Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **AUGUST 2012**

Collaboration on the development of Emergency Medicine in Myanmar* *p.16

The College of Surgeons of Australia and New Zealand

Hearing *hope*

A new technique gives hope for regenerative hearing

AUSSTAT Medical Recruitment
www.ausstat.com.au

KIWISSTAT Medical Recruitment
www.kiwisstat.com

Enjoy the benefits of locuming

Locuming in surgery puts flexibility back into your life. You may want to take time off to study, explore new horizons, seek a new pace of life, embark on new pursuits, or gain valuable extra experience.

AUSSTAT/KiwisSTAT seeks surgical doctors, from junior level through to consultants, for locuming in hospitals throughout Australia and New Zealand.

When we have a locum position for you we organise it all including introductions, contracts and your travel and accommodation arrangements. Make sure you are registered with AUSSTAT/KiwisSTAT for great locum opportunities.

How you'll benefit with AUSSTAT/KiwisSTAT:

- Australasia's most experienced recruitment professionals
- Great rates, rewards and incentives
- Locations across Australia and New Zealand
- Regular notification of locum positions available
- We make it easy and hassle-free

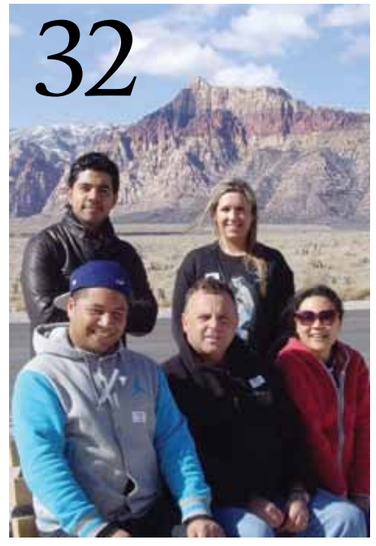
Best people, best opportunities, no problem!

Register with us today, *it's easy!*

AUSTRALIA
1800 422 966
www.ausstat.com.au

NEW ZEALAND
0800 562 867
www.kiwisstat.com

contents



Certified System
Quality ISO 9001
SAI GLOBAL

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org
Letters to the Editor should be sent to: letters.editor@surgeons.org
Or The Editor, Surgical News, Royal Australasian College of Surgeons,
College of Surgeons Gardens. 250-290 Spring Street, East Melbourne, Victoria 3002
T: +61 3 9249 1200 **F:** +61 9249 1219 **W:** www.surgeons.org
ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis / © 2012 Royal Australasian College of Surgeons / All copyright is reserved.
The editor reserves the rights to change material submitted / The College privacy policy and disclaimer apply – **www.surgeons.org**
The College and the publisher are not responsible for errors or consequences from reliance on information in this publication. Statements represent the views of the author and not necessarily the College. Information is not intended to be advice or relied on in any particular circumstance.
Advertisements and products advertised are not endorsed by the College. The advertiser takes all responsibility for representations and claims.
Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

ON THE COVER:
Professor Gunesh Rajan with a patient at Fremantle Hospital

President's Perspective

Value for money

What the College offers you

Every July I go through this stage of questioning my year's expenditure. Maybe it has something to do with the end of the financial year and the need to convert my shoe-box of receipts and documents to something that my accountant will not laugh at.

There is a common theme for Fellows – College fees, Specialist Society fees, special interest group fees and AMA membership. In my case I pay College subs, GSA subs, AHPBA subs, ANZGOSA subs and ATS subs, two other College subscriptions – over $5,000 worth. Each of these groups provides a different service or opportunity. Are they value for money?

The question is how do I determine which of these groups does provide value for money?

Taking the College as an example the best way to answer the question is to look at those services the College provides and which I use on a regular basis. Those that come to mind are advocacy and Fellowship services – audit, CPD, the Annual Scientific Congress (ASC) and the library.

How do we measure advocacy? There is no scientific way of doing so. It remains subjective assessment. Those of you who have completed an Australian Institute of Company Directors Course will appreciate that a significant proportion of a company's value is its reputation or name.

I use the FRACS logo on my letterhead. I cannot measure its value to my practice, but I believe it sends a clear message to prospective referring doctors, and to patients, that I have a level of training and a commitment to on-going professional development commensurate with what the Australian and New Zealand public expects.

Some areas where the College advocates on my behalf directly affect my professional life such as the separation of elective and emergency surgery, the surgical safety checklist and medical indemnity issues. Let's not forget that the College played a crucial role in the passage of medical indemnity legislation in NSW a decade ago. For some of us the decrease in insurance premiums has more than repaid our subscriptions over the ensuing years.

Whether we like it or not CPD is now a part of our professional lives. AHPRA demands it as a condition of registration. I use the College program. I could develop a similar one for myself or use a society specific program. For me part of the value for money I receive from being a Fellow is using an established CPD pro-forma, one which is regularly reviewed and improved, which I can access online and where I can upload proof of my learning activities.

I also use an audit program provided on the College website courtesy of David Watters. Once again it is free, user friendly and more comprehensive than the hand entered data I used to collect.

I also access the library almost weekly. It may be to prepare a lecture or presentation, search the literature or it may be to answer a patient management question or look up a condition of which I have no experience. I do not need to pay for relevant articles; I also get to read the whole article, not just an abstract.

As a member of different colleges, associations etc, I have access to a variety of clinical meetings. Certainly, the society specific meetings are unparalleled for specialised information. Nonetheless the ASC is an excellent opportunity to explore non-technical matters, sharing the information with surgeons who do not just practise in my area of expertise. As an examiner

"The question is how do I determine which of these groups does provide value for money?"

What we offer: clockwise; A NOTSS course underway, the *ANZ Journal of Surgery* and the Audit of Surgical Mortality.

and as a busy surgeon, I also find the keynote lectures are an excellent way to stay up-to-date in areas where I do not practise on a day to day basis.

More than two-thirds of surgeons undertake pro bono activity as part of their professional life. I learnt a great deal about how to teach from the College sponsored EMST Instructor Course. There are a number of College approved CPD Courses either run by the College such as NOTTS, or College accredited courses run by other organisations.

The College provides a framework and support for international activities of Fellows. As a professional I also have social responsibilities and I am keen to be associated with an organisation that advocates on issues such as road safety and alcohol abuse.

I enjoy reading *Surgical News* and the *ANZ Journal of Surgery*.

The College has also provided me with some wonderful professional opportunities such as being an examiner, teaching EMST and serving on Council. Such activities may not be for every surgeon, but for me they are part of the overall equation that tells me my College subscription is excellent value for money.

In summary, I cannot cover all the opportunities the College affords to us as Fellows; each of us will have differing expectations. While many organisations play a role in my professional life, the College provides me a one stop site for a multiplicity of professional activities and responsibilities.

Mike Hollands
President

Meetings in the Regions

There is something for you at your regional meeting

One of the good things about becoming Vice President of our College is the opportunity to attend meetings organised by the regional committees and the New Zealand National Board and held in the far flung corners of Australia and New Zealand.

The history of the College's regional meetings can be traced back to the original Memorandum and Articles of Association of the College. The 'founding fathers' of our College foresaw the need for fellowship opportunities in the regions. Clause 17 of the articles provided for the formation of regional committees for Australia and New Zealand and stated:

"The respective Committees shall convene one meeting at least in each year of the Fellows in their respective States and in New Zealand."

In part this reflected the fact that travel in the 1920s and '30s was a much more problematic undertaking and it was less likely that Fellows could regularly attend the College's Annual Scientific Congress. Regional Annual Scientific Meetings (ASMs) flourished as an alternative means for Fellows to learn of scientific advances in surgery.

With increased specialisation and with the greater role and prominence of specialty societies, the need for a regionally based scientific meeting fell away and for a time the ASMs went into a state of decline. In NSW, the meeting concept was abandoned altogether several years ago.

In recent years, however, with a revamping of the format, the regional meeting has experienced something of a resurgence.

Many regional committees now focus on important regional issues of advocacy for surgeons, surgery and the health system more broadly. Recent ASMs across the regions have covered a diverse array of topics including:

- Surgical Challenges West of Longitude 131;
- Training, Working, Living... Finding the Balance;
- Quality and Safety; and
- Sustainable Surgical Services for Rural and Remote Regions.

Dr Jacob at the 2011 WA/SA/NT Annual Scientific Meeting

In addition, the ASMs provide an opportunity for surgical Trainees to present their thoughts, research activities and to refine their presenting abilities.

This year's ASMs are being held in a variety of locations, for differing durations and with an outstanding range of topics under consideration. From Bunker Bay in Western Australia's Margaret River region, North Stradbroke Island in Queensland and chilly Queenstown in New Zealand's south island, there is a range of meetings and activities to suit a wide variety of interests.

The meeting at Bunker Bay in Western Australia is a combined meeting of the WA, SA and NT regions. This is the third such meeting to have occurred, the previous two having been held in Darwin and at Uluru.

This meeting will devote a session to the important issue of the so called Four Hour Rule. Western Australian Fellows, having lived with the rule for some time now will provide important perspectives on its application, while all Fellows will be able to contribute to the issues surrounding its roll out into their region under the National Health and Hospital Agreement. There will also be a session with the intriguing title, *"Medical Ethics and Futility – Balancing expectations and outcomes"*.

The New Zealand meeting, "Surgery 2012 – A Life of Learning" will take place in picturesque Queenstown in New Zealand's south island. The meeting will focus on a variety of educational approaches including professionalism and learning, simulation, digital and web based learning and mentoring. Given its location, it is also anticipated that some Fellows will use the opportunity either before or after the meeting to ski or indulge their passion for 'extreme sports'!

There will also be meetings in Victoria, Tasmania and the ACT which will similarly cover a range of topics and provide the opportunity for the delivery of registrars' papers.

And it seems likely that from next year NSW will reintroduce a meeting – possibly in conjunction with Victoria.

One of the more interesting and historic aspects of the regional meetings is the Henry Windsor Visiting Lectureship.

This annual award, founded in 1968 by Henry Joseph Windsor is awarded "for some contribution to surgery" as determined by Council.

The College policy states that, "The purpose of the award is to enable each State Committee or the New Zealand National Board on a rotational basis to appoint a visiting surgeon or scientist from another State or New Zealand to attend and contribute to its Annual or other General Meeting of Fellows."

Henry Windsor was born in Omagh, County Tyrone, educated in Armagh, and graduated in medicine from the University of Glasgow in 1909. After postgraduate training in England, he migrated to Queensland in 1914 and set up general practice in Toowoomba. Four years later, he moved to Brisbane and joined the staff of the Mater Misericordiae Public and Children's Hospitals.

His areas of interest were in abdominal and gastric surgery, local anaesthesia, and the nutrition of surgical patients. He gained a high reputation throughout Australia for careful surgery, in the days before transfusion and sophisticated anaesthetics. He was elected FRCS in 1957 and FRACS in 1963. He was Senior Surgeon at Mater from 1948 to 1956.

Astonishingly, after retirement from operative practice, he carried on as a consultant, working right up to three days before his death at the age of 91 years.

The award moves around the regions on a rotational basis. This year it is the turn of the Northern Territory to select the lecturer. The NT Regional Committee has chosen Mr Ian (Val) Lishman, a highly decorated general surgeon who will deliver the lecture at the combined WA/SA/NT regional meeting.

As can be seen, with a wonderful range of topics, there is something for almost every surgical interest at the College's many regional ASMs. I look forward to meeting you there.

For more information please see the Upcoming Events section of Fax Mentis or visit your region's page on the College website.

Michael Grigg
Vice President

LEADERSHIP IN A CLIMATE OF CHANGE

14 to 15 September, Sydney

Change provides an ongoing challenge to surgical leaders. Understanding your own style of leadership and adapting it to the situation and personalities of others in the workplace is crucial in today's dynamic world.

This workshop encourages a journey of self-discovery by undertaking a psychometric behavioural profiling exercise, indicating an individual's preferred leadership style. Group discussions identify alternative leadership styles, the value of emotional intelligence and a range of appropriate management styles that can enhance workplace relations.

According to Prof Cliff Hughes FRACS, CEO of the Clinical Excellence Commission who enrolled in the diploma and helped facilitate this workshop, "I was mightily impressed with the way the presenter worked with a group of clinicians, not known for their ready acceptance of some of the issues raised. It was great fun.... The informal discussions illustrate the way in which the presenter engaged each member of the group and developed their enthusiasm, including me. More importantly, I think there is still a lot to learn."

For further information, please contact Professional Development Department.

Ph: +61 3 9249 1106
Fax: +61 3 9276 7432
Email: PDactivities@surgeons.org

Students at cutting edge

Two medical students from the University of Western Sydney feel they have a solid career path after attending the academic surgery course at the College's Annual Scientific Congress in Kuala Lumpur this year.
Sarah Rashid and Sundus Khan were sponsored after an impressive general surgery rotation at Mt Druitt Hospital. Fellow Richard Hanney said their enthusiasm and understanding was refreshing. "If all our students and all our doctors had those standards and values, we wouldn't have half the problems that we do at different levels of the profession," Mr Hanney said.
***Blacktown Sun*, June 26.**

Long hours for doctors

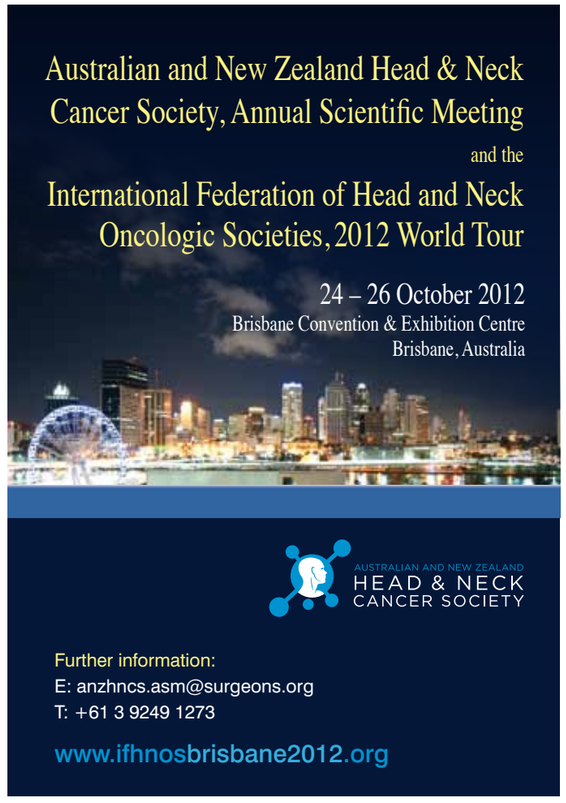
Seventy-seven per cent of surgeons reported a high risk of fatigue in a survey of doctors working hours from the Australian Medical Association. The findings demonstrate the onerous hours of surgeons after 1500 doctors were surveyed in August last year. Overall 53 per cent were found to be working unsafe hours.
"We need urgent action from governments and administrators to create and maintain safer working environments for doctors," AMA vice-president Geoffrey Dobb said.
***Canberra Times*, July 14.**

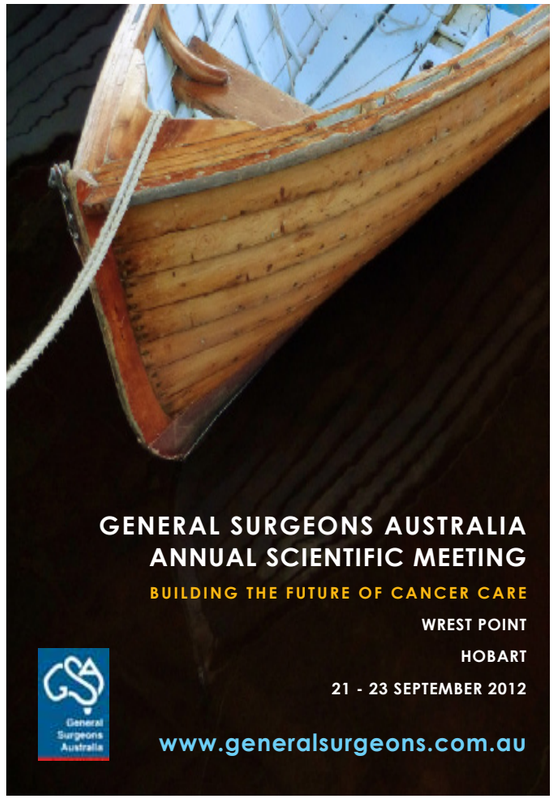
Registry closure slammed

The College's Trauma Committee has slammed Queensland Health's closure of the state Trauma Registry, labelling the move as grossly short-sighted. Information from the registry was used to compare management of trauma cases between states and seen as a way to improve trauma systems. Collecting data since 1998, the $2 million funding for the Registry ceased from June 30. Trauma Committee Chair Associate Professor Daryl Wall said the registry saved lives.
"Trauma systems depend on data which is current. There was state-wide support at all levels for the registry from nurses, administrators, doctors, rehabilitation physicians."
***Courier Mail*, July 2.**

Lethal fists

People are not heeding the message of health experts that 'One punch can kill' says Fellow Gold Coast neurosurgeon Dr Teresa Withers. Weekends in emergency rooms have become home to victims of alcohol-fuelled violence, often after single punches or brief altercations. Dr Withers also said even non-fatal injuries can have life changing consequences. "With a severe brain injury you may be in hospital for six to 12 months and if you can get home there's the cost of nursing, physiotherapy and not being able to work," Dr Withers said.
***Gold Coast Bulletin*, July 17.**





Strength in collaboration

I was disappointed and concerned to note the problems in the provision of public hospital surgical services in Tasmania identified in Greg Harvey's article (*Surgical News*, Vol 13, No 3, April, Regional News, pages 22-23) and echoed in John Hunn's letter (Surgical News, Vol 13, No 5, June, Letters to the Editor, page 11).

