRI technique which can assess haemodynamic properties within the parenchuyma of the brain.

"Despite appearing identical under light microscopy, GBMs are a heterogeneous group of tumours with varying degrees of aggressiveness and responsiveness to treatment," Dr Bennett said.

"We believe that biomarkers of GBM vascularity may provide an objective means of sub-classifying GBM and be of use in both the selection of patients most likely to respond to novel anti-angiogenic agents as well as allowing clinicians to monitor response to treatment in real time.

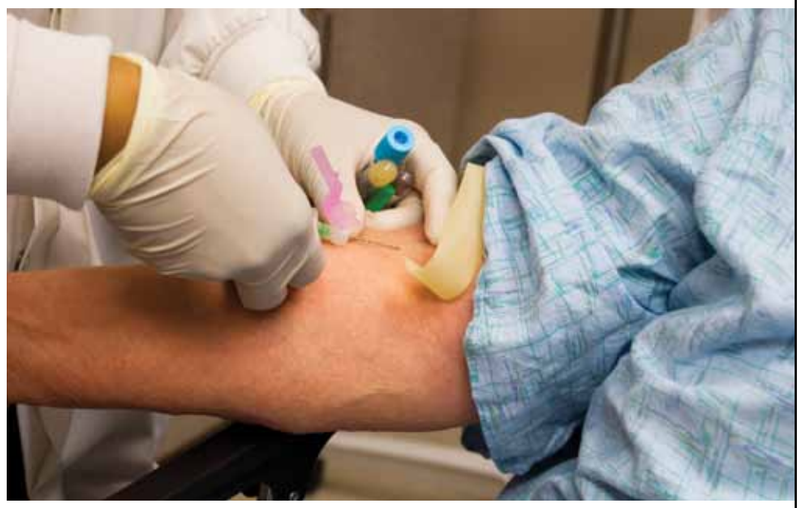
"So far we have demonstrated that circulating endothelial cells (CECs) are significantly elevated in patients with GBM as compared to controls and that these levels decrease post-operatively as would be expected.

"However, while CECs do not appear to be predictive or prognostic in patients receiving conventional therapy such as surgery, chemotherapy and radiation therapy, their true utility could be for patients receiving anti-angiogenic therapy."

A novel parameter

As part of his PhD research being conducted through the University of Melbourne's Department of Surgery and the Royal Melbourne Hospital, Dr Bennett also helped develop a novel parameter to measure the amount of vasculature within a given tumour.

He said the new measurement method had been dubbed the "cerebral blood volume (CBV) load" by the research team.



"Our parameter uses advanced MR imaging to determine the total amount of vasculature within a given tumour but its significance will depend on the ease of calculation so that clinicians can use it on a day-to-day basis and its usefulness in patient care," Dr Bennett said.

"Unlike many novel parameters of tumour perfusion being developed by other research groups, CBV load is an easy parameter to calculate.

"Any researcher or clinician already analysing perfusion MRI for quantitative data could calculate our parameter in just a few steps with software and techniques they are already likely to have.

"However, the key to the usefulness of this parameter will depend heavily on the development of anti-angiogenic therapy for the treatment of GBM.

"Nevertheless, it provides an ideal method of non-invasively monitoring the tumour vasculature and could be of use in both patient selection and monitoring of treatment.

"We have shown that the degree of reduction in CBV load following anti-angiogenic therapy predicts survival in a study of 15 patients, but this will need to be confirmed in larger studies."

Dr Bennett's research has been supported by the College through funding attached to a Foundation for Surgery Scholarship which he received for 2013.

His PhD thesis is being supervised by neurosurgeon Dr Andrew Morokoff, from the University of Melbourne and the Royal Melbourne Hospital as well as Associate Professor Christopher Hovens, a published researcher in the field of vascular biomarkers in prostate cancer.

He said he felt particularly fortunate to have been able to conduct his research through the University of Melbourne's Department of Surgery located as it was in the Clinical Science Building of the Royal Melbourne Hospital campus. ▶

RESEARCH AWARDS AND PRIZES

2011: Neurosurgical Association of Australasia Research Scholarship

2011: Brain Foundation Research Grant

2011: Peter Leech Memorial Prize

2012: Neurosurgical Association of Australasia/Cure for Life Research Scholarship

2013: RACS Foundation for Surgery Research Scholarship

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"The head of the Department, Professor Andrew Kaye, is also the Head of the Royal Melbourne Hospital's Department of Neurosurgery," Dr Bennett said.

"His combined position and our geographical location create a fairly unique situation in the world of brain tumour research and allow a level of collaboration between clinicians and researchers that is not seen in many other parts of Australia or indeed the world."

Dr Bennett said anti-angiogenic therapy was now an area of immense global interest making his research both scientifically exciting and clinically useful.

"As anti-angiogenic therapy for GBM becomes more common and effective, biomarkers of tumour vascularity will provide a means of determining which patients are likely to benefit most from these therapies which is important as not all patients may respond to these agents in the same way, if at all," he said.

"The less invasive nature of the testing protocols I have been investigating for biomarkers means that patients could be monitored throughout therapy and not just at times when the patient undergoes surgery.