I agree it is very worrying, and inappropriate, that a head of surgery should be appointed to report to a senior nurse, and it would appear from their communications that the public hospital environments in which both Mr Harvey and Professor Hunn work are far from welcoming to senior surgeons. What is not clear is whether the problems they describe are limited to a single hospital (in this case, the Royal Hobart), or state (Tasmania), or are more widespread.

There can be little doubt that recent decades have seen a substantial erosion of medical dominance and autonomy, and a significant increase in the influence of managers over doctors1, and that relationships between the two groups have deteriorated2, so that the "them and us" attitude of doctors towards "health bureaucrats" has become widespread. However, more recent evidence suggests that, if anything, managers are more alienated and disempowered than doctors, who are protected by their professional status and socialisation3.

Arguably this situation will be addressed more effectively by involving doctors more closely in health care administration than by widening the gulf of communication and understanding between the two groups; and it is in the interests of managers to re-engage their senior medical staff and increase their influence on medical practice in public hospitals3.

Having become a full-time medical administrator after nearly 30 years of clinical practice as a consultant surgeon, I can report that, at least in Victoria, the situation is not as bad as it seems to be in Hobart. My own hospital remains part of an independent health service with its own Board of Management, which takes the advice of its senior medical staff (including surgeons) very seriously and is committed to the development and expansion of clinical services within the limited budget which is inevitable for a public sector organisation.

The clinical directors of our acute medical divisions, including surgery, internal medicine and obstetrics and gynaecology, are full-time staff specialists who report via me to the CEO, whose door is always open to them as to any other senior medical staff who wish to put their views to him. The contributions of our VMOs to training and research as well as clinical practice are highly valued, and I believe that they appreciate the collegiality that results from their public hospital work. While it would be ridiculous to suggest that our senior doctors and managers never disagree, we usually succeed in resolving our differences in an atmosphere of transparency and free debate.

I cannot claim, and would not wish to, that my own organisation is an exemplar of good practice in its relationships with its senior medical staff, but I do believe that public health care providers in different locations can usually learn a great deal from each other, a process which is bi-directional. I would certainly be happy to discuss these issues further with surgical colleagues in Tasmania and elsewhere in the hope that this might benefit all concerned.


Regional News

How do we continue our role in the public system?

Strength in numb

"But how to juggle a family life ... a private surgical practice, pro bono work like College roles, and working at a public hospital?"

PAGE 22 / Surgical News April 2012

Associate Professor Philip Reasbeck
MA MBBChir MD (Camb)
MRCP FRCS FRACS MBA
Grad Dip Law
Executive Director of Medical Services
Ballarat Health Services

References

1. Davies HTO, Harrison S. Trends in doctor-manager relationships. *British Medical Journal* 2003; 326: 646-9.
2. Harrison S, Smith C. Neo-bureaucracy and public management: the case of medicine in the National Health Service. *Competition and Change* 2003; 7 (4): 243 – 54.
3. Reasbeck PG. Relationships between Doctors and Managers in an Acute NHS Trust. *International Journal of Clinical Leadership* 2008; 16 (2): 79 – 88.

A lapsus calami


Surgical Services

Poison'd Chalice

Whilst I agree wholeheartedly with Dr U.R Kidding that knowledge of the classics be a requisite for selection into surgical training (Poison'd Chalice, *Surgical News*, Vol 13, No 5, June 2012). I hesitate, as a mere humble provincial surgeon, to mention that he has used "criteria" as a noun in the singular number – I am sure that this is just a lapsus calami.

He knows, I know and all those doctors of our generation and before know that κριτήριον is second declension, singular number, the plural form of which is ικριτήρια; these ancient Greek words transcribe into English as criterion and criteria, respectively sans change.

All my professional life, I have taught some Latin and ancient Greek to my students, residents and registrars to enable them to enable them to render classical plurals correctly, e.g., fistulae, diverticula, sarcomata. Some classical phrases have also been introduced, e.g., mens sana, in corpore sano; entia non sunt multiplicanda praeter necessitatum. Whether they have ever taken any notice is, of course, another matter. I concur totally with Dr U.R. Kidding's opinion about knowledge of the classics – we are meant to be learned and our patients expect it from their doctors.

William Renton Power FRCS FRACS

Dear William,

Firstly I hope you will forgive my presumption in addressing you by your forename – feel free to use mine – Ulysses though most people address me as UR or simply as Prof.

Secondly, thank you for taking the time to write. I do receive quite a lot of mail and try, not always successfully, to respond.

Thirdly, I am of course mortified by my incorrect usage of the plural "criteria" when in fact, as you correctly point out, I should have employed the singular "criterion". It was indeed a lapsus calami. I have no excuse but by way of explanation all I can say is that I tend to write my little contributions late at night when, for one reason or another, my usually razor sharp intellect is impaired. The examples that you cite in your letter are all ones that I also dwell on with the Trainees. The one that you have omitted that causes a mixture of consternation and pleasure is "this data" – consternation because I feel the Trainees should know better, and pleasure because it provides an opportunity for me to point out their inadequacies!

Fourthly, I am intrigued that you have chosen to include "Entia non sunt multiplicanda praeter necessitum" meaning "Entities are not to be multiplied beyond necessity". If I had a personal Coat of Arms this would feature. Alas, every management structure, committee etc. that I have ever been involved in, has failed to heed this maxim. I commend you for giving it 'air'.

And finally, thank you for reading my minor contributions. My intention has been to provide some amusement, but also to try to strike a chord that provides some resonance with surgeons.

Professor UR Kidding.

Surgical News always welcomes letters from readers.

Please write to The Editor, Surgical News, Royal Australasian College of Surgeons, 250-290 Spring Street, East Melbourne. Victoria 3002 or email: **letters.editor@surgeons.org**

Accommodation for Visiting Scholars

Through the RACS **International Scholarships Program** and **Project China,** young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to twelve months.

Due to the short term nature of these visits, it is often difficult to find affordable accommodation for visiting scholars. If you have a spare room or suitable accommodation and are interested in helping, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a modest rental and eternal appreciation.

If you would like to be contacted by the College if the need for accommodation in your area arises, please register your details by contacting the International Scholarships Secretariat on the details below. We are currently seeking accommodation in Melbourne (near Royal Melbourne Hospital and The Alfred), Brisbane (near Princess Alexandra Hospital), Sydney (near Westmead Hospital) and Adelaide (near Royal Adelaide Hospital) for visits in 2012. We would love to hear from you.

International Scholarships Secretariat Royal Australasian College of Surgeons, College of Surgeons' Gardens
Spring St, Melbourne Victoria 3000, Australia
T: + 61 3 9249 1211 F: + 61 3 9249 1236
E: international.scholarships@surgeons.org

I enjoyed these dinners – cross-generational gatherings of those 'skilled with the knife'. Some of my teachers and mentors, a few of my close colleagues and the 'young Turks' – those 'up and coming' who had already been acknowledged as the leaders of the future. Colleagues, but I also called them friends. It made one recall the lines from Shakespeare such as Ulysses to Achilles of "Love, friendship, charity are subjects all. To envious and culminating time" and from Richard II, "I count myself in nothing else so happy, as in a soul remembering my good friends."

The entree had been exquisite and I was now at the stage of admiring a very fine New Zealand red that would go so well with the steak. I had been telling the group about my ongoing use of the Code of Conduct and its key components in our Unit meetings. After the initial stammering of "Code of what..." it had produced an interesting discussion about the need to maintain standards across all aspects of surgery.

We need to get back to the good old days highlighted my previous Professor. The more senior members of the group thought that it may even work to correct the rampant effect of commercialisation and fee gouging that was their usual point of concern. Had never happened in their day was the ongoing and usual refrain.

A number of them had read the section on ageing quite carefully. There were concerns about those who were approaching retirement and perhaps should be embracing it more rapidly. Although "a friend should bear his friend's infirmities" (Cassius to Brutus in Julius Caesar), it was different when clinical care and outcomes were being considered. Fortunately the surgeon concerned was in a hospital for which I had no responsibility. But how to confront the issue tactfully? Was the older generation assuming Gen Y characteristics?

And then one of the 'young Turks' spoke up. "How do you cope with the issue of bullying Professor Kidding? You know you do have a reputation for being a bit 'over the top'. 'Full of sound and fury – perhaps even signifying nothing' and all that sort of stuff." I looked at him aghast.

"Do you mean my quoting of Shakespeare could be construed as bullying?"

"No, no, not at all. However, our registrars are saying the Clinical Director role must be getting to you. Sometimes a bit short tempered and not as supportive as I remember. Maybe it is a generational thing with people not keeping to your high standards."

There was silence. And here I had this image of myself as mellowing somewhat in my maturing years. But maybe he had a point. It was difficult to adapt to the seemingly endless alphabetical changing generations, the rise of political correctness, the absence of the concept of individual fault nowadays.

There were standards that I believed in and indeed had lived my professional life by, but how to convey these to the new generation without being thought a bully! I remembered an incident with my old Professor, a cultured man, now sitting opposite.

Way back when...

It had been a long night in the emergency theatre – I was a young inexperienced, but eager registrar attempting to assist the "master" in his work. Suddenly he downed tools, reached across the operating table, grabbed me by the operating gown and lifted me bodily off my feet. "Listen," he shouted at me. "I'm finding this operation a problem! I just want to know one thing – are you helping me solve it, or are you part of it?"

I remembered being shocked, in retrospect both physically and verbally abused, but at the time feeling that I should concentrate more. We never spoke of it – there was no need. For him it was an "educational moment" – gone, passed, of no further significance. For me, it was a "learning moment" – the impact perhaps lifelong. I hadn't felt victimised or bullied. I did feel I had received an important lesson.

"I count myself in nothing else so happy, As in a soul remembering my good friends"

But try that today, particularly if the registrar is female; well, the law would likely be changed and the death sentence re-introduced! Today, the "correct" might be something along the lines of "Dr Kidding, if it isn't too much trouble, I wonder if you would mind terribly moving the sucker just slightly closer to the bleeding point. Oh, and please don't hesitate to let me know when your shift is up so that you can get a good night's sleep!" Of course, I am being a little unfair – reacting defensively to my own inadequacies.

"Maybe you do need another glass of that Shiraz," said one of my mentors. "Tell us about the stresses in this management job of yours," offered another. "Is it true the higher you get up the management tree, the fewer friends you have?" I looked around. How could I tell them of the frustrations of commitments scorned, of politicians tainted and Chief Executives turned? Would it be more of 'strutting and fretting my hour upon the stage'?

It could all be a bit heavy. However, I did pursue my friend – the 'young Turk'. "Now tell me who I have offended." I remembered those lessons from the HR people. The first step in dealing with any bullying is to acknowledge and apologise. Maybe I was getting a bit pompous and demanding. Never thought the code of conduct would turn out this way...

Professor UR Kidding

Case Note Review

This is the third in our series and a very important note

This case, from the national program of mortality audits, demonstrates an unusual complication that seems so simple and avoidable, and yet proved fatal. The patient was an elderly person who fell at home lacerating the lower leg. The patient was in reasonable health for age, suffering from reduced vision in one eye, hypertension and cardiac disease.

The patient lived with a spouse in their own home. A long laceration over the lower leg was noted on presentation to the emergency department. It was still actively bleeding and the patient was mildly hypotensive.

Multiple attempts to gain venous access for resuscitation were unsuccessful and a large bore femoral venous catheter was inserted by a consultant in the emergency department for fluid replacement.

Operation followed that night. The operation to explore, debride and suture the wound was uncomplicated. The first post-operative day was uneventful, but on the second day the patient was confused.

A MET call was made because of unresponsiveness and hypotension. The bed sheets contained a large amount of blood; the bung from the femoral vascular catheter was not in position – the patient had exsanguinated from the large bore vascular catheter, presumably as the bung had been pulled out by the confused patient.

Resuscitation was started with blood transfusions and although there was initially some response with a rise in BP (previously markedly hypotensive), deterioration occurred again with Cheyne Stokes respirations, cardiac arrhythmia and no palpable systolic BP. Treatment was withdrawn and death rapidly followed.

A retrospective nursing note records that the femoral catheter was being used for IV access and that the site was checked every 30 minutes. It was last checked 15 minutes before the sudden deterioration of the patient. Despite the frequent checks there was no chart in the notes recording these observations.

Outcomes

The notes only mention the large bore femoral venous catheter twice – when it was inserted and after the death of the patient. There was no other warning of the nature of the IV line. It appears that the staff continued to use it as IV access.

Confused patients often pull out medical devices such as urinary catheters, IV drip lines and ECG lines without any ill effects. However, a large bore femoral catheter in a confused patient who may have been already somewhat hypovolaemic is a disaster waiting to happen – and happen it did.

To their credit the unit initiated a review of the use of wide bore IV catheters and as a consequence a hospital-wide policy has been introduced that such devices must not remain in patients in normal wards. All hospitals and surgeons should learn from this case and follow this very sensible policy.

A review of the literature for the past 10 years did not reveal any similar cases.

Guy Maddern
Chair, ANZASM

PRELIMINARY NOTICE

SURGICAL RESEARCH SOCIETY ANNUAL MEETING

The Surgical Research Society; 49th Annual Scientific Meeting will be held in Adelaide on Friday 9th November 2012

This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers, scientists and medical students.