"This would enable clinicians to monitor patient response to therapy in real time and enable them to make management decisions in a more timely fashion which we hope will ease the treatment burden and improve outcomes for such sick patients as those with GBM.

"Our findings are also likely to extend into other areas of neuro-oncology and oncology in general wherever anti-angiogenics are being used and that is also exciting."

A 5th year SET Trainee, Dr Bennett said he hoped to complete his thesis in June this year and then return to full-time training.

He has given oral presentations of his work at the Royal Melbourne Hospital Academic Centre Research Symposium and the Melbourne Brain Centre Research Symposium and is in the process of writing papers for submission to the American Journal of Neuroradiology and Neuro-oncology.

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Dr. Craig Bond, ENT surgeon, Visiting Medical Specialist, on (07) 3202 4636; or
Ms Chris Went, Chief Executive Officer on (07) 3816 9901; m: 0417 998 322 or email: wentc@ramsayhealth.com.au

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Developing a Career in Academic Surgery

Monday 5 May 2014, 7:00am – 4:00pm

SANDS EXPO AND CONVENTION CENTER
MARINA BAY SANDS, SINGAPORE

Provisional Program

7:00am Registration and Breakfast

7:15am Welcome . . . . . *Michael Hollands (President, Royal Australasian College of Surgeons)*
Introduction

SESSION 1: A CAREER IN ACADEMIC SURGERY 7:30am - 9:00am
Chairs: Sandra Wong (Ann Arbor, USA) and Christobel Saunders (Perth)
What is a career in academic surgery? . . . . . *Philip Crowe (Sydney)*
Academic Surgery – the essentials
1. Research – How to get research started – ideas, grants, ethics and collaboration. . . . *Timothy Pawlik (Baltimore, USA)*
2. Teaching, leadership, administration. . . . . *Julie Ann Sosa (Durham, USA)*

9:00am MORNING TEA

9:15am **HOT TOPIC IN ACADEMIC SURGERY - Comparative Effectiveness Research** . . . . . *Caprice Greenberg (Madison, USA)*
Chair: John Windsor (Auckland)

SESSION 2: CAREER DEVELOPMENT 9:40am - 11:20am
Chairs: Julie Ann Sosa (Durham, USA) and Philip Crowe (Sydney)

9:40am I want to be an academic surgeon. What can I do as a:
Medical Student . . . . . *Arthur Richardson (Sydney)*
Trainee – The pros and cons of fulltime surgical research during training. . . . . *Tarik Sammour (Auckland)*
Fellow . . . . . *Vincent Lam (Sydney)*
Consultant. . . . . *Mark Smithers (Brisbane)*

11:20am LUNCH with the faculty and small discussion groups

12:20pm **KEYNOTE PRESENTATION - ACADEMIC LEADERSHIP** . . . . . *Carlos Pellegrini (President, American College of Surgeons)*

SESSION 3: CONCURRENT ACADEMIC WORKSHOPS 1:00pm - 2:40pm

Workshop 1: Tools of the Trade
Chairs: Julie Ann Sosa (Durham, USA) and Wendy Brown (Melbourne)

Bedside to bench to bedside
John Windsor (Auckland)
Basic science
Michelle Locke (Auckland)
Randomised clinical trials
David Watson (Adelaide)
Outcomes research
Niraj Gusani (Hershey, USA)
Surgical education and research
Stephen Tobin (Dean of Education, RACS)

Workshop 2: Career Development Q & A
Chairs: Caprice Greenberg (Madison, USA) and Russell Gruen (Melbourne)

Multiple faculty
Frank Frizelle (Christchurch)
Michelle Locke (Auckland)
Timothy Pawlik (Baltimore, USA)
Henry Pleass (Sydney)
Andre van Rij (Dunedin)
Wei Zhou (California, USA)

Attendees to bring along their own current or past research challenges for a masterclass with the faculty

Workshop 3: Presenting Your Work
Chairs: Guy Maddern (Adelaide) and Ian Bennett (Brisbane)

Writing an abstract
Julie Margenthaler (St Louis, USA)
Writing a paper
Timothy Pritts (Cincinatti, USA)
Presenting a paper
Sandra Wong (Ann Arbor, USA)
The ANZ Journal of Surgery – What the Editor wants and where the Journal is going
John Harris (Sydney)

2:40pm AFTERNOON TEA

SESSION 4: A CAREER IN ACADEMIC SURGERY 3:00pm - 4:00pm
Chairs: Timothy Pawlik (Baltimore, USA) and Frank Frizelle (Christchurch)

3:00pm Choosing and being a mentor . . . . . *Andrew Hill (Auckland)*
3:20pm Work-life balance . . . . . *Julie Howle (Sydney)*
3:40pm On the shoulders of giants . . . . . *Russell Gruen (Melbourne)*

Registration **Cost: A$255.00 per person**

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There are fifteen complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org or for further information telephone +61 3 9249 1273.

As per Regulation 4.9.1a for the SET Program in General Surgery, Trainees who attend the RACS Developing a Career in Academic Surgery course may, upon proof of attendance, count this course towards one of the four compulsory GSA Trainees' Days.

Presented by:
Association for Academic Surgery
in partnership with the
RACS Section of Academic Surgery

AAS Association for Academic Surgery

Royal Australasian College of Surgeons, Section of Academic Surgery

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NOTE: New RACS Fellows presenting for graduation in 2014 will be required to marshal at 3.30pm for the Convocation Ceremony.

CPD Points will be available for attendance at the Course with point allocation to be advised at a later date.
Information correct at time of printing, subject to change without notice.

CASE NOTE REVIEW

Poor immediate postoperative communication in a bleeding patient

GUY MADDERN
CHAIR, ANZASM

Case summary

An elderly patient was admitted for a rigid cystoscopy and resection of a bladder tumour. There was a medical history of hypertension and an abdominal aortic aneurysm (AAA) repair. A transurethral resection of the bladder tumour was performed.

Postoperatively on the ward the patient had active bleeding. Continuous bladder irrigation was performed and traction applied to the indwelling catheter. The urologist was not informed of the active bleeding but did, however, notice the active haematuria and that the blood pressure (BP) and haemoglobin levels had been low.

The patient was taken to theatre for evacuation of blood clots and control of the bleeding. A blood transfusion was required. A cardiac arrest occurred shortly postsurgery and the patient was intubated, resuscitated and transferred to the Intensive Care Unit (ICU). An emergency echo-cardiogram confirmed the presence of anterior wall and apical left ventricular hypokinesia. The patient received several units of blood and other blood products. Inotropic drugs were required to maintain the BP; however, further deterioration occurred and the patient required increasing inotropes. A second echo-cardiogram showed akinesia of the anterior wall and a left ventricular function of less than 20 per cent. The patient progressed to palliative care and died soon thereafter.

Clinical lessons

The case adhered to reasonable and routine well-established clinical pathways for an elective endoscopic resection of a bladder tumour that was complicated by active haemorrhage. No communication occurred between the ward staff and the surgeon regarding the clinical deterioration of the patient in the immediate postoperative period, in regard to the clinical management of the post-active bleeding.

It is unclear as to whether the urologist reviewed the patient in recovery or on the ward during the postoperative period. There was thus no opportunity to discuss with the nursing staff the intraoperative findings and instructions about the plan of management post-operation.

The lack of communication between the surgical ward staff and the surgeon is an area of concern. With continuous active bleeding and low systolic BP, it is imperative that the surgeon should be called. The active bleeding led to hypovolaemia, which contributed to the onset of acute myocardial infarction in an elderly patient with vascular disease, resulting in multi-system failure and the death of the patient.

College Awards

Established in 2000, the RACS Excellence in Surgical Research Award is an honour created to recognise the contribution of a pre-eminent surgeon scientist who has made significant contributions to surgical research.

Professor Franklin Rosenfeldt
Surgical Research Award

Professor Franklin Rosenfeldt has been the leading Australian and New Zealand surgeon scientist within the field of Cardiothoracic Surgery for over 20 years.

He has been the Head of the Cardiac Surgery Research Unit at the Alfred Hospital, within the Department of Surgery at Monash University and at the Baker Heart Research Institute. He has held a full professorial appointment at Monash University since 2006.

Professor Rosenfeldt has made significant contributions to the basic science of myocardial protection during cardiac surgery. Many of his findings have been translated into the clinical practice of general cardiac surgery and also that of cardiac transplantation. He has provided a better understanding of the metabolic function of the heart during the stress of cardiac surgery especially in the elderly population. He has been an outstanding advocate for routine metabolic supplementation in patients undergoing cardiac surgery. A broad spectrum of highly cited basic science and clinically relevant publications has resulted from this work.

The above activity has been competitively funded on a regular basis by the ARC, NHMRC and the National Heart Foundation. This has been supplemented by a significant amount of commercial funding.

Many young academic cardiothoracic surgeons and scientists have been supervised by Professor Rosenfeldt in achieving Masters Degrees or Doctorates. A number now hold significant leadership positions in Cardiothoracic Surgery both locally and internationally.

Professor Rosenfeldt was a Founder of the Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS), the ANZSCTS Research Foundation and the Founding Editor of 'Heart Lung and Circulation'. Each of these entities has greatly promoted academic Cardiothoracic Surgery in Australia and New Zealand.

Professor Rosenfeldt has made a major contribution to Cardiothoracic surgical research and it is fitting that this be recognised through the Royal Australasian College of Surgeons Surgical Research Award.

Citation Kindly provided by Professor Julian Smith

The RACS International Medal is awarded to Fellows who have made lasting contributions of an exceptional nature over a long period of time in the delivery or development of surgery for underprivileged communities overseas.

Mr Gordon Low AM, FRACS And Mrs Rosie Low
International medal

Gordon and Rosie Low founded Project China in 1988, and they are also the coordinators of the Project up to the present. Their effort has created a lasting legacy for the outreach programs of the College. Their tireless work has contributed to greater understanding and cooperation between Australasia and China and in some instances has contributed to the surgical experience of both China, and Australia and New Zealand. During this period, Project China has arranged the visits of more than 110 Chinese surgeons and nurses to Australasian hospitals. And over 160 health care professionals and English teachers from Australia and New Zealand have visited various hospitals in China.