JEPSON LECTURER:
Professor John A Windsor FRACS
Professor of Surgery, Director of Surgical Research, The University of Auckland, New Zealand
Chair, Section of Academic Surgery
Lecture title: "Streams in the Desert"

ASSOCIATION FOR ACADEMIC SURGERY GUEST SPEAKER:
Associate Professor Heitham T Hassoun MD, FACS
Medical Director – Global Services, Johns Hopkins Medicine International in Baltimore, Maryland, USA
Lecture title: "Kidney-Lung Crosstalk during Surgical AKI"

CALL FOR ABSTRACTS:
The call for abstracts will be open on Monday 30 July 2012 and must be submitted no later Monday 24 September 2012. Abstract forms will be available from the email address below.

AWARDS AND GRANTS
The following will be awarded to the best presentations:
Young Investigator Award
Developing a Career in Academic Surgery Award
Three Travel Grants
Best Poster Award

CONVENOR: Professor Guy Maddern

PRESIDENT: Professor John McCall

CONTACT: Mrs Sue Pleass
T: +61 8 8219 0900
E: academic.surgery@surgeons.org

Extending our audit arm

ANZASM collaborates with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Since the inception of the Audit of Surgical Mortality (ASM) in Western Australia more than 11 years ago, there has been recent interest in extending this program to incorporate other colleges nationally. The audit is currently underway in every state and territory in Australia.

Each region continues to have its own autonomy, and is led by a clinical director who works with a project manager and staff to interact with surgeons, hospitals and their department of health, ensuring that regional reports produced are relevant to all their needs and requirements.

The primary objective of the mortality audit is peer review of all deaths associated with surgical care. The audit process is designed to highlight system and process errors and trends associated with surgical mortality in an educative manner.

Each of the regional ASMs has produced a range of reports (annual, progress, surgeons and hospital reports) plus case note review booklets and newsletters. These can be accessed on the RACS website: www.surgeons.org/racs/research-and-audit/audits-of-surgical-mortality

A formal proposal was presented to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) on a possible collaboration with ANZASM to review deaths associated with gynaecological admissions using the ANZASM audit (peer-review) process. The RANZCOG Board has formally approved the participation and involvement of its Fellows in the ANZASM.

The collaboration is intended to be focused at the regional level with each ASM to include deaths associated with gynaecological surgery in the peer-review processes. It was also agreed that the current methodology used by ANZASM would be appropriate for this purpose and that no amendments to the current surgical case form would be necessary.

A RANZCOG representative will be appointed to each regional ASM management committee. The ASM Clinical Director will work with the RANZCOG representative, to allocate first and second-line assessments to participating Fellows of RANZCOG, i.e. assessors who are appropriate to the area being assessed and not located at the same hospital.

As part of the collaboration, gynaecology will be included as a specialty in each of the ASM annual reports, and the regional and national case note review booklets. In the coming months, the intention is to disseminate a formal communication to their Fellows inviting them to participate in the audit.

I would like to formally welcome our colleagues from RANZCOG into the ANZASM fold as part of this important initiative.

Thank you for your ongoing support.

Guy Maddern
Chair, ANZASM

Up to the job?

No-one likes being out-performed

There is one thing that really annoys me and that is Annual Scientific Congress (ASC) Coordinators. Now take the recently resigned ASC Coordinator, Campbell Miles. He is a perfectionist and always gets things right, unlike me who fouls up from time to time.

It annoys me that he is so much better than me at following up on things and getting it all right. We curmudgeons do not like being out-performed. At the Kuala Lumpur ASC I was sitting near him and he seemed to be having two conversations simultaneously, one about a change of rooms for a session and the other re-arranging the travel arrangements of a visitor.

I assume he got both correct and did not send the visitor to Room 405 and send the Section of Academic Surgery to the KL International Airport.

Now Campbell is a vascular surgeon and, like neurosurgery, precision is vital so I would expect little else from him. Unfortunately after eight years at the helm he is leaving the ASC Coordinator position.

Now I would have thought the obvious replacement should be a vascular surgeon or maybe a neurosurgeon. Precision, attention to detail, obsessional, pedantic are all words that should be in the job description. But what have they done – appointed a colorectal surgeon.

Now a leaking artery will cause you to bleed to death, but a leaking colon does not, to me, seem as serious. Is he going to be able to match Campbell's precision? Can he perform two tasks at the same time?

Initially I thought not, but on reflection as a colorectal surgeon he will almost certainly be anally-retentive and should manage fine.

In Memoriam

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

Narayanan Sampangi, NZ Urologist
John Goldie, NSW General surgeon
George Westlake, Vic Cardiothoracic surgeon
Christopher Elmes, Qld General surgeon
Damian McMahon, ACT General surgeon
Mathew Green, Vic General surgeon
Ratan Edibam, WA Orthopaedic surgeon

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: Susan.Burns@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

Essential emergency *skills*

A collaboration of specialists are helping to develop Myanmar's Emergency Medicine

Australian and Hong Kong specialists have delivered the initial component of intensive Emergency Medicine (EM) training in a swift and effective response to the request made earlier this year by Myanmar medical leaders for assistance in developing the specialty in time for the South East Asia Games in 2013.

In response, emergency physicians, surgeons and anaesthetists designed, wrote and delivered in June the Myanmar Emergency Medicine Introductory Course (MEMIC), the first stage of the Phase One Post-Graduate Diploma in Emergency Medicine to be awarded by the University of Medicine in Yangon.

The entire collaborative project will include Three Phases covering the establishment of formal specialty training and the introduction of EM systems including ED design, pre-hospital and emergency nursing care.

Myanmar has a population of 59 million people, the vast majority of whom live on only $1 per day. It has no dedicated emergency medicine systems or specialists and virtually no pre-hospital trauma care such as an ambulance system.

Yet, senior politicians including the Minister for Health, his Excellency Dr U Pe Thet Khin who officiated at the Opening Ceremony of MEMIC, and senior medical academics and specialists are determined to develop the emergency health care system across the country.

The formal five-day MEMIC program was held at the University of Medicine Yangon and was delivered to 18 course participants, a core group of junior specialists selected to form the foundation cohort of Emergency Medicine specialists for Myanmar.

The group, chosen across a range of specialties including orthopaedic and general surgery, medicine, paediatrics and anaesthesia, will become the leaders in local EM development and provide clinical leadership at key hospital emergency departments in Yangon, North Okkalapa, Mandalay and Nay Pyi Taw during the 2013 Games and beyond.

Partners in the international collaboration to develop the specialty of EM are the Australasian College for Emergency Medicine (ACEM), the International Federation for Emergency Medicine (IFEM) and the RACS alongside the Myanmar Ministry of Health and the Myanmar Medical Association.

Funding for the course was given by the Australian Government and underwritten by the RACS.

The team members were College Fellows Dr James Kong and Mr Phil Truskett, Emergency Physicians Dr Georgina Phillips, Dr Michael Augello, Dr Kerry Hoggett, Dr Antony Chenhall, Dr Chris Curry and Dr Phil Hungerford and Hong Kong specialists, Dr Tai Wai WONG, Dr Tsun Woon Lee and Dr Yu Fat Chow.

Burmese born, College Fellow Dr James Kong is the Myanmar International Program Director and has been at the helm of the College's involvement with Myanmar since 2009 when the College began supporting Primary Trauma Care (PTC) training in Myanmar.

With the support of RACS and its Fellows, Emergency Physicians and Anaesthetists from Australia and Hong Kong, the Myanmar Medical Association and the Myanmar Orthopaedic Society have successfully rolled out an effective PTC program throughout the country, building on existing infrastructure and services. The success of the program triggered the request by health officials for help in developing the more specialised field of Emergency Care.

The June MEMIC course was Dr Georgina Phillips' fifth visit to Myanmar since her participation in the inaugural PTC course in 2009.

She said the enthusiasm and commitment from health authorities and medical academics, the Myanmar Medical Association, students and international lecturers was extremely high.

"The Myanmar health leaders have had this vision for a long time and although it is a daunting endeavour, they are very ambitious," Dr Phillips said.

"Overarching themes embedded through the course included leadership, communication, teamwork and teaching."

"It is amazing what is required, for instance there is no ambulance service, only one ED department in Yangon, no EM specialists and limited EM nursing skills, yet they are determined to achieve change and it is exciting to be part of that."

Dr Philips said the MEMIC used adult learning principles adapted to a low resource environment including lectures, skill stations, facilitated discussions and group workshops to cover both clinical and EM systems topics.

She said overarching themes embedded through the course included leadership, communication, teamwork and teaching along with the specific aims of:

- Introducing the concept of EM – definition, how it is practiced and core competencies;
- Introducing and training participants in key EM systems and concepts including triage, ED design and patient flow management, ED leadership, crisis resource management skills, disasters and pre-hospital systems;
- Introducing core knowledge and skills covering resuscitation, important clinical and undifferentiated presentations, assessment, investigation and observation medicine;
- Providing a framework and relevant resources for the Post Graduate degree and future short course components.

"In the context of preparation for the SEA Games, a significant proportion of time was spent on pre-hospital systems, preparing for mass gatherings and disasters," Dr Phillips said.

"While the course participants were more familiar with didactic lecture style learning, we designed MEMIC around a more informal teaching method.

"During the five days of the course we provided hands-on skills stations, scenario-based workshops and discussions and activity tasks such as giving participants a floor plan from a hospital department as it now exists and asking them how they would re-design it into an effective and efficient emergency department. ▶

Memic instructors: Chris Curry, TW Wong, Michael Augello, James Kong, Georgina Phillips, Kerry Hoggett, Phil Truskett, Antony Chenhall, Phil Hungerford, TW Lee.

"We also included the integration of medical, surgical, paediatric and obstetric/gynaecological emergencies throughout to reflect the reality of undifferentiated and symptom-based clinical ED practice.

"Attendance and active participation was extremely high and maintained throughout the MEMIC even though most participants, assistants and observers were working in their hospitals and other practices before and after the long course hours.

"Participants told us that they appreciated the novel educational techniques we used which they found stimulating and challenging."

Over the next 18 months, course participants would extend this initial training in EM through rotations working under the supervision of an Emergency Physician at the ED in Yangon.

Senior EM specialists in Australia and Hong Kong have volunteered to travel to Myanmar on rotation to supervise the junior specialists as they progress through the Post Graduate Degree training requirements.

Short skills courses in trauma, emergency life support, paediatric emergency care, toxicology and disaster preparedness are also scheduled for the next 18 months. Dr Phillips said she would be returning to Myanmar later this year to supervise the EM trainees.

Inspiring people

She praised all of the Colleges involved for their support and particularly noted the "instrumental" contribution made by surgeon Dr James Kong, who was born in Myanmar and who provides on-going assistance in helping his country of birth develop its health systems.

The Second and Third Phases of the emergency medicine project would involve assistance in designing and creating mature EM systems including the training of nurses and GPs across the country, and providing hospital staff with basic emergency medical and triage skills.

"All the course participants were very inspiring and committed people who have all bravely put up their hands to change their professions to become Emergency Physicians in a country which does not yet have an emergency medical system," Dr Phillips said.

"Their level of commitment and engagement was heartfelt and moving, as if they had a glimpse of what they could achieve and contribute as leaders in this field and as members of a modern, international community of specialists."

Dr James Kong, the Myanmar International Program Director, agreed.

He said that while developing an internationally acceptable standard of emergency medical care in time for the SEA Games was obviously a challenge, there was a strong determination to achieve it both from authorities and the junior specialists involved.

"It is important for people to understand that we are taking 18 volunteer specialists in their own field with their own career pathway and asking them to trust both a group of foreigners and a few of their own senior colleagues to lead them down a new pathway," Dr Kong said.

"Emergency medicine is something which is totally radical from their current concept of care delivery and we are asking them to trust that at the end of the tunnel there will be a new career, new opportunities and that they will be able to do something important for their country.

"To me that is not just a tall order, but an amazing story."

As a sign of the appreciation felt by Myanmar health authorities, MEMIC instructors and key stakeholders were hosted to a dinner by the Minister for Health upon their arrival while the Australian Ambassador Ms Bronte Moules addressed the opening session of the week-long course.

MEMIC team instructor, Fellow Mr Philip Truskett, also presented the Minister for Health with a College shield in commemoration of the historic international collaboration.

With Karen Murphy

The alpha and the omega

Should I take fish oil, Dr Double Begloved? So asked the middle-aged and slightly heavier surgeon, *Satu-rated Trans-sicks*, rising from my couch after a health check, brought on by last month's column. The cholesterol was high (again) and there was a gain of a couple more kilos.

I wasn't sure any advice I would give would see the light of day, but I gave the usual spiel – the sort of information any surgeon could obtain on the web, if they made even a little effort. But I have found it is remarkably difficult to change people's diet, or at least that is true in the years before they develop ischaemic heart disease.

My experience is that after the urgent coronary artery stents or bypass grafts, patients are much better motivated to address diet and lifestyle. Another thing I've found among both doctors and patients is that everyone thinks they eat well, whether they do or not.

I trotted off the usual patter: "fish oil is a good source of Omega-3 fatty acids and they are good for you. How often do you eat fish?"

"Seldom; I like red meat," came the honest response from *Satu-rated Trans-sicks*.

Fish is a rich source of protein and one that does not have a high concentration of saturated fat. The American Heart Association has even put its reputation behind omega 3s by recommending at least two fish meals per week. So that means eat tuna, sardines, salmon and trout and have less beef. Fish is not only advised for Catholics on Fridays.

Fish consumption has been shown in cohort studies to reduce mortality from coronary artery disease. Omega-3s are good for the cardiovascular system particularly the vascular endothelium. They are also anti-arrhythmic and reduce blood coaguability.

Virchow would love them on all three counts. They not only protect against coronary artery disease in the first place, but many studies have demonstrated a reduced recurrence or progression rates where the disease is already present.

They also reduce inflammation. Evidence from prospective secondary prevention studies suggests that EPA_ DHA supplementation ranging from 0.5 to 1.8 g/d (either as fatty fish or supplements) significantly reduces subsequent cardiac and all-cause mortality.

But apparently there's omega 3 and omega 3. They can be fishy or flax seedy. You can go eicosapenaenoic, docosahexaenoic or linolenic.

Fatty fish include salmon, mackerel and herring. They are ideal as long as they are not crammed with mercury from the environment. Check the mercury levels in fish from time to time. These are monitored and measured in parts per million.

The marine-derived eicosapentaenoic acid, C20:5n-3 [EPA] and docosahexaenoic acid, C22:6n-3 [DHA]) are the fishy omega-3 fatty acids. In your efforts to partake of the oily fish, avoid fast food establishments, as well as many frozen, convenience-type fried fish products. These are low in omega-3 and actually high in trans-fatty acids.

If you want to take supplements, up to three 1-g fish oil capsules per day will be necessary to provide _1g per day of omega-3 fatty acids.

There is also alpha linoleic acid (linolenic acid, C18:3n-3) which comes from plants, including canola and flaxseed, for which total intakes of 1.5 to 3 g/day seem to be beneficial.

Fish oil is also good for blood pressure because it stimulates arteriolar relaxation, better microvascular compliance, improved endothelial function and enhances nitric oxide production. Even those with already established cardiovascular disease are likely to reduce their risk of cardiac arrest from arrhythmias.

Fish oil also reduces platelet aggregation and exerts anti-inflammatory and anti-atherogenic effects, in return for a modest increase in bleeding times. Those plaques you already have are likely to be more stable and attract less attention from opportunistic passing platelets. Virchow be praised.