After graduating from the Institute of Business Administration in Hong Kong, Rosie Low, née Wei, had worked at the Hong Kong University Library, Oxford University Press and Television Broadcast Limited in Hong Kong before spending four years in Vancouver, Canada. Gordon On-Ting Low graduated Bachelor of Medicine and Bachelor of Surgery (MB BS) from the University of Hong Kong in 1956 with distinctions in Surgery and in Obstetrics/Gynaecology. He became a Fellow of the Royal College of Surgeons of Edinburgh in 1960, and a Fellow of this College in 1988. Coming from Asia, they share a vision of the enormous potential of better cooperation between China and Australia/New Zealand in all fields of human endeavour.

Their work in this exchange program of medical and surgical personnel of Project China required appreciation of Chinese culture and the rapidly changing political and social scenes in China in recent years. Gordon was awarded the Royal Australasian College of Surgeons Medal in 1994; and in 1999, Rosie was awarded a Certificate of Appreciation by Council. In 2003, Gordon was made a Member of the Order of Australia. From China, Gordon received Honorary Professorships from four medical schools.

Another initiative by Rosie and Gordon is to send English teachers to China to improve the English speaking ability of the medical personnel in the Chinese hospitals. Rotary International has recognised the importance of this program, and has made them Paul Harris Fellows of the Rotary organisation. Gordon and Rosie's consistent efforts in China have also contributed to the good international standing of the College. It is only fitting that the International Medal of 2013 be awarded to Gordon and Rosie Low to mark the 25th anniversary of Project China.

Citation kindly provided by John Batten

Orthopaedic and General Surgeons Required

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Anita.tait@globalmedics.com.au T: 02 8248 2912 | M: 0420 654 516

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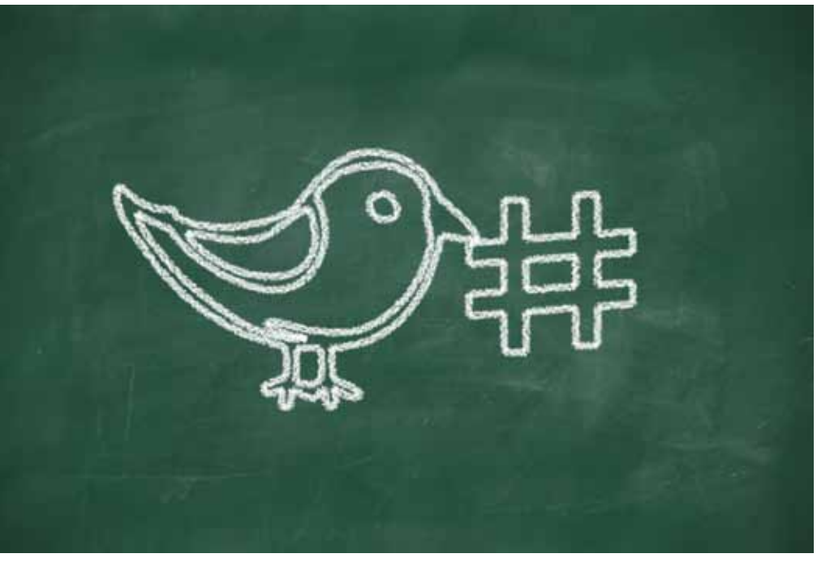
DOCTORS: ADVERTISING AND SOCIAL MEDIA

New guidelines for medical advertising have just come into effect



MICHAEL GORTON
COLLEGE SOLICITOR

All doctors are registered under the Health Practitioner Regulation National Law Act (National Law). Under the National Law, in relation to advertising, it is not acceptable to:

- make false and misleading claims;
- offer inducements, such as gifts or discounts, unless the relevant terms and conditions are also included;
- use testimonials;
- create unreasonable expectations of beneficial treatment;
- encourage the indiscriminate or unnecessary use of health services.

Penalties can be up to a $5000 fine for individuals.

The approach of the Medical Board of Australia (MBA) to date has usually been to send warning letters to offenders, but only take action when persistent advertising breaches occur.

The MBA guidelines for advertising have recently been reviewed, and new guidelines came into effect on 17 March 2014.

The guidelines recognise that advertising is a legitimate way for doctors to provide reliable and useful information to consumers and potential patients to make informed decisions about accessing health services. The National Law provides that this should not be done in a misleading or deceptive way.

The guidelines offer suggestions for doctors who may be advertising, whether on their own website or through other media.

- Advertising should not exaggerate competence, education, training or experience. Professional qualifications quoted should be accurate.
- Claims made in advertising should be able to be substantiated.
- Information should be factual and objective. It can include accurate financial information of the doctor's experience, teaching positions, publications and qualifications.
- It should not create unrealistic expectations about the services offered or the results that may occur.
- Advertising should not encourage inappropriate, unnecessary or excessive use of health services.
- The use of testimonials is not permitted.
- Information to compare a doctor's services with others is not permitted, unless there is objective evidence on which comparison can be based. Claims should not be made that a particular doctor is safer or better.
- Advertising is not a substitute for normal informed consent processes for any procedure or treatment.
- Pricing information should be accurate and clear.
- Advertising should be "in good taste" and not in a manner which may bring the health profession into disrepute.

Recent media reports have highlighted the application of the new guidelines to social media, which may often convey messages about doctors' competence, care and treatment. Some websites allow patients to anonymously post comments about doctors, for both good and bad reasons.

Testimonials infringe

The MBA guidelines make it clear that any testimonial, whether by an identified person or not, which is used or promoted by a doctor, or where a doctor has authorised or procured a third party to promote the testimonial, will infringe the guidelines and the National Law. Despite media commentary, the MBA recognises that doctors cannot control everything that is said about them on social media sites. It will be an offence if a testimonial is used with the authority of the doctor, or where the doctor is using the testimonial to promote the doctor's practice. This is different from unsolicited online comment, over which doctors do not have control.

The Chair of the MBA has noted:

"The Board expects practitioners to take reasonable steps to remove testimonials they are using to advertise or promote health services they provide, or when the testimonials are used by someone advertising the regulated services on their behalf. (This could be a third party who is advertising the services the doctor provides at the doctor's request).

But the Board recognises that practitioners are unable to control what is written about them in a public forum.

The Board does not expect practitioners to actively monitor internet sites. We do expect them to ensure that their own advertising, or that done by others on their behalf, meets the MBA guidelines."

It should also be noted that doctors are subject to ordinary trade practices and consumer legislation requirements that services be advertised and offered in a way which is not otherwise misleading or deceptive.

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Some ANZAC and other recollections

FELIX BEHAN
VICTORIAN FELLOW

Opus XXI

The ANZAC period is a time of reflection and it was only recently when watching the Winter Olympics in Russia on French television that the term 'hors piste' appeared on the screen (cross-country skiing).

I found its meaning as a result of a lexicographic investigation. Adjacent to it was a term also new to me – hors de combat – that in diplomatic parlance refers to non-combatants involved in the war effort; surgeons, nurses, the sick and disabled and any civilian captives involved in these conflicts, hence the title.

Chronologically I am indebted to Ian Ferguson's handbook *Aussie War Heroes* for some enticing 'pearls' that have helped me to improve the scope and reliability of this text. I recall reading the story of John Simpson (Fitzpatrick), a member of the Army Medical Corps, 27 years of age, and his three donkeys Murphy, Duffy and Abdul, who conveyed the injured personnel to the First Aid Station at Gallipoli before he himself was gunned down (should he have been wearing a red crescent also).

I liked Ian Ferguson's account of Sir John Monash, of Jewish/Polish/Russian background, whom Montgomery described as "the best general on the Western Front". Magnificantly he breached the Hindenburg line.

His philosophy was to bypass the cannon-fodder ideology of Gallipoli, replacing it with his own principles of onslaught: smoke, gas, shells, artillery and aircraft.

Commemorated in many Melbourne institutions, his fundamental creed of life (paraphrased) was "you must equip yourself for life, not solely for your own benefit, but for the benefit of others".

The next item in the theatre-of-war (before WWII) must include Sir Benjamin Rank who arrived in London in the 1937 to work at St James' Hospital in Balham under the guidance of the triumvirate of New Zealand reconstructive experts in this embryonic specialty – Gillies, McIndoe and Mowlem.

With the outbreak of war, Benny was sent to North Africa with the AIF (like Bill Manchester from New Zealand). Eventually he was sent to El Qantara, of which he said, "if the Egyptian hospital were the a---hole of the world, this was 20 miles up it".

Benny was the first Plastic and Reconstructive surgeon to return to Melbourne in 1942 to Heidelberg to proclaim the gospel, establishing a new specialty in the Antipodes. He became a leading force in reconstruction thanks to his Gillies exposure and his Sidcup experience. Incidentally, Sir Henry Newland, also a graduate from the Sidcup School in WWI, returned to general surgery in Adelaide, as did Les Le Souef, following his efforts in WWII. He returned to Perth before the late Harold McCombe joined him at the instigation of Benny to establish plastic surgery there.

The next feature in this tale of recollections is Weary Dunlop (the nickname referred to his being "tired" like a Dunlop tyre). From a Wallaby international and a medical graduate, he became a Captain in the Australian Military Corps; metamorphosing from his early pharmacy days. His medicine chest is now housed in the Monash School of Pharmacy in Royal Parade, on display for all to see.

I happened upon this scientific find thanks to Laura Dean, a senior lecturer at the School of Pharmacy who is one of the passing parade who frequents the Royal Parade boulevard in Parkville on a daily basis (pictured above). Weary's dedication to the common good was reflected in his work on the Burma-Thailand railway in 1943, which Ian Ferguson describes as costing a life for every 25 metres of its length.

In the recent documentary about the 'Railway Man' featuring Lomax, the narrator said there were 250,000 sleepers there – each one a memento for all those who died in this gruelling saga. Rudyard Kipling's tombstone quote "Known only to God" (the unknown soldier), was quite remarkable. It took Lomax 60 years to forgive his captors. Weary just walked away, saying "in suffering we are all equal" and forgave the Japanese graciously. (RIP 16,000 in 16 months).