I advised *Satu-rated Trans-sicks* that early mankind used to ingest an omega ratio of almost 1:1 Omega 6: Omega 3. The average western diet now has a ratio of closer to 10:1, which is not only extreme, but also dangerous. So eat oily fish, and if the family chef won't change, then at least take fish or flaxseed oil capsules.

Dr BB G-loved

Cover Story

Hearing the revolution

A new technique could change lives

A new technique that uses bio-engineered fibroblastic growth factor to rebuild the tympanic membrane in patients with Chronic Suppurative Otitis Media (CSOM) is being hailed as one of the most exciting developments in ear health and hearing loss since the development of the cochlear implant.

Patient trials now being conducted in WA using the regenerative technique pioneered by Professor Shin-Ichi Kanemaru from Japan have now demonstrated the complete closure of the tympanic membrane perforation in 90 per cent of cases, with complete healing occurring in some patients within weeks of the procedure.

The work in WA is being led by College Fellows Professor Gunesh Rajan and Professor Harvey Coates with their colleagues Professor Francis Lannigan and Mr Steve Rodrigues from the Department of Otolaryngology, Head and Neck Surgery at the University of Western Australia (UWA) with patient trials already underway at the Fremantle Hospital and soon to be underway at the Princess Margaret Hospital for Children. Both academic surgeons now believe that the technique – which is minimally-invasive, cost effective and fast – could mirror the global impact of cataract surgery for the blind, in terms of treating those with hearing loss caused by ear drum perforations.

A serious health condition associated with poverty, there are more than 100,000 Australians with CSOM, with the highest patient cohort found in Aboriginal and Torres Strait Islander children.

Professor Rajan said the new technique involved using a local anaesthetic to allow surgeons to remove the rim of the perforation to stimulate the wound healing cascade with the perforation then plugged with a resolvable gel foam scaffold soaked in the Basic Fibroblastic Growth Factor (b-FGF) and fibrin glue.

Left: Professor Harvey Coates at work and above; Professor Gunesh Rajan with a patient at Fremantle Hospital.

The b-FGF is engineered from E.coli and the fibrin glue derived from the plasma of screened patients with the polypeptide mitogen stimulating the proliferation of epidermal and connective tissue cells and the gel foam acting as a sustained release substrate of the b-FGF.

The procedure takes approximately 10 minutes, the b-FGF costs less than $30 per patient, healing occurs within weeks and hearing is restored.

The treatment offers a permanent cure, particularly in those patients who had suffered multiple middle ear infections.

"The current conventional treatment is a time-consuming, complicated operation that requires a general anaesthetic which is frequently beyond the reach of developing countries as well as Australia's indigenous children in remote communities," Professor Rajan said.

"Professor Kanemaru's ingenious method involves a five to ten-minute procedure for adults, following preparation of the perforation, which stimulates the body to close the perforation itself to reproduce nature's three layer tympanic membrane.

"The remarkable healing qualities of the human body grow back the tissue and close the hole, completely restoring the ability to hear.

"The hearing loss associated with CSOM condemns many people to a life of struggle and poverty by robbing them of their hearing and sadly Australia's Indigenous population has one of the world's highest incidences of chronic ear disease and ear drum perforations."

Now known as the "Smart Ear Fix Method", Professors Rajan and Coates have so far treated 16 patients at the Fremantle Hospital with a 90 per cent success rate with Stage Two of the trials expected to take place at the Princess Margaret Hospital for Children later this year.

Their work builds on Professor Kanemaru's trials which reported the complete closure of 52 of 53 tympanic perforations in a paper titled "Regenerative Treatment of Tympanic Membrane Perforation" published last year in the journal Otology and Neurotology.

According to Professor Rajan, the WA otolaryngology research team is now also working to finesse and improve the technique to suit Australia's particular conditions.

"CSOM is a multi-factorial disease that requires a multi-factorial response and that is what we continue to work on," he said.

"It is about nutrition, about hygiene, about access to clean water so we are working on improving the technique and the scaffold to speed the healing, we are working at making the growth factor more water resistant because getting water in the ear can destroy the healing process and we are investigating how we might rapidly boost nutrition to support that healing.

"We are also working on ways to better treat the infection because this technique does not work on those patients with a current inflammatory infection of the affected ear. "

Professor Coates said he had read of Professor Kanemaru's work and approached him at a conference in the US three years ago to discuss a scientific and clinical collaboration.

"I realised how important his work was, particularly for us here in Australia where we have the worst ear health of any first world nation, with CSOM far more prevalent here than in Japan," he said.

"There has been a lot of activity in terms of understanding and treating Otitis Media and while we have slowly been making progress this technique represents an enormous advance in ear surgery and ear health."

Of global importance

Professor Coates said he would deliver a presentation on the UWA team's work at the American Society of Paediatric Otolaryngology next year and also present the trial results at an Otitis Media Meeting in Stockholm in 2014 while Professor Rajan has already met with World Health Organisation officials.

"This technique will be of global importance and has been described as the greatest advance in ear health since the introduction of the cochlear implant," Professor Coates said.

Now both Professor Coates and Professor Rajan are seeking government and private financial support to fund an "Ear Bus" to take medical teams out into remote areas to treat both adults and children suffering of CSOM.

"We envisage the ear bus as the first way of delivering this new surgical technique to the people in need, but in the future we also believe that GPs and allied health professionals could be trained to conduct the procedure based on very clear protocols and post-operative management guidelines," Professor Rajan said.

"We hope this will be the 'cataract' surgery of ear health in that it takes only a few minutes, you can use very standard equipment, it is affordable and most importantly it can change people's lives forever."

With Karen Murphy

Unity in a multi-ethnic society

The following is the first half of the President's Lecture delivered at this year's ASC, by Professor Chandra Muzaffar from the Universiti Sains Malaysia.

Professor Chandra: Friends, peace be with you. I would like to begin by thanking the organisers, the Royal Australasian College of Surgeons for this very kind invitation. I am happy and privileged to share some thoughts which have been very much part of my research and my writings over the last 40 years about ethnic relations; about multiculturalism in our day and age.

Let me approach this topic from two related angles. I shall look at the challenge of forging national unity within particular multi-ethnic societies and then I shall reflect upon this challenge at the global level.

Let me begin with societies which are multi-ethnic. There are very few societies today which are not multi-ethnic. This is a phenomenon which has become more pronounced since the end of the Second World War for a variety of reasons related to migration, to education, to globalisation; you find that societies have become more and more multi-ethnic.

If we are looking at these societies in general, there's going to be a bit of a problem because multi-ethnic societies, more than perhaps mono-ethnic societies, are difficult to generalise. You cannot draw general conclusions about these societies, which is what social scientists like to do all the while; trying to draw general conclusions about how societies function. That's going to be difficult. But one has to do it nonetheless because you can't be talking about every multi-ethnic society. I wouldn't even dare to talk about my own multi-ethnic society which is one of the most complex in the world.

So with your permission, let me indulge in a bit of unscientific generalisation about multi-ethnic societies in different parts of the world. What are the challenges that confront them? What are some of the solutions? I would regard the following as the three greatest challenges facing multi-ethnic societies everywhere.

Number 1, is the challenge of reconciling individual community identities within a nation state and the identity of the nation state itself. That is one of the great challenges. How does one reconcile the identity of a particular community and the larger identity of the nation state to which that community belongs?

A second challenge is the challenge of wealth and power and how wealth and power are distributed in multi-ethnic societies in such a way that individual communities feel that they have a place in that society in relation to wealth and power. This is a very big challenge.

A challenge which expresses itself in all sorts of ways in different multi-ethnic societies; alienation, marginalisation, the feeling of exclusion, all of this is connected with issues of wealth and power. That's the second challenge.

And the third challenge: How does one develop positive feelings across ethnic, cultural and religious boundaries? A feeling of empathy for the other which goes beyond questions of wealth and power in some instances, it goes beyond institutions and structures. It is at a very fundamental level. How do people feel for one another across religious and cultural boundaries?

So these are three challenges. The challenge of identity, the challenge of distribution of wealth and power, which translates as a challenge of justice; and the challenge of empathy. How you feel for the other; the challenge of empathy.

Friends, what would be some of the solutions to these challenges? Again, we're talking in very general terms. The first, the challenge of reconciling individual community identities with the larger, national identity. If one looks at the attempts by various societies to deal with this challenge, we have had societies which have attempted some sort of assimilation.

In other words, you try to assimilate into the culture of the larger community; the majority community. That's the assimilation approach. It has not really worked. Even in societies which, for a while, one thought that they'd established some sort of arrangement between the different communities, but after a while you find that that arrangement just breaks down. So that, I think, is a model which perhaps we cannot really pursue; assimilation. In other words, wanting everyone to fit into a particular model.

Professor Chandra is a Noordin Sopiee Professor of Global Studies at the Centre for Policy Research and International Studies at the Universiti Sains Malaysia. He is also President of the International Movement for a JUST World.

Professor Chandra has an extensive involvement with non-government organisations including the Global Advisory Council on global climate change, human security and democracy. He is a member of the Governing Council of the International Institute for Dialogue amongst Cultures and Civilisations. This is to select but two from a very significant list of organisations and affiliations. The 2012 President's Lecture which is entitled: The challenge of forging unity in a multi-ethnic society.

At one time, they called it The Melting Pot theory and it was based upon the United States of America. But then they realised that there were some things that just didn't melt into the melting pot. Then, of course, people started talking of the Salad Bowl. Which may make more sense but, in the ultimate analysis, it's very clear that getting everyone to assimilate into a dominant mould just doesn't work.

Then there is the segregation model, meaning by which keep communities separate, minimal interaction, that way they would be able to preserve the identities, they may feel happy. But, again, that model doesn't work. Because you don't have a feeling for the larger polity since you emphasise segregation; in other words, very little interaction and that model has not worked either.

There is, perhaps, a third model which, in some ways, has become the preferred model in various parts of the world and that is integration. The model which social scientists sometimes describe as integration. Meaning by which you recognise the uniqueness of different cultures and religious communities, you accept diversity and provide space for the expression of that diversity within the larger society.

But at the same time, you integrate that society. The various communities come together through the market place, through public areas; they integrate at a certain level. Perhaps there's a common language, a common value system. You have certain common institutions like parliament, for instance, which everyone can identify with or certain symbols; a king, a queen, a flag, a national anthem. But communities retain their individual characteristics. In other words, you integrate at one level, but you also recognise the uniqueness of each and every culture.

I'd like to suggest, friends, since you're here in Malaysia, that my own country is a very good example of that particular model; integration. The different communities that make up Malaysia, the product of different histories, they retain their own characteristics. You have in Malaysia, for instance, a school system where the languages of the different communities in Peninsular Malaysia are part of the national primary school system.

In other words, for six years of primary education, Malays, Chinese and Indians, they go to schools where the medium of instruction, is their own mother tongue. They have a common syllabus, they all learn the national language and they learn ▶

English. National language being Malay, English, of course, the language which is used very widely in this country, but a language that we had inherited from our Colonial past.

So you have education at the primary level in Malay, in Chinese, in Tamil. Then they go on to secondary school where they come together. Malay is the main medium of instruction, but you can still learn other languages as subjects of study at the secondary school level. That's an example of integration at work within the school system.

They're many other examples in Malaysia. If you look at mass media, for instance, you'll find that you have radio and television programmes in the different languages. Sometimes separate channels, but you also have a national channel. This is how we integrate the different communities and it has worked fairly well.

I dare not say that it is a complete success; it is not. But, at the same time, given the complexity of our situation, a society where 60 per cent of the population belongs to the Malay-Muslim community and you have 25 per cent of the nation Chinese in terms of its origin. Another eight per cent Indian and then you have other ethnic communities from Sabah and Sarawak in particular, the Kadazans, the Dayaks; it's a very, very complex society. In fact, in Sabah and Sarawak, those two states which are on the eastern side of Malaysia, you'll find that within those states, the diversity is immense. You have something like 25 different sub-ethnic groups in Sabah and perhaps about 28 different sub-ethnic groups in Sarawak. So these are very, very diverse communities. Yet, we have been able to pull together.

"There are very few societies today which are not multi-ethnic"

We are a nation. There is a sense of oneness. There is a sense of common destiny. We have a lot of problems; there's no doubt about it. Problems related to the distribution of justice, related to wealth, to power, problems of empathy; some of the issues which I raised at the beginning. These are real challenges that confront us. But, at the same time, one has to recognise that the integration model seems to have worked to some extent.

So perhaps that is the model that one should give serious attention to; integration, rather than assimilation or segregation as such.

This lecture will be concluded in the next issue of *Surgical News*.

Workshops & Activities

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

Preparation for Practice

25 to 26 August Melbourne

This two day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice.

Keeping Trainees on Track (KToT)

28 August, Perth; 30 October, Melbourne; 30 November, Sydney

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.

Leadership in a Climate of Change

14-15 September, Sydney

This two day workshop can help you to understand what it takes to be an effective leader in this century. It uses the DISC model (DISC stands for dominance, influence, steadiness and conscientiousness) to examine the nature and practice of organisational leadership, through the exploration of issues such as organisational communication, influence, power and styles of leadership. You can also learn more about working as a team and gaining team commitment. These issues will be discussed in the context of organisational change and management

Supervisors and Trainers for SET (SAT SET)

15 September, Wellington; 26 October, Melbourne

(Vic. Scientific Meeting – incl dinner)

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.

Non-Technical Skills for Surgeons (NOTSS)

28 September, Brisbane; 12 October, Launceston; 12 October, Perth

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.

Surgical Teachers Course

18 to 20 October, Hobart

This revised two-and-a-half day intensive course enhances educational skills of surgeons who are responsible for the teaching and assessment of Trainees. Participants learn the foundation of improved educational skills, which are further developed during the course through practical application. The course is delivered through four main modules, which are integrated to achieve progressive acquisition of knowledge and skills.

Management of Acute Neurotrauma

31 October, Adelaide

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.

DATES
AUG-OCT 2012

NSW

19 - 21 October, Sydney
Process Communication Model

NZ

15 September, Wellington
SAT SET

11 - 13 October, Wellington
Process Communication Model

30 October, Wellington
Non-Technical Skills for Surgeons

QLD

28 September, Brisbane
Non-Technical Skills for Surgeons (NOTSS)

SA

31 October, Adelaide
Management of Acute Neurotrauma (rural)

TAS

12 October, Launceston
Non-Technical Skills for Surgeons (NOTSS)

18 to 20 October, Hobart
Surgical Teachers Course

VIC

25 - 26 August, Melbourne
Preparation for Practice

6 September, Melbourne
How Well Do You Know Your Practice? A Game Plan for Success

21 September, Geelong
Occupational Medicine: Getting Patients Back to Work

17 October, Melbourne
Writing Medico Legal Reports

26 October, Melbourne
Strategy and Risk Management for Surgeons

26 October, Melbourne
SAT SET

30 October, Melbourne
Keeping Trainees on Track

WA

28 August, Perth
Keeping Trainees on Track

3 September, Perth
Writing Medico Legal Reports

12 October, Perth
Non-Technical Skills for Surgeons (NOTSS)

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

Taking the toll seriously

33,900
The Australian Road Safety Collaboration
www.33900.org.au

DECADE OF ACTION FOR ROAD SAFETY 2011-2020

The College Trauma Committee is now part of a zero road toll collaboration

The Chairman of the College's Trauma Committee, Associate Professor Wall has seen some revolutionary changes in public attitudes to health and safety over the course of his life, yet is now working within a nation-wide collaboration to promote what may be the biggest shift of all.

Under the College banner, Mr Wall is a member of a new initiative called Vision Zero 2020 which aims not just to reduce the road toll within the next decade, but to eradicate it.

The initiative will work within a broad coalition comprising road safety organisations, private industry and government bodies established last year called "33,900: The Australian Road Safety Collaboration", named in recognition of the number of people killed or seriously injured in road crashes in Australia in 2010.

That same year, 1.5 million people died around the world in road accidents with 30 million injured, a staggering toll that was recognised by the United Nations as a global disaster. That, in turn, led to a UN resolution to make 2011-2020 the Decade of Action for Road Safety.

With the Federal Government a signatory to the resolution, the collaboration was formed to push for action to improve road safety across the spectrum from vehicle and road design, to learner-driver programs, improvements in rapid trauma care, extra road policing and the increased use of rail to move freight rather than heavy transport vehicles.

Associate Professor Wall said that while the aim of zero fatalities in 2020 was ambitious, it was achievable.

"I have been privileged to see in my lifetime some amazing advances not only in the design of roads and cars to maximise safety, but also in public thinking," he said.

"I can remember how the College worked so hard to get mandatory seat belt laws in place and the reaction of some people at the time that they were a dreadful 'un-Australian' idea, as if we were asking them to give up a limb.

"Yet that was an Australian win, the wearing of helmets was an Australian win, we were in the vanguard of wide-spread testing for alcohol and drugs and now all these initiatives are taken for granted.

"Therefore I see no reason why we cannot eliminate road deaths if we are committed enough.

"This is not to say there will be no accidents for there will always be human error, but if roads are designed well, if car safety features are improved, if driver education is as good as we can make it and if we as a community have a zero tolerance for road deaths, people will not have to die."

Participants of the 33,900 Collaboration include:

- the RACS;
- the Australia New Car Assessment Program (ANCAP);
- the Australian College of Road Safety (ACRS);
- the Australian Road Research Board (ARRB);
- the Australian Road Assessment Program (AusRAP);
- Anglo Coal and BHP Billiton;
- the National Transport Commission;
- the Centre for Road Accident Research and Road Safety; and
- the Federal Department of Employment, Economic Development and Innovation.

Associate Professor Wall said the collaboration was keen to follow the lead of Sweden which, following its decision to embrace a zero tolerance to road fatalities, reduced its death toll down to one per 100,000 of population per year.

He said that while Australia's road death toll was once as high as 50 deaths per 100,000 prior to the introduction of mandatory seat belt laws, we now had five deaths per 100,000.

He said the collaboration had established five pillars for road safety action to guide the group's activities over the next few years.

Change road use

The first is Road Safety Management which is aimed at creating partnerships to lead the national road safety strategy including research, advocating improvements in road design and evaluating changing road use such as moving freight from road to rail.

Associate Professor Wall said: "Under this Pillar we are looking at projects such as the Peak Downs Highway Road Safety Alliance in Queensland which is working to eliminate deaths on this road which is a known black spot. With more mines likely to be established in the area, key stakeholders are working to fully understand the causes of mortality and morbidity along the Highway and eliminate all deaths within the next decade."

The second is called Safer Roads and Mobility which aims to make roads safer for all road users including cyclists, drivers and pedestrians.

Third is Safer Vehicles which will work to lessen the likelihood of an accident (primary safety) and increase the safety of occupants in the event of an accident (secondary safety).

Mr Wall said: "Scientists and researchers believe we have achieved only about 100th of the safety possibilities in modern vehicle engineering, in other words that we have just scratched the surface. The increased use of cameras and the ultrasound detection of obstacles and environmental hazards all offer great potential to increase safety for both passengers and other road users."

The Fourth Pillar covers Safer Road Users.

"We know that 25 per cent of accidents are known to be a result of illegal activities so it is clear that we need much more intensive road policing," Associate Professor Wall said.

"Obviously that will cost money, but it would be negligible when compared with the cost of treating the severely injured and the incalculable cost associated with deaths on the road.

"Under this Pillar we are also looking at how we can change the driving behaviour of young men who don't fully understand consequences and risks until they are aged 30. We now have clear evidence, however, that shows that if you teach young male drivers CPR and present them with road accident scenarios that have some fidelity, their behaviour does change.

"There is also a project called the Prevention of Alcohol Related Trauma and Risk Taking Behaviour which allows young learner drivers to meet young people who have been severely injured in car accidents and that also is proving very effective."

The final Pillar covers Post Crash Response in which the RACS will have most input.

Associate Professor Wall said widely available community education programs teaching CPR, an increase in both ambulance services and paramedic numbers, more advanced training and the increased use of telemedicine would all be researched, promoted and advocated to State and Federal Governments under this arm of the 33,900 Collaboration. ▶

"The collaboration was formed to push for action to improve road safety across the spectrum"

"The rate of change in the information we are getting on the care of the seriously injured is accelerating all the time and we need the training and systems to keep up," Associate Professor Wall said.

"We have even learnt an enormous amount from Australia's involvement in Iraq and Afghanistan in terms of getting injured soldiers into an Australian medical base, stabilising them and moving them onto sophisticated hospitals in Europe, all of which we can use in this road safety campaign.

"We know that you can move the severely injured, for example, but you have to time it very carefully."

Associate Professor Wall said as part of the RACS' commitment to Vision Zero 2020 and the 33,900 Collaboration, it will be hosting a Symposium in November to bring together representatives of all road users such as drivers, cyclists, emergency services and transport companies.

Rail for freight

He said the RACS plans to advocate that roads should not be shared, that cyclists need dedicated bike lanes and that rail should replace roads for national freight delivery.

"The Trauma Committee has chosen to advance road safety through a campaign to separate all road users including pedestrians, cars, cyclists, heavy vehicles and rail crossings," he said.

"I have a dream that within the decade someone could ride all the way around Australia and through every city and town on a dedicated bike path.

"It is an enormous engineering challenge and it will require a fundamental attitude shift from all road users to achieve zero road deaths by 2020, but I have seen enough miraculous advances in my lifetime to believe it can be achieved if we want to achieve it."

With Karen Murphy

KEW MEDICAL
SPECIALIST CENTRE

260 COTHAM RD KEW 3101

New fully furnished medical rooms to lease weekly or full time

- 6 Fully equipped modern decor medical suites
- 2 Separate generous patient waiting rooms
- Fully air-conditioned
- Opposite Cotham Private Hospital
- Tram stop outside front door
- Excellent off street parking for 20 cars

Enquiries - Phone: 9817 2608 8am - 5pm

NSW GOVERNMENT Health
Hunter New England
Local Health District

Locum Visiting Medical Officer in ENT Otolaryngology Surgery (Head and Neck) John Hunter Hospital, Newcastle

Applications are sought from suitably experienced ENT and Otolaryngology Surgeons with skills in head and neck surgery as well as microvascular reconstruction. This role focuses on the provision of elective and emergency ENT surgical services.

Applicants must have a medical degree registrable in NSW and possess Fellowship Royal Australasian College of Surgeons (FRACS) or other specialist recognition as provided for in the Staff Specialist (State) Award or Health Insurance Act (1973).

Enquiries: Dr Paul Walker, (02) 49562460
Applications and Information: Kerrie Kelly, Senior Medical Recruitment Consultant 0417635206
kerrie.kelly@hnehealth.nsw.gov.au

Position # 85940 Closing Date: 2/9/12

New tools to aid IMG assessment

International Medical Graduates are important for Australasian healthcare

International Medical Graduate (IMG) surgeons form a vital and important role in service delivery to Australia's healthcare consumers. Increasingly IMGs are attracted to regional areas where there is a workforce shortage of Australian and New Zealand trained surgeons.

IMG surgeons wanting to practice in Australia must undertake a specialist assessment process which is conducted by the College in conjunction with the Australian Medical Council (AMC) and Medical Board of Australia. This process ensures that IMGs seeking to practice in Australia are comparable to locally trained surgeons.

The IMG surgeon assessment process consists of:

- a document based assessment of their education, qualifications and training; and/or
- a semi-structured face to face interview.

If an IMG is assessed as not comparable to a locally trained surgeon then to pursue a surgical career they must apply to and complete the College's Surgical Education and Training (SET) program.

Partially comparable IMGs must undergo 12 to 24 months of clinical assessment under supervision and pass the Fellowship exam in order to be awarded the Fellowship.

Substantially comparable IMGs are required to undertake 12 to 24 months of clinical assessment under oversight. In addition, the IMG will be required to undertake any additional skills courses and activities nominated by the Assessment Panel.

At any one time the College has 70 to 80 IMGs in clinical assessment. While Trainees on the SET program are assessed in posts accredited against standardised criteria, no similar system exists for IMGs. Assessment posts are approved as required, but may not necessarily conform to a similar standard.

Clinical assessments and examinations – necessary components of the overall assessment of an IMG – do not always test comparability against all of the College's nine competencies. The Fellowship Examination as an assessment tool is mainly restricted to the domains of clinical judgement and decision making, medical expertise and communication. It does not address the other key competencies of technical expertise, collaboration, management and leadership, health advocacy, scholar and teacher and professionalism.

As a result, the College has introduced three new assessment tools to assist in the clinical assessment of an IMG's clinical practice. The three new assessment tools are:

- Multi-source feedback (MSF) or 360 degree evaluations – This tool is used to ascertain an IMG's performance from other medical and nursing staff at the hospital where the IMG is based. It is a method of assessing competence within the remit of a team.

As part of a multi-professional team, IMGs work with other people who have complementary skills. They are expected to understand the range of roles and expertise of team members in order to communicate effectively to achieve an excellent service for the patient.

At times they will be required to refer upwards and at other times assume leadership appropriate to the situation. MSF or 360 degree evaluation comprises a self-assessment and the collated views from a range of co-workers of an IMG's performance. Competencies assessed include technical expertise, communication and collaboration.

- Direct Observation of Procedural Skills in surgery (Surgical DOPS) is a method of assessing competence in performing diagnostic and interventional procedures during surgical practice.

It facilitates feedback in order to develop behaviours and performance related to operative, decision making, communication and teamwork skills. The assessment involves an assessor (a surgeon) observing the IMG perform an operative procedure within the work place. The assessor's evaluation is recorded on a structured checklist, which enables the assessor to provide verbal and specific feedback to the IMG immediately after the procedure. The observed procedure should be a major procedure that the IMG has had prior exposure to.

- Mini-clinical examination (mini-CEX) is a method of assessing a range of clinical assessment and management skills in various clinical settings. It facilitates feedback in order to develop behaviours and performance related to knowledge, communication, decision-making, management and advocacy skills.

The assessment involves an assessor (a surgeon) observing the IMG interacting with a patient within the work place and in an unrehearsed clinical encounter. The assessor's evaluation is also recorded on a structured checklist. The nature and complexity of the patient's condition should be equal with what the IMG as a consultant surgeon would be expected to encounter in surgical practice.

IMGs are required to participate in at least one DOPS and mini-CEX assessment during each three-month term, and one MSF or 360 degree evaluation during each six-month term while under supervision or oversight. Performance of an IMG undergoing clinical assessment is judged against predetermined, publicised standards (the College's nine competencies).

The aim of the introduction of the three new assessment tools, in addition to the requirements stipulated for clinical assessment and/or Fellowship Examination, is to clearly identify the areas of unsatisfactory performance and to provide support, supervision and any additional up-skilling or training to allow the IMG to meet the standards of a competent and proficient surgeon.

Barry O'Loughlin,
Deputy Chair of BSET

WA update

Time flies when you're having fun

The College was involved at the recent Australian Medical Student Association's National Convention.

With the Four Hour Rule being introduced into Western Australia and the removal of the medical practitioner exemption from jury duty, our immediate past Vice President, Mr Keith Mutimer, joked that it was 'all happening in WA'. Wishing this wasn't necessarily the case the WA Committee has been working hard to further these and other issues.

Following increased pressure on the WA State Government by my predecessor, Dr Jess Yin, and the state committee, a study of the Four Hour Rule was commissioned and Professor Bryant Stokes was tasked with putting the poorly conceived and under-resourced initiative into perspective.

The report is available online (link below) and has come up with some interesting and yet predictable observations, ranging from the re-engaging of consultant staff to improvement of patient safety, through quality of care and adequacy of staffing numbers.

http://www.health.wa.gov.au/publications/documents/FourHourRule_Review_Stokes.pdf.

As yet, despite assurances, we are awaiting a timeline for the implementation of the many recommendations made in the above report. We would be hopeful that, as such, these recommendations will in turn be taken on board by the health departments around Australia.

Workforce

One of the most important offspring from the above review, however, is the health department's closer scrutiny of the workforce issues being faced in WA. Much discussion has ensued between WA Health Minister Kim Hames and myself, Colin Whitewood, the Chairman of the WA Branch of AOA and James Aitken, who as Clinical Director of WAASM, has the statistics and workforce information at his fingertips.

These discussions have been stimulating and confronting to say the least and have highlighted the significant shortage of surgeons in WA both presently and into the longer term. With the opening of the new Fiona Stanley Hospital in WA planned for mid-2014, a spotlight has been focused on the surgical workforce needs of the future.

The advice, statistics and information have been provided to the Health Minister and Director General on multiple occasions and, we understand, are being worked on to what we believe will be a positive outcome for surgery and health delivery in general.

This is very much a long term project and more work is planned in this area.

Jury Duty

An article published in the West Australian late last year headlined 'Doctors want to get out of jury duty', brought to a head the fact that WA, like many other states has lifted the exemption on doctors to be summoned to jury duty.

The AMA and the AOA have come on board to appeal this exemption's removal with the hope that the Attorney General will be sensitive to the fact that patient care is bound to be significantly compromised by this action.

Thus far, the Attorney General has not moved from his stance that doctors must now perform what is considered their civic duty. Currently jury duty itself may be deferred for up to six months, which is considered an adequate time for medical practitioners to re-schedule appointments.

However, although automatic exemption no longer applies, the summoning officer and the trial judge can refer to a 'Critical Impact Assessment' which allows a person who can identify significant impacts on others associated with the effect compulsive jury duty will have on their attendance to their occupation, to be excused without the need for a deferral.

Here each case will be dealt with on a case by case basis. The Attorney General assured me that particular circumstances of doctors and specialists will not be overlooked by summoning officers when assessing the merits of an application for excusal.

Despite this appeal, on very reasonable grounds and across a broad front of the health care sector, it would appear jury duty is here to stay. We are still collecting data in WA on surgeons called for jury duty, their empanelment rate and the impact on patients in general (both public and private).

UWA Surgical Society

Noteworthy is the fast growing UWA Surgical Society. They are an enthusiastic and energetic group of senior medical students and junior residents who are aspiring to use their networking ability and energies to bring surgery into a new dawn. Headed by president James Preuss, the society is run out of the University of Western Australia and boasts more than 300 members.

James and members of his team have attended WA State Committee meetings frequently to update us on the progress the Society is making. The Committee and Regional Office has successfully assisted the Society on multiple occasions with Career Expos, key note speakers and various other events, including a highly successful 'Women in Surgery' evening. We look forward to the Society continuing to prosper and, indeed, providing many future Trainees.

Australian Medical Student Association National Convention

The Royal Australasian College Of Surgeons were involved with the recent AMSA National Convention held at the Perth Convention and Exhibition Centre. We enjoyed one on one contact with many of the more than 1000 students registered who enjoyed either attending our booth or listening to some of the many speakers representing surgery. The feedback received from the students was excellent and indicated an elevated interest in surgery.

On a more personal note, I am thoroughly enjoying the role as Chair of the Western Australian Committee. I feel very fortunate to have such a wonderful and hardworking group of fellow committee members and office staff who make this role all the more enjoyable. Special thanks should also go to my predecessor, Dr Jessica Yin, for her enthusiasm and limitless ability, to Mr James Aitken for his tireless efforts in bringing the rest of us up to speed on workforce shortage and other issues, and my long suffering wife Joylene for her endless support and good humour!