Recently I photographed Wayne Morrison at the Bernard O'Brien Institute in preparation for my New Zealand lecture on the history of plastic surgery in Australia, for the W Manchester Memorial celebration in March 2014. While there, I incidentally saw the portrait of Weary Dunlop in Scottish Highland dress.

Wayne explained that Weary was on the board of the Bernard O'Brien Institute from its inception until his death in 1993, offering his advice catering for the advancement of science and ignoring the controversy of people, personalities and precincts, which had formerly plagued microsurgical development in Melbourne. Yes, he was beneficent.

Now, on a lighter note, my oracle of Delphi – Don Marshall – told me a story about Weary on his return to Melbourne following the war. He returned to private practice in the 1950s and had reason to visit one of his patients in East Melbourne. One Saturday morning he became the victim of an incident of road rage.

Foundation for Surgery Tour de Cure Cancer Research Scholarship

Background

Tour de Cure is a pre-eminent health promotion charity that raises funds for cancer research through cycling and other events. Together with the Foundation for Surgery, Tour de Cure has generously offered to fund the newly-created and prestigious Foundation for Surgery Tour de Cure Cancer Research Scholarship, which is offered for College Fellows, Surgical Trainees and International Medical Graduates (IMGs) on a pathway to Fellowship who are proposing to undertake an important cancer research project. This year there will be two intakes for applications:

Foundation for Surgery Tour de Cure Cancer Research Fellowship – 2014 – Inaugural Offer

Applications for the 2014 Scholarship close on 28 April 2014, and the successful applicant will be advised early June 2014 for commencing the scholarship in July 2014.

Foundation for Surgery Tour de Cure Cancer Research Fellowship - 2015

Applications for the 2015 Scholarship close on 28 April 2014, and the successful applicant will be advised early August 2104 for commencing their Scholarship in February 2015.

Eligibility Conditions

Applications for this Scholarship are open to Fellows, Surgical Trainees of the College and IMGs on a pathway to Fellowship. All scholarships, fellowships and grants are conditional upon the applicant being a permanent resident or citizen of Australia or New Zealand, or an IMG accepted into the College as a Trainee.

Value and Duration

The duration of this scholarship is 12 months. The gross value of this scholarship is $100,000, comprising $90,000 in stipend and $10,000 in departmental maintenance. The successful applicant will be required to procure 25% of the value of the scholarship from his/her research department.

More information

Please refer to our website at www.surgeons.org/scholarships/ and follow the links for application forms as well as more information about the scholarship including full eligibility requirements and conditions.
Alternatively contact Mrs Sue Pleass on 08 8219 0900 or email scholarships@surgeons.org.

To see more information on Tour de Cure, please go to **www.tourdecure.com.au**.

I have no details other than that the 'gentleman' concerned gave verbal abuse through the closed front window of Weary's car. Not one to hide behind screens, Weary opened the window and addressed the gentleman about his concerns, whereupon a fist came through the window, fracturing Weary's nose. Weary got out, stood up (6'3"+) and with a single punch knocked the man to the ground, breaking his jaw in the process (what else would you expect from a man with a University blue in boxing).

He may have said "oops, that's a bit heavy". He put the 'patient' in the back of his car and drove him to Royal Melbourne Hospital for admission and treatment of his fractured jaw, presumably with John Piercy or Bob Cooke, the oral surgical experts.

The epilogue of the story is even better. While in the Emergency Department, Weary managed to retrieve two implements and in front of the mirror in the gentlemen's bathroom re-aligned his own nasal septum (Don said he used two toothbrushes as Walsham forceps), reducing the fracture. It says a lot about the man's personal fortitude, whom I met also fleetingly.

The next feature that warrants a snippet of recollection is Bertie Coates. From a WWI ambulance officer to country postmaster to a medical graduate to his sagas with the Japanese invasion, he was a man of ability and immense talent, but with the experiences of the common touch.

I had the privilege of meeting him and must repeat a story I have told before. Stuart Archbold, the QANTAS Captain who entertained me monthly in London when I could not afford it over my three years there, grew up in Wycheproof and flew Spitfires for the RAF in the Battle of Britain; he was subsequently entertained by Pope Pius XII having staved off Luftwaffe bombers that were out to bomb the Vatican. This was a constant source of amusement to him, knowing my own religious background.

It was Bertie Coates who treated Stuart's son for near terminal ulcerative colitis, when others refused, who went on to become Professor of Geology at University of Melbourne. The Bertie Coates quote I tell all my students came when Bertie realised I had done three years of Head and Neck in London. He said, "Felix, never forget that tumours that grow towards you are inviting, those that grow away are sinister, like their prognosis." This advice was given over dinner at Maxim's in Toorak Road in 1974.