Wishing you all the best in health and surgery.

Robert Love
Western Australia Regional Chair

The Royal Australasian College of Surgeons seeks a

Long term Ophthalmologist

to work in its program in Timor Leste (East Timor)

Are you up for the challenge?

Based at the National Eye Centre, *Hospital Nacional Guido Valadares* in Dili and working closely with in-country staff, your position will involve:

- Working closely with the Ophthalmology team in leading ophthalmology services at the National Eye Centre
- Supporting district outreach services
- Assisting in the management and running of the Eye Departments in the district hospitals
- Providing in-country training, mentoring and supervision for East Timorese doctors, nurses and other health personnel
- Engaging in surgical audits and conducting public health research
- Liaising with and supporting visiting eye teams from Australia
- Contributing to the development and implementation of eye treatment protocols and standards of care

Interested?

Send your CV and Cover Letter to RACS today!

You need to:

- Be a fully-qualified General Ophthalmologist (Fellow of RANZCO or an equivalent international body preferred);
- Have confidence in your clinical skills in challenging environments;
- Be passionate about working in a developing country; and
- Be available long term (at least 12 months).

The remuneration package includes secure accommodation in Timor Leste's vibrant capital city, as well as access to a vehicle for work purposes.

Contact:
karen.moss@surgeons.org
+61 3 92767436

"Despite appreciating that surgical interns can greatly influence the students' clerkship learning environment, there is currently limited understanding of their exact role"

Improving learning

The Academy of Surgical Educators 2012 ASC Surgical Education Research Prize

The South Auckland Clinical School Surgical Research Team visiting Red Rock Canyon, Las Vegas, Nevada (clockwise from top left: Dr Parry Singh, Miss Ashleigh Young, Dr Tzu-Chieh Wendy Yu, Professor Andrew Hill, and Dr Daniel Lemanu).

The winner of the 2012 ASC Surgical Education Prize was Tzu-Chieh Wendy Yu who presented a paper entitled "Improving the Learning Environment of Medical Students during General Surgery Clerkships – How Can Interns Help?" This paper was the result of collaborative research with Daniel Lemanu, Marcus Henning, Andrew MacCormick, Susan Hawken and Andrew Hill.

Junior doctors fulfil crucial roles in undergraduate medical education. As clinical preceptors they are advantaged by the large amount of clinical time they spend with medical students and play an important role due to the directness of their supervision, closeness in age and professional development.

Despite appreciating that surgical interns can greatly influence the students' clerkship learning environment, there is currently limited understanding of their exact role in student learning. Without this knowledge, it is difficult to support interns in their role as student preceptors.

A mixed-methods study was conducted by the Department of Surgery at South Auckland Clinical School, University of Auckland to explore how general surgical interns contribute to the clinical learning environment of medical students. It was conducted in collaboration with the Department of General Surgery, Middlemore Hospital, Counties Manukau District Health Board.

In June 2011, six general surgical interns from Middlemore Hospital volunteered to participate in the first of two study focus groups, conducted to explore their perceptions about intern-facilitated student learning. Two investigators led the focus group and data transcripts were systematically analysed using codes to cluster together common opinion and generate themes.

A second focus group was then conducted in August 2011, attended by five volunteer Year 4 medical students from the University of Auckland who had completed their six-week clerkships with the Department of General Surgery at Middlemore Hospital.

After qualitative analysis of focus group transcripts, it emerged that surgical interns play four distinct roles when contributing to student learning – the Physician, Teacher, Supervisor and Individual. As the Physician, interns contributed to student learning by role modelling clinical and profession competencies. They also contributed to student professional development by offering job and training advice and personal insights into "what it's like being a doctor".

As Teachers, surgical Interns gave brief explanations during routine clinical activities such as admission of acute patients and ward rounds, pointed out interesting cases, demonstrated ward procedures and answered many of the students' questions. In this way, interns complemented teaching conducted by consultants and registrars.

In the role of Supervisors, the intern's key task was integrating students into the surgical team. They were responsible for orienting students to the hospital environment, explaining team schedules and work-place protocols, and involving students in patient care. Students in particular appreciated this as it made them feel 'part of the team' and increased their motivation to learn.

Lastly, as Individuals, interns significantly influenced the clerkship learning environment by demonstrating approachability, friendliness and helpfulness. Their ability to relate to students was also a highly appreciated quality.

Armed with this new appreciation for how surgical interns contributed to student clerkship learning, the investigators then constructed a questionnaire to gather quantitative information about intern-facilitated clerkship learning from a larger sample of Year 4 students at the University of Auckland.

It was distributed in September 2011 and 85 completed questionnaires were returned (response rate of 67 per cent). The questionnaire also collected data on the frequency, duration, setting and content of intern-led learning encounters during surgical clerkships.

In summary, the questionnaire results found that intern-student encounters typically occurred on a daily basis, lasted one to two hours and occurred in the surgical wards or in the emergency department when interns were assessing and admitting acute patients.

Interns most commonly taught students about ward procedures, interpretation of laboratory tests and radiology and administrative tasks and processes. Of all the desirable intern attributes, the questionnaire results showed that approachability, friendliness and ability to relate to students were deemed to be the most important.

Students also indicated that interns were valuable for establishing clerkship expectations and learning outcomes and helping students build on pre-existing knowledge. Finally, there was overwhelming agreement among students that interns are crucial in making them feel less like a burden to the team and this is closely linked to enjoyable clerkships.

Based on these study findings, the investigators concluded that surgical interns play an important role in integrating students into the surgical team and this consequently has a significant impact on student learning. Furthermore, interns can influence the student learning environment simply by demonstrating interpersonal skills such as approachability, friendliness and relatedness. It is hoped that these finding will help to better prepare surgical interns for their role as clinical preceptors.

Tzu-Chieh Wendy Yu

Surgeons leading cultural change in patient care

Annual Victorian Scientific & Fellowship Meeting

FRIDAY 26 OCTOBER & SATURDAY 27 OCTOBER 2012
Venue: Rydges Exhibition St, Melbourne

Dinner Venue: MCG
(pre-drinks in the National Sports Museum with guest speaker Prof David Fletcher)

CALL FOR ABSTRACTS

Please indicate that your abstract is for AVSFM 2012 and which area you wish your topic to be submitted under.

All successful abstracts will be printed in the Final Program.

ABSTRACT SUBMISSION DEADLINE IS FRIDAY 10 AUGUST 2012

All Submissions must include:
- A title
- An abstract of 250 words or less
- A short presenter bio (50 words) to facilitate the Chairperson's introduction
- Authors (Presenter in CAPS and UNDERLINED, i.e J.L.M Peterson, A.K.MATTHEWS, A. Thomas, N. Bravo)
- Address and Contact Details
- Conflict of Interest Declaration

Email: denice.spence@surgeons.org

Prizes for the following categories:

2012 DR Leslie Prize – For the best clinical registrar paper

2012 RC Bennett Prize – For the best laboratory based research paper presented

Audio visual instructions will be sent to all successful authors.

Please note that single case reports will not be accepted for presentation or poster

Royal Australasian College of Surgeons
Denice Spence,
Victorian Regional Manager,
Royal Australasian College of Surgeons,
College of Surgeons Gardens,
250 - 290 Spring Street, East Melbourne ,
VIC 3002, Australia
Telephone: +61 3 9249 1254,
Fax: +61 3 9249 1256,
Email: denice.spence@surgeons.org

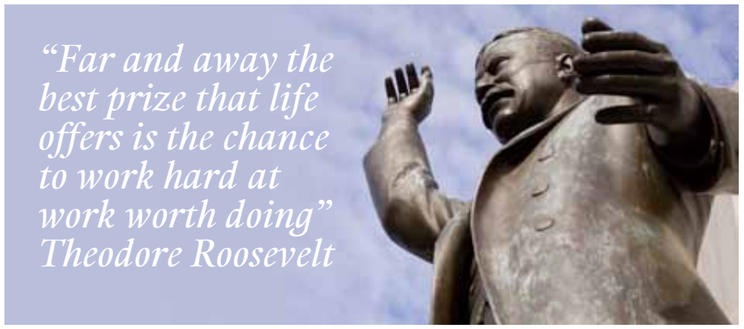
Taken to task

If you're not moving forward, you're going backwards.
If you're standing still, then you'll inevitably be left behind

The College is undoubtedly moving forward right now, it is currently evaluating all its activities and processes, and a more relevant, functional and value oriented organisation will be the end result. Value for money is high on the agenda, giving every dollar of Fellows' subscriptions a use and purpose, with the aim of eliminating unnecessary waste and duplication.

Evaluation and re-evaluation are the keys to progress for any organisation or individual. Identifying areas of need and redressing them is key to improvement. Refreshing your knowledge, your skills and then adding to them are fundamental to gaining insight, defining purpose and providing relevance. This process is useful not only to the college as a whole, but to Fellows individually as well.

The younger Fellows have been tasked with focusing this process in certain key areas.



Task 1

Developing a new 'welcome pack' for new Fellows and Trainees

A detailed user friendly guide outlining College processes, or a 'welcome pack' is essential for new FRACS members and new Trainees to understand the workings of the College and to provide pathways for those interested to become involved in College activities. There is a lot of great work the College does, but it is not always so good at advertising these great works, and this will be a chance to redress that.

What would you have liked to receive upon achieving FRACS and convocating?

Would you like to see more information on financial advice or business practice models? Would you want to see advice on how to become an examiner with the court? Or would you want a blueprint on how to become the president one day?

Please let me know what you think would be of benefit to new Fellows or Trainees and to help us clean the doors of perception as the new Fellow walks through them.

Task 2

'How I Do It' videos

As a resource for learning, 'How I Do It' videos are invaluable. The College e-learning platform is in its infancy, and the aim is to create a database of operations performed for the benefit of Trainees and younger Fellows which could then be viewed online and accrue CPD points as part of the learning process.

If you have any such material or would be interested in providing some, please contact me so we can develop a library for the benefit of all.

Task 3

Leadership and mentoring

All of us have 'heroes', maybe even idols, but certainly we all know Fellows, scholars, and teachers who have helped shape our career and enlivened our surgical journey.

All surgeons are role models (like it or not, mostly good but sometimes bad) and all have had mentors either informally (mostly) or formally.

Setting up a mentoring network for all surgeons and Trainees regardless of what stage of their career they are at will enable a greater sense of fellowship, a closer community and allow for greater dissemination of knowledge and experience and allow for a smoother transition through the various stages of a surgical career.

All ideas and all those interested in being a part of this work are most welcome to help progress this great initiative; please contact me to let me know your ideas or your interest in participating.

Task 4

Business for Trainees

Many training programs offer teaching about running a successful business, either during or after graduation. We would like to develop a module for Trainees to begin their journey with some knowledge of the pitfalls and pathways to optimise their career development.

"The world is full of willing people, some willing to work, the rest willing to let them," – Robert Frost

All ideas, comment, information, etc, are greatly appreciated.

The College is here for your benefit, join in and let us know how we can do it better for you.

Richard Martin,
College Councillor

Trainee Working Hours

Where is the Balance?

How many hours per week should a surgical Trainee work? Has declining working hours stunted our training, compared to previous generations? Or should Trainee hours be reduced further, to allow more time for rest, study, and life outside surgery?

These questions are currently hot topics for Surgical Colleges and Trainees Associations world-wide. In the UK, surgeons have criticised the European Working Time Directive for hindering training opportunities and compromising models of surgical care. In the US, the introduction of uniform duty-hour regulations has been just as controversial.

Within this context, a RACSTA Working Group has recently undertaken a comprehensive review of surgical Trainee working hours in Australia and New Zealand. A primary aim of the working group has been to understand our current working hours and rostering habits, which had not been well defined. The group also attempted to identify the most appropriate working hours for Trainees, in order to compare current practice against an ideal standard.

One important part of the research was to comprehensively survey Trainees from all specialties to determine their working hours, experiences and attitudes. The survey received a healthy response rate of 55 per cent, and has been of great value to the working group. The results have been released in full in two publications in the *ANZ Journal of Surgery*. [1,2]

The findings of the survey showed that ANZ Trainees work on average around 61 hours per week, with 75 per cent of Trainees being on call for an additional 28 hours per week.1 There were only slight differences between Australia and New Zealand, but some variation was noted between the specialties, with neurosurgical Trainees working the longest hours (73 per week). By international comparison, ANZ Trainee working hours are around average, being more than in the UK, but less than in the US.

These findings compare reasonably well against the RACS Safe Working Hours Standards, showing our profession has generally been responsive to the need to manage fatigue. However, 13 per cent of Trainees still work more than the 70 h/week recommended in the Standards, and 5 per cent exceed 80 h/week. The Standards also wisely recommend a good nights' rest, however, due to the demands of 24 hour service provision, many Trainees doing on-call shifts routinely obtain less than five hours of uninterrupted sleep, which can induce fatigue.

Therefore, while most Trainees work near the suggested RACS Standards, ongoing efforts are still needed to promote safe rostering practices. For example, of significant concern was the finding that nearly 30 per cent of Trainees reported 'sometimes' or 'often' momentarily dozing while driving to or from work.

Attempting to identify an ideal balance of Trainee working hours proved a more difficult exercise for the working group.[2] The demands of training and service provision compete with the need to rest, study, and enjoy life outside surgery, and the appropriate balance between these factors can vary between individuals.

An overall 'ideal work-life balance' is often thought of as unattainable for Trainees, but the survey was able to consistently identify 60 h/week as providing a reasonably good balance between the factors competing for our time. Below 60 h/week, Trainees tended to perceive that their training needs were not being met, whereas above 65 h/week, Trainees tended to experience more fatigue, potentially compromising their work, study, and driving safety. Study and work-life balance needs were better satisfied at around 55 h/week.

In conclusion, the working group found that current ANZ training hours are about right, being close to the appropriate balance of 60 hours per week.

In a prominent recent commentary, Purcell Jackson and Tarpley suggested that it takes perhaps 15,000 contact hours to train a surgeon.[3] Although raw working hours are a blunt measure of training quality, current ANZ training hours also accord well with this target. Taking into account annual leave, this equates to about 15,000 hours.

We thank all those Trainees who took the time out from their busy schedules to contribute to this work. The findings support the status quo, and it is hoped the data might proactively inform the working hours debate in our region. Unlike in the UK and US, important decisions on surgical working hours should not be left to others, who do not fully understand the complex demands of our profession.

Greg O'Grady
Member of RACSTA Working Hours Group

Members of the RACSTA Working Hours Group were: Simon Harper; Ben Loveday; Brandon Adams; Matthew Peters; Ian Civil

References and Further Reading

1>Working hours and roster structures of surgical trainees in Australia and New Zealand. *ANZ J Surg* 2010;80:890-5.
2>Appropriate working hours for surgical training according to Australasian trainees. *ANZ J Surg* 2012;82:225-9.
3>How long does it take to train a surgeon? *BMJ* 2009;339:b4260.

A History of War Surgery

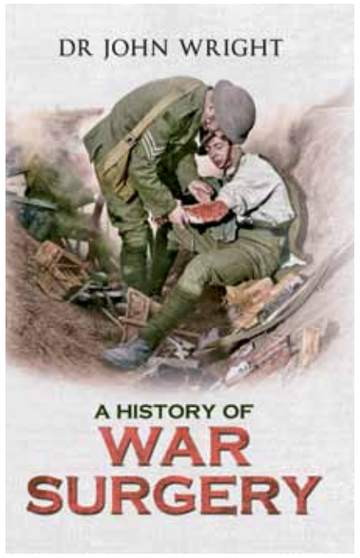
From antiquity to Afghanistan, in A History of War Surgery, John Wright has outlined the milestones in the development of this discipline.