John Snell

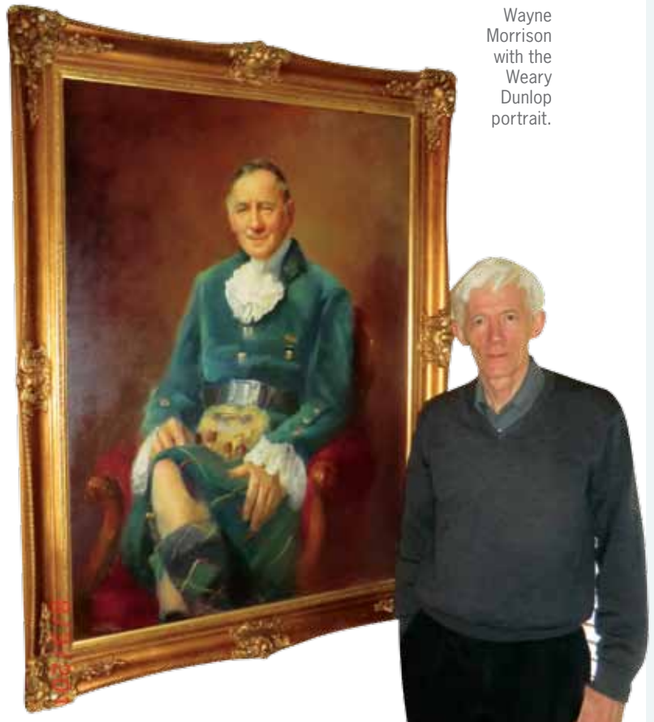
Another connection with Bertie Coates is John Snell, whose stepfather was in business in Malacca. Bertie was visiting the 10th Allied General Hospital and was invited to lunch with the Snell family. When the option of John's pursuing a medical career in war-torn Britain was discussed, Bertie suggested he might do so in Australia. John became fully credentialed and in two weeks and with Bertie's assistance arrived in Melbourne to commence medicine at the University of Melbourne, living at Ormond College.

He was a fine academic student whose football ability and sporting prowess (later a pennant golfer), made him a sporting icon (even as an import), but more importantly he finished his training in plastic surgery working with John Jeffs in London and took over at the Alfred as Head of Unit. During his time, this unit did the world's first microvascular scalp replacement in 1974. Earlier he served as Secretary of the International Society of Plastic Surgeons for the 1971 meeting. Thus he also can be called a plastic surgical icon. He will be 90 years of age in June and still as crisp as ever.

There are two other episodes that also feature in this saga of military recollections. In the New Guinea campaign it was Tom Ackland who saved Allan Wakefield's life. When the Japanese 'Zero' bombers were strafing the countryside of the Owen Stanley Ranges, Tom used his large frame to shield Allan throwing him under a muddy culvert near the Kokoda Trail. Both lived to tell the tale.

And finally, in the Korean campaign of the 1950s, John Hueston was working just below the 38th parallel. A bombardment of heavy artillery was going on incessantly. He was operating in a M.A.S.H. type atmosphere at the time and said to the American colonel next to him in theatre in a quite irascible way, "Can't those bastards shut up?" The colonel turned to John and said, "Those guns are our guns, John. When they stop, you start running."

As Cahier quotes in Quelques Sis Mille Proverbes, "tout passe, tout casse, tout lasse"; "Everything passes, everything perishes, everything palls."



Wayne Morrison with the Weary Dunlop portrait.

2015 Rowan Nicks Pacific Islands Scholarship & 2015 Rowan Nicks International Scholarship
2015 Rowan Nicks Australia & New Zealand Exchange Fellowship

The Royal Australasian College of Surgeons invites suitable applicants for the 2015 Rowan Nicks Scholarships and Fellowships. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to become leaders in their home countries.

The Rowan Nicks International and Pacific Islands Scholarships provide opportunities for surgeons to develop their management, leadership, teaching, research and clinical skills through clinical attachments in selected hospitals in Australia, New Zealand and South-East Asia.

The goal of these Scholarships is to improve the health outcomes for disadvantaged communities in the region, by providing training opportunities to promising individuals who will contribute to the development of the long-term surgical capacity in their country.

Application Criteria:
Applicants for the both the Rowan Nicks International and Pacific Islands Scholarships must:
- commit to return to their home country on completion of their Scholarship;
- meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in Australia or 7.5 in New Zealand, in every category);
- be under 45 years of age at the closing date for applications.

Applicants for the International Scholarship must:
- hold a relevant post-graduate qualification in Surgery;
- be a citizen of Bangladesh, Bhutan, Cambodia, Indonesia*, Laos, Mongolia, Myanmar, Nepal or Vietnam

**With preference given to Indonesian applicants from outside the major capital cities of Jakarta and Surabaya who will return to practice in regional areas.*

Applicants for the Pacific Islands Scholarship must:
- be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;
- hold a Masters of Medicine in Surgery (or equivalent). However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.

Selection Criteria
- The Committee will consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
- The Committee must be convinced that the applicant is of high calibre in surgical ability, ethical integrity and qualities of leadership.
- Selection will primarily be based on merit, with applicants providing an essential service in remote areas, without opportunities for institutional support or educational facilities, being given earnest consideration.

Value: Up to $50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare from home country and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Tenure: 3 - 12 months

The Rowan Nicks Australia and New Zealand 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 judged by the College to be of national excellence for a period of up to one year, or an Australian to work in a New Zealand unit using the same criteria.

Application Criteria:
Applicants must:
- have gained Fellowship of the RACS within the previous ten years on the closing date for applications.
- provide evidence that they have passed the final exit exam to allow them to obtain a Fellowship of the Royal Australasian College of Surgeons by the time selection takes place.