This book is essentially about all those who provide that care; from stretcher bearers to surgeons and so many others; the overwhelming challenges faced, the personal impact. For this, John Wright has used a very fine brush.

For the student of military surgery, this volume will be an indispensible addition to one's library. The depth and detail of the research is exemplary; but what sets this volume apart is that the author has detailed the personal experiences of many who served, both from their personal diaries and from his own interviews. This is an attempt "to understand the challenges that faced war surgeons and their teams, how they responded to those challenges. "

The origins of trauma surgery are described from the archeological record, such as the evidence of trephined skulls from around 15,000 BC. From the historical record, the evolution of military surgery is charted; Greek, Roman, Arabic influences and through the Middle Ages to the Napoleonic Wars. The further evolution of military surgery through the Crimea, the American Civil War, World Wars 1 and 2, and the current conflicts in Iraq and Afghanistan is detailed. The impact of selected smaller conflicts and civil wars is briefly described. Advances in antisepsis, anaesthesia, battlefield recovery, resuscitation, damage control surgery and echelons of staged care are placed in their historical context. There is a fascinating chapter on the American political assassinations.

What I found best about this book are the extracts from diaries, from other personal accounts, but especially from the interviews of the author with those who had cared for the wounded. These extracts poignantly recall the profound



impact of triaging and treating hundreds of wounded, such as those of: surgeons at Waterloo; Edward Wrench, a British surgeon at Balaclava; Dr. Jonathan Letterman, the Medical Director of the Army of the Potomac; Matron Grace Wilson at Lemnos and Sister Alys Ross at Rouen, both of the Australian Army Nursing Service; a report describing the terrible conditions in a dressing station in the Libyan campaign of 1941.

Interviews by the author with AIF regimental medical officers, several decades after WW 2, describe their frustration at grossly inadequate preparation, little use of their skills and no attempts to improve those skills. A US Army surgeon's assistant describes his experience from Normandy to the Battle of the Bulge to entering Buchenwald.

The differences and challenges to the medical services of the WW2 campaigns in North Africa and Europe are

"For the student of military surgery, this volume will be an indispensible addition to one's library"

described; in particular highlighting the exceptional challenges in the south west Pacific. The sophisticated system of levels of care developed in Iraq and Afghanistan has resulted in the lowest mortality rates from wounds, mostly due to IEDs, in the history of warfare.

The book also deals with those injured in mind. There is a moving account of the indomitable spirit of some multiple amputees. It looks at the permanent impact on 'middle America', those communities that provide a disproportionate number of their sons and daughters to the US military.

Most chapters have detailed reference lists, which will provide a very useful guide for any researcher wishing to explore a topic in greater depth.

John Wright has had a very distinguished career as a cardio-thoracic surgeon; the first Australian to obtain a professorial appointment in that discipline as the Foundation Head of Paediatric Cardiac Surgery at the Prince of Wales Hospital, Sydney.

Cliff Pollard
Queensland Fellow

A History of War Surgery is published by Amberley Publishing PLC, Gloucestershire, UK;
www.amberley-books.com
Priced $39.95 plus postage.

The VASM Annual Report

The latest report from the Victorian Audit of Surgical Mortality

The 2011 report of the Victorian Audit of Surgical Mortality (VASM), a quality assurance program aimed at the ongoing improvement of surgical care, was released on 22 May, 2012.

The audit process is designed to monitor the surgical system, address process errors and identify significant trends in surgical care. It is vital to improving the quality of healthcare in Victoria and is funded by the Victorian Department of Health (DH) and managed by the Royal Australasian College of Surgeons. VASM works closely with the Victorian Surgical Consultative Council (VSCC), which reports to the state's Health Minister, on issues of surgical care.

VASM involves the clinical peer review of all cases where patients have died while under the care of a surgeon. Cases notified to VASM are reviewed by at least one surgeon, practicing in the same specialty. The assessors are unaware of the identity of the treating surgeon, the hospital in which the death occurred and or the name of the patient.

Where there is insufficient information for the assessor to reach to a conclusion, or if further review of the case is felt necessary, a detailed case note review by another independent surgeon is done.

The feedback is formally directed to the treating surgeons for their consideration and is essential to the audit's overarching purpose – the provision of ongoing education to surgeons and the improvement of surgical care.

VASM noted that all Victorian public hospitals, 80 per cent of Victoria's private hospitals and 87 per cent of Victorian Fellows are now actively participating in the audit.

The 2011 annual report contains clinical information on 4,177 deaths reported over the past four years. Of these 4,177 deaths, 2,013 have completed the audit process. The remaining cases are still under review and will be included in next year's annual report. The annual report is sent to all surgeons and hospitals, and is available at www.surgeons.org/VASM

Colin Russell
Clinical Director, VASM

Following my retirement, I am pleased to announce that Mr Barry Beiles is taking over as Clinical Director of the VASM project. He brings a wealth of knowledge from his time spent on the Vascular Audit. I would like to thank the Victorian Fellows for your ongoing commitment to the mortality audit process.

Among the findings in the 2011 annual report:

- The majority of surgical deaths in this audited series occurred in elderly patients with underlying health problems.
- The actual cause of death was often linked to their pre-existing co-morbidities
- Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved, and not the surgical treatment provided.
- Only 10 per cent of audited cases required a detailed case note review, or second-line assessment.
- Unplanned return to the operating theatre, often necessitated by a complication of the initial procedure, is associated with increased risk of death. Consultant involvement in such complex cases is important and has increased significantly with time.
- There has been a significant decrease in the frequency with which assessors are identifying issues of clinical management. In 85 per cent (1,713) of audited deaths no or only minor issues of patient care were suggested. Sixty nine per cent of these clinical management issues were attributed to the surgical team. Only five per cent of these management issues were felt to have contributed to the death of the patient.
- In six per cent of the 2,013 cases, the clinical management issues were serious enough to be classified as adverse events by reviewers.
- Assessors identified more clinical management issues than the treating surgeons. This is not unexpected and underlines the value of independent peer review.

Tharawal Elder, Staff and CEO Darryl Wright , Peter Corlette ENT specialist and Mike Harman from Inline Medical and Dental, during installation of microscope.

Continuing Indigenous health support

"Although it is nice to say that governments need to do this and communities need to do this, by us rolling up our sleeves and pulling up our socks, and by the Foundation for Surgery showing they are serious about supporting Indigenous health initiatives, we can actually show that we as surgeons, we as Fellows of the College of Surgeons, want to help, and can provide help through donations to the Foundation for Surgery. This will give us the infrastructure and the capital to do more great work and add to what has already been done." Kelvin Kong

Foundation for Surgery Supports ENT Outreach Clinic at Tharawal Aboriginal Medical Service

Simon Greenberg and Peter Corlette are two of many College Fellows across Australia providing specialist care to Aboriginal and Torres Strait Islander communities through outreach clinics. Simon and Peter are Ear Nose and Throat (ENT) surgeons, who for the past year have been providing regular ENT outreach clinics at the Tharawal Aboriginal Medical Service in Campbelltown, south-west of Sydney.

Tharawal is a well-established and successful Aboriginal community controlled health organisation providing general medical practice services, preventative health care and community education programmes for Aboriginal families and individuals living in the MacArthur region (Campbelltown, Camden and Wollondilly). Tharawal has a patient register of 3,800 active patients (about 95 per cent Aboriginal and Torres Strait Islanders). Tharawal is governed by a community appointed Board of Directors, with a CEO responsible for daily management of the centre.

Recently the Foundation for Surgery provided Tharawal with an Ecleris OM100 ENT microscope made possible through generous donations to the Foundation and in-kind support from industry supplier Inline Medical and Dental.

The microscope will support a comprehensive program aimed at the prevention, early detection, treatment and management of ear disease in the communities serviced by Tharawal, and especially among its children.

Ear disease in Aboriginal and Torres Strait Islander communities living in and on the fringes of our cities is just as deleterious in impact, as is its occurrence in Aboriginal and Torres Strait Islander communities living in rural and remote Australia.

Simon provides a clinic once a month. "Eighty-five per cent of the Aboriginal children in the Tharawal community have on-going hearing problems, and 25 per cent require surgical intervention. This new microscope will enable us to examine the ears properly to obtain a more accurate diagnosis of ear disease. I thoroughly enjoy the clinic, it's the highlight of my month. I would love to hear from any Fellow wanting to get involved."

Peter is semi-retired from practice and offers a half day clinic each fortnight where most of his patients are children. "Doing outreach work at Tharawal is a very rewarding experience. I strongly encourage other Fellows to consider getting involved in outreach clinics."

"The operating microscope for Tharawal children's ENT service will enhance our spectrum enormously. It is the most valuable contribution to the Tharawal ENT clinic that I can ever imagine. Thank you so much for such wonderful and significant support."
Peter Corlette.

"Can I congratulate everyone involved in this development. This is a wonderful testament to the people involved and will provide benefit to the community for years to come."
Simon Greenberg.

Ear disease is one of the largest priorities in the provision of health care services in any Aboriginal community. It contributes to the burden of ill health as a chronic disease, but unlike the lifestyle related diseases of diabetes and cardiovascular problems, ear disease, and in particular Otitis Media, starts from the age of one onwards. Left untreated, ear infections can lead to hearing loss which may limit the development of language skills, adversely effecting educational and social outcomes well beyond childhood.

New South Wales has the largest Aboriginal population in Australia. Thirty six per cent are children under the age of 15 years.1 While data on the prevalence of Otitis Media for Aboriginal children in NSW is not complete, Otitis Media screenings for 0-6-year-old Aboriginal children undertaken by NSW Health in 2007/2008 showed that 32 per cent of children did not pass the first screen and required some form of referral or re-screen at a later date.

"The microscope will ensure that the clinics are appropriately equipped to attract visiting specialists now and in the future, hence guaranteeing access by the local Aboriginal community to the multidisciplinary specialist services that they need. This in turn will help to close the gap in Indigenous health outcomes on ear problems."
Dr Pauline Vunipola, Tharawal AMS.

The Indigenous Health Committee is one expression of the College working to reach out and support communities in need. The College is also helping to support, recruit and enable people of Aboriginal, Torres Strait Islander and Maori descent to successfully look at surgery as a career.

Realising it will take at least two to three generations to achieve significant numbers of Indigenous surgeons, we need to look at our current workforce and ensure they have every opportunity to contribute to Aboriginal and Torres Strait Islander health. A lot of our Fellowship wants to contribute and have a desire to. Our job is to ensure we create an environment where they can help, and to make that transition easy for them.

For people already contributing, it is important they are acknowledged and recognised, and that they realise we appreciate the great work they are doing. It is equally important that we make sure they are delivering the service in a way that is suitable for the community.

The Foundation for Surgery has recognised this and is doing a lot to acknowledge the need to close the gap in Indigenous health. It also acknowledges the important role that we as surgeons, and we as the surgical fraternity, can play.

I acknowledge the Chairman of the Foundation for Surgery, Professor Kingsley Faulkner, his predecessor, Professor Bruce Barraclough and the Board of the Foundation for taking a lead role in this endeavour. They have led the charge, supported by the staff of the College.

Importantly, we need to show the Australian community that we as surgeons and Fellows of the College care about the plight of Aboriginal and Torres Strait Islander health, that we acknowledge it and want to do something about it.

Reference

1. 2011 CENSUS COUNTS — ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2075.0main+features32011

Kelvin Kong
Chair, Indigenous Health Committee

Foundation for Surgery
Passion. Skill. Legacy.

For those who want to support our work in Indigenous health you can do so by donating to the Foundation for Surgery. A donation form is included in this, and every issue of *Surgical News*.

For those who want to give their time, we are more than happy to get them involved in some capacity and they are encouraged to contact the Indigenous Health Committee by telephone on (03) 9276 7407 or by emailing indigenoushealth@surgeons.org

New Advertising Regulations for Doctors

Strict rules introduced to protect patients

Four new bodies have been added to the list of registered health professionals under the Health Practitioner Regulation National Law Act. The National Law is regulated by the National Boards (including the Medical Board of Australia) and the Australian Health Practitioner Agency (AHPRA).

The Medical Board of Australia (MBA) has now issued new guidelines for advertising by doctors which apply across Australia.

Which four boards are required to comply from July 2012?

From July 2012, four new boards have been added to the original 10 required to comply with the National Scheme. These are:

- Aboriginal and Torres Strait Islander Health Practice
- Chinese Medicine
- Medical radiation practice
- Occupational therapy

What are the new advertising guidelines for doctors?

Under the National Law it is not acceptable to:

- Make false or misleading claims
- Offer inducements, such as gifts or discounts, unless the relevant terms and conditions are also included
- Create unreasonable expectations of beneficial treatment
- Use testimonials
- Encourage the indiscriminate or unnecessary use of a health service.

If health practitioners are found to be in breach of the National Law, they may be subject to a $5,000 penalty (for an individual) or $10,000 (for a body corporate).

The MBA has indicated that it will send a warning letter to offenders. Persistent advertising breaches may also result in restrictions being placed on an individual's registration and ability to practise.

It is the responsibility of individual practitioners to ensure advertising adheres to the requirements, but if they have inadvertently breached the rules, they may rectify the issue after the first warning letter from the National Board.

The new guidelines issued by the MBA apply to all doctors. It applies to any form of advertising, whether print, visual or electronic. Advertising is recognised as a legitimate way to provide reliable and useful information to consumers and potential patients to make informed decisions about accessing health services. However, it should not be done in a misleading or deceptive way, and should not be done in a way which adversely impacts upon potential patients.

The guidelines cover not only the health services offered by the doctor, but also products, which might be considered "therapeutic goods" associated with professional practice.

In developing any advertising doctors should consider their professional ethical obligations, as well as their legal obligations. The MBA indicates that advertising should not be "in a manner that could be considered as attempting to profit from or take advantage of limited consumer understanding" of medicine or therapeutic products.

Some general suggestions from the guidelines include:

- Advertising should not exaggerate competence, education, training or experience of the doctor. Professional qualifications quoted should be accurate.
- Any claims made in advertising should be able to be substantiated objectively.
- Doctors have the responsibility to check and authorise advertising on their behalf.
- Advertising which contains information that is factual and provides objective information about the health practitioner is entirely appropriate. It can include accurate factual information in relation to the doctor's experience, teaching positions, publications and qualifications.
- Advertising should not create unrealistic expectations about the service offered.
- Advertising should not encourage inappropriate, unnecessary or excessive use of health services (and avoid references such as "don't delay", "achieve the look you want", or "looking better and feeling more confident").
- The use of testimonials is not permitted.
- The use of information to compare a doctor's services with others is not permitted where there is no objective evidence on which the comparison can be based. Claims should not be made that a particular doctor is safer or better.
- Advertising is not a substitute for proper informed consent in relation to any procedure or treatment.
- Any pricing information should be strictly accurate and clear, and not misleading in any way.
- Advertising should be "in good taste" and not vulgar or sensational, or in a manner which may bring the health profession into disrepute.

The guidelines also contain some specific requirements in relation to the use of graphic or visual representations, particularly "before and after" comparisons or material. There is specific information in relation to comparative advertising generally and the use of qualifications and titles. All doctors should review this detail in the guidelines, if applicable to their practice and advertising.

As noted above, the guidelines are not a substitute for other legal requirements, including fair trading legislation which also restricts false and misleading claims, and therapeutic goods legislation which limits advertising in relation to certain therapeutic products associated with health services and treatment.

What are the consequences for breach of advertising requirements?

The MBA will investigate any complaint, whether from another doctor, patient or other person, in relation to a breach of advertising requirements.

While initially the MBA may issue warnings, and allow a period for correction of any advertising, any flagrant breach of the advertising requirements can still constitute unprofessional conduct or professional misconduct. Breaches can be dealt with under the disciplinary mechanisms available under the National Law.

Other advertising regulations

Alongside compliance with the new National Scheme, health practitioners are also required to take care when advertising that they comply with the provisions of the Competition and Consumer Law (2012) (and similar State-based fair trading laws), which prohibits misleading or deceptive conduct and unfair practices, such as bait advertising (advertising a product that is not reasonably available). Doctors should familiarise themselves with those laws specific to their state or territory.

Michael Gorton,
College Solicitor
With Sarah Walker, Law Clerk

Experience on foreign shores

Mr Greg Rice used his Margorie Hooper Scholarship to gain more experience in the minimally invasive field in the US

The 2010 recipient of the Margorie Hooper Scholarship, Mr Greg Rice, spent more than 12 months as a Senior Clinical Fellow in Cardiac Surgery at one of the largest hospitals in Boston, US.

Recently appointed a Consultant Cardiac Surgeon at the Flinders Medical Centre in South Australia, Mr Rice spent from September 2010 to December 2011 at the Brigham and Women's Hospital (BWH), an 800 bed quaternary referral centre providing cardiac surgery to much of New England, an area of north-eastern US with a population of nearly 15 million.

Mr Rice said during that time he had been involved in over 200 cardiac surgical procedures, the majority of which he performed as surgeon under the supervision of a faculty member.

He said the procedures ranged from straightforward coronary artery surgery to complex multiple-time re-operative valve surgery, as well as a number of minimally invasive valve procedures, either by partial sternotomy or mini-thoracotomy, and transcatheter aortic valve implantation procedures.

"The BWH has a long and proud history of pioneering developments in transplantation, neurosurgery, anaesthesias and cardiac surgery," Mr Rice said.

"The cardiac surgical service comprises seven surgeons and performs about 1,600 procedures per year, many of which are extremely complex such as re-operative surgery, multiple valve surgery, mechanical cardiac assistance and transplantation.

"My goals while at the BWH were to build on my exposure to complex cardiac surgery and also to gain particular exposure to minimally invasive cardiac surgical procedures including minimal-incision aortic valve and mitral valve surgery, pioneered by Dr Lawrence H. Cohn at BWH in the mid-1990s.

"I was also pleased to be involved in transcatheter aortic valve implantation, an emerging technique of catheter-based aortic valve replacement in those patients who are not fit for conventional surgery.

"One of the other great benefits of this Fellowship was the opportunity provided to gain considerable experience in the perioperative management of patients following cardiac transplantation and ventricular assist device implantation."

Mr Rice became a Fellow of the College in 2011 and also has a Masters of Surgery from Flinders University where he conducted his thesis research into cerebral micro-emboli and neurobehavioural impairment after prosthetic aortic valve replacement.

Professionally invaluable

With a particular interest in minimally-invasive cardiac surgery, he has given a number of presentations on his work at meetings of the Australasian Society of Cardiac and Thoracic Surgeons and the International Society for Minimally Invasive Cardiothoracic Surgery.

Mr Rice, who travelled to Boston with his wife and young daughter, said the experience had been both enjoyable for the family and professionally invaluable.

"As surgeons in Australia know, while we do see many difficult and complex cases here and perform surgery of a world-class standard, the number of very complex cases seen in any one hospital over a given period of time is relatively low, which impacts on our ability to become familiar with and comfortable undertaking such difficult procedures," he said.

"At the BWH there were days when across the four theatres, eight complex cases would be done with nothing straightforward on the list.

"These were patients who might have been undergoing a third- or fourth-time re-operation, patients who needed a great deal done in one procedure, or patients whose fitness for surgery was borderline."

Mr Rice said he now hoped to be able to offer some of the procedures he conducted in the US to the cardiac patients of South Australia and thanked the College for its support in providing the funding to undertake the Fellowship.

The Margorie Hooper Scholarship was made possible by a bequest and is designed to enable the recipient, who must be a resident of South Australia, to undertake postgraduate studies outside the state, either elsewhere in Australia or overseas, for the benefit of the South Australian community.

The Scholarship is open to both Fellows and Trainees with preference given to those surgeons travelling overseas to learn new surgical skills and comprises a stipend of $75,000.

With Karen Murphy

Right: The Brigham and Women's Hospital in Boston; Greg Rice with his wife, Kate.

profile

Awards and Grants

2010: Margorie Hooper Scholarship

2006: Australasian Society of Cardiac and Thoracic Surgeons (ASCTS) Foundation Research Grant

2006: TAG Medical Prize for Best Research Presentation by Registrar, Fellow or Trainee, Combined Annual Scientific Meeting of ASCTS and the International Society for Minimally Invasive Cardiac Surgery.

Rooms With Style

Winner of 2011 business excellence award

Rooms With Style offers 3 core services exclusively for Surgeons

>Medical Fitouts

>Practice Management Consulting

>Recruitment

Call today to find out how we can tailor our services to suit your practice.

1300 073 239
info@roomswithstyle.com.au
www.roomswithstyle.com.au

ROOMS WITH STYLE

CONGRATULATIONS on your achievements

Mr Brian Randall OAM
Honorary Fellowship

It gives me enormous pleasure to recommend Mr Brian Randall for the award of Honorary Fellowship. Mr Randall has given many years of service to this College as an Honorary Advisor and Chairman of our Investment Committee. For over 50 years Brian has also made significant and continuing contributions to other aspects of the community including the business world, sport, especially athletics, and education, particularly at Scotch College in Melbourne.

Brian was educated at Scotch College where his athletic prowess soon became evident. Leaving school he entered Ormond College and Melbourne University. He found time around his studies to continue his love of athletics. Competing at national and international levels, he was selected to represent Australia at the 1956 Olympic Games in his home city of Melbourne. Unfortunately, injury robbed him of the opportunity but nonetheless he was intervarsity sprint champion for three consecutive years and held the Australian sprint record for 100 yards.

Later, and with significant insight, in 1968, with other famous Australian athletes he founded Athletics International. The Foundation provided international competition for young Australian athletes, a role later assumed by the Australian Institute of Sport. Funding was provided by a Trust set up by Brian in 1969. From a small base it now has funds of over $650,000.

In 1955, he completed his Bachelor of Commerce and joined Price Waterhouse in the audit department. The following year he was transferred to the London office. After returning to Australia he worked for Reid Murray and Wallace H Smith stockbrokers before purchasing Reid and Company. After several name changes it became "Randalls", a highly respected Melbourne institution. Brian played a leading role in the securitisation of mortgage lending in Australia through Central Mortgage Registry. In 1983 he founded The International Foundation of Financial Planning in Australia and was the President until 1985.

"Randalls" was sold in 1987 and Brian moved to Potter Partners, now known as UBS. He was joined by his sons Michael and James. Brian retired from stockbroking in 2000. Throughout his busy professional life Mr Randall also made a major contribution to Scotch College, serving on its Council from 1981-1993, was the 41st president of the Old Scotch Collegians, and was a committee member of the Scotch Foundation. He still serves on the investment committee.

Brian has also been a member of the Ovarian Cancer Foundation and is a keen farmer, starting Salisbury Estate Wines.

Brian joined the College and was the inaugural Chair of the Investment Steering Committee in 2002, and subsequently chaired the first meeting of the Investment Committee and he has remained its chair since that time. Prior to Brian Randall joining the College, the College's investment strategy was ill-defined and lacked focus.

Brian changed all that. Since then we have had a clear policy governing our finances and our investment portfolio has outperformed the market. He has encouraged others to join him providing the College with a range of Honorary Advisors who make an enormous contribution to our College. In 2012 he was awarded the Medal in the General Division of the Australia Day Honours. He is a very worthy recipient of an Honorary Fellowship of this College.

Citation kindly provided by Associate Professor Michael Hollands FRACS

Professor Robert Sutherland AO FAA
Honorary Fellowship

Professor Robert Sutherland is the Director of the Cancer Research Program, Garvan Institute of Medical Research and the inaugural Director of The Kinghorn Cancer Centre, St Vincent's Hospital, Sydney. He has the distinction of being Australia's most-cited breast cancer researcher being an international leader in cancer research and a mentor to many of Australia's leading cancer researchers. He has been rightly honoured for his achievements in cancer research, mentoring and capacity building in Australia.

Professor Sutherland was educated in New Zealand where he completed M Agr Sc (Hons I) before moving to Australia to undertake a Doctorate at the John Curtin School of Medical Research, Australian National University, Canberra. On completing his PhD he undertook post-doctoral training with Professor Etienne Baulieu (Lasker Award winner in 1989) in Paris working on estrogen receptors and estrogen action in animal models.

This work led to some of the first insights into the mode of action of the first targeted therapy for cancer, the synthetic anti-estrogen tamoxifen. In 1977, Sutherland returned to Australia as the first scientist recruit to the newly established Ludwig Institute for Cancer Research at the University of Sydney. He moved to the Garvan Institute of Medical Research in 1986 where he has built one of Australia's largest cancer research programs encompassing a multi-disciplinary, multi-institutional approach to basic and translational cancer research. More recently he has driven the strategic development, funding, building and commissioning of The Kinghorn Cancer Centre, a $110M joint venture of the Garvan Institute and St Vincent's Hospital, which will enable research findings to be rapidly translated into clinical application in a personalised medicine model of cancer management, where the genetic makeup of the patient and their cancer will allow the right treatment to be delivered to the right patient at the right time.

More recently, the focus has been on the dramatically advancing field of cancer genomics where he and his colleagues have been integral to the International Cancer Genome Consortium's efforts in pancreatic and prostate cancer.

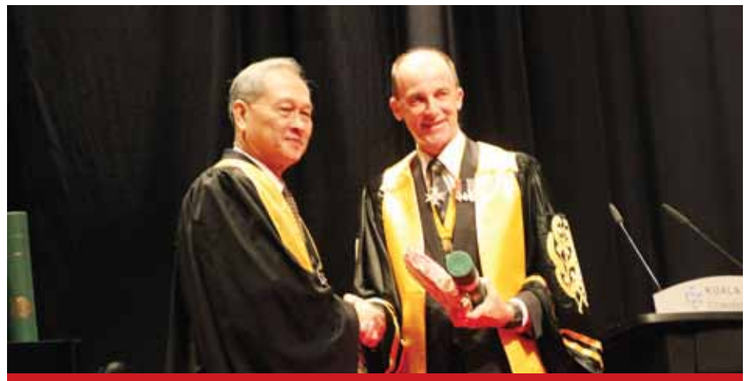
In the past decade Professor Sutherland has been widely recognised for his achievements including an Honorary Doctor of Science from his alma mater. In 2000, he was awarded the Ramaciotti Medal, a national award for Excellence in Biomedical Research; in 2002, he was admitted as a Fellow of the Australian Academy of Science and subsequently he received the Centenary of Federation Medal. At the San Antonio Breast Cancer Symposium in 2000 entitled: "Celebrating Survival: A Century of Advances in Early Breast Cancer", he was declared to be one of the 100 most frequently published breast cancer researchers of the 20th Century, the only Australian so honoured. Finally, in 2010 his contributions to cancer research were recognised with award of the New South Wales Premier's Award for Outstanding Cancer Researcher, the highest state honour for cancer research, and with one of Australia's highest national awards, Officer of the Order of Australia (AO).

Professor Sutherland is a world leader in breast, prostate and pancreatic cancer research: he has played a leadership role in developing cancer research in Australia and trained some of Australia's leading cancer researchers and clinicians. In 20 years at the Garvan Institute he has developed a multidisciplinary team of over 100 scientists, clinicians and students with major interests in basic and translational cancer research.

The clinical collaborations include strong scientific interactions with many Fellows of the Royal Australasian College of Surgeons and the mentoring of young surgeons through College training programs. Two of his former students are Directors of major research institutes, nine past and present members of the Program are Professors, eight are Associate Professors and 16 currently hold clinical or research positions at a Group or Department Head level at major research institutes or teaching hospitals. Over a third of these are from medical backgrounds including over 15 surgeons.

Professor Robert Sutherland is an extremely worthy recipient of the award of Honorary Fellowship of the Royal Australasian College of Surgeons.

Citation provided by Professor Andrew Biankin FRACS



Lieutenant General Nopadol Wora-Urai MD, FACS, FRCST, FRCSEd, FICS
Honorary Fellowship

Lt. General Nopadol Wora-Urai is a distinguished Thai surgeon with an international profile. After graduating from the Faculty of Medicine, Mahidol University at Siriraj Hospital in Bangkok, Thailand in 1970, Dr Wora-Urai completed his internship and subsequently trained in surgery in the USA. He was resident in General Surgery at the Columbus Hospital in Chicago from 1972-77 and had further Fellowship experience in hand surgery at the Cook County Hospital and in Urology at the Columbus Hospital, also in Chicago.

After returning to Thailand, he established a distinguished career in general surgery, trauma and surgical education. In 2011, he organised a comprehensive review of surgical training in Thailand.

He has held numerous leadership roles at the Phramongkutklao Military Hospital and the College of Medicine of Thailand.

He has been Governor of the Thailand Chapter of the American College of Surgeons and National delegate to the International Society of Surgery. He was Secretary-General of the Thailand Chapter of the International Association of Surgeons, Gastroenterologists and Oncologists and Chairman of the Definitive Surgical Trauma Care Thailand Subcommittee.

More recently, his roles have included Professor of Surgery at the Phramongkutklao College of Medicine, Editor-in-Chief of the Thai Journal of Surgery and Chairman of the Royal College of Surgeons of Thailand, Advanced Trauma Life Support subcommittee.

He has published numerous scientific papers and delivered more than 120 lectures to international audiences.

He has held multiple important leadership roles in the Royal College of Surgeons of Thailand (RCST) and is that College's immediate Past President. He is a good friend of the RACS and was the "Weary" Dunlop Memorial lecturer in 2006. Lt. General Wora-Urai has facilitated the selection and mentoring of the "Weary" Dunlop Boon Pong scholarship program and strongly supported the exchange of younger Fellows at the annual scientific congresses of our two Colleges. He was instrumental in arranging two joint surgical conferences between the RCST and the RACS.

Lt. General Nopadol Wora-Urai is a worthy recipient of Honorary Fellowship of the RACS.

Citation kindly provided by Professor Ian Gough FRACS

Have your message seen by more than 9000 surgeons and associates each month.

Advertise in **Surgical News**
Contact surgical.news@surgeons.org for rates and deadlines.

The Royal Australasian College of Surgeons
Member Advantage Benefit Program

Member ADVANTAGE®

Benefits to enjoy all year round

10% off land tours with Intrepid Travel
A variety of tour styles to suit every taste and budget for destinations around the world. See the Member Advantage website for discount and booking information.

12% off Adrenalin lifestyle experiences
Over 2,000 adventures across Australia and NZ, including hot air balloon rides, winery tours, sky diving and more. Access the discount via the Member Advantage website.

Rate reductions for airline lounge memberships
Access exclusive corporate rates for Qantas Club, Virgin Australia and Koru Club (NZ) airline lounge memberships. Apply via the Member Advantage website.

Save up to 20% on new car purchases
Take advantage of free access to our car buying service (save $178), and take the hassle out of buying a new car. Average