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 $50,000 for a 12 month attachment, depending on the funding situation of the candidate and provided sufficient funds are available, plus one return economy airfare between Australia and New Zealand and support to attend the Annual Scientific Congress of the College, if the Scholar is in country at the time of the Congress.

Tenure: 3 - 12 months

Application forms and instructions are available from the College website:
www.surgeons.org
Closing date: **Monday 2 June, 2014.**
Applicants will be notified of the outcome of their application by **30 October 2014.**

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

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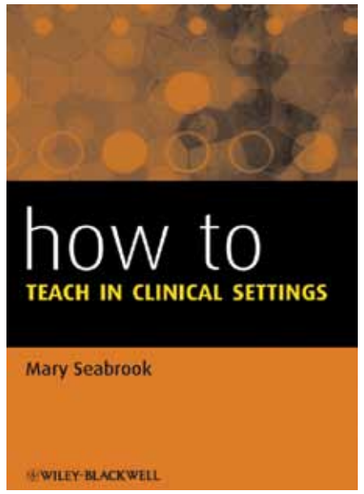

How to Teach in Clinical Settings

Mary Seabrook
136 pages, January 2014
~~A$52.95~~ | **A$34.42**
Member Price

How to Teach in Clinical Settings is a practical guide to support all doctors wishing to develop their skills in clinical teaching and supervision. It provides hands on strategies to address common problems such as giving critical feedback effectively and teaching mixed-level groups. It gives guidance on the particular challenges of teaching in clinical settings including the need to manage teaching with service provision, to engage patients, motivate students, and to judge the balance of support and independence appropriate for each trainee.

How to Teach in Clinical Settings is invaluable for all doctors involved in teaching and training at any stage of their career. It is also useful and accessible to medical students who increasingly need to consider and develop their own teaching skills as part of their career progression.

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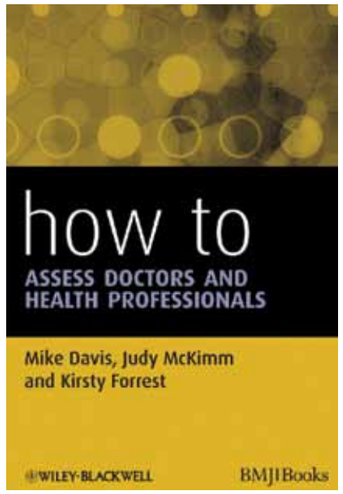

How to Assess Doctors and Health Professionals

Mike Davis, Judy McKimm, Kirsty Forrest
158 pages, March 2013
~~A$54.95~~ | **A$35.72**
Member Price

This important book offers an introduction to the theory and the varying types of assessment for health care professionals. The book includes information on such topics as Where have work based assessments come from?; Why do we have different parts to the same exam like MCQs and OSCEs?; How do colleges decide who has passed or not?; Why can people pick their own assessors for their MSF?; The role of formative assessment Portfolios and their value. The book avoids jargon, is clear and succinct, and gives the pros and cons of the different assessment processes.

25% Discount

Mentorship in Academic Medicine

Sharon Straus (Editor), David Sackett (Editor)
170 pages, November 2013
~~A$62.95~~ | **A$40.92**
Member Price

Mentorship in Academic Medicine is an evidence-based guide for establishing and maintaining successful mentoring relationships for both mentors and mentees.

Drawing upon the existing evidence-base on academic mentoring in medicine and the health sciences, it applies a case-stimulus learning approach to the common challenges and opportunities in mentorship in academic medicine. Each chapter begins with cases that take the reader into the evidence around specific issues in mentorship and provides actionable messages and recommendations for both correcting and preventing the problems presented in the cases.

Accompanying the text is an interactive, online learning resource on mentorship. This e-tool provides updated resources for mentors and mentees, including video clips and podcasts with effective mentors who share their mentorship tips and strategies for effective mentorship. It also provides updated departmental and institutional strategies for establishing, running, and evaluating effective mentoring programs.

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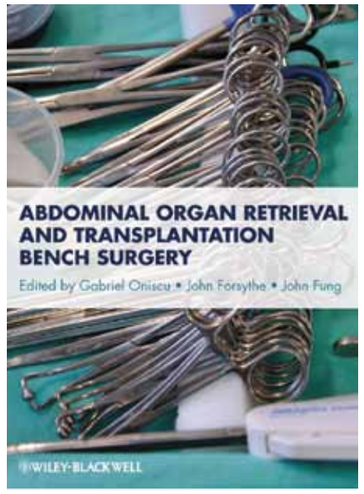

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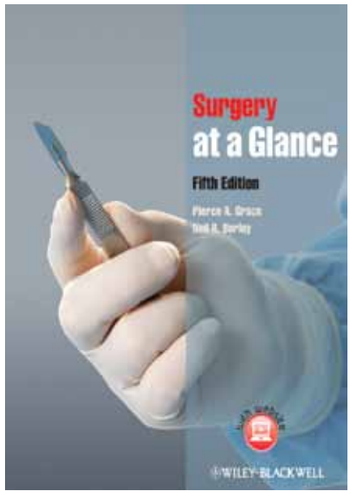

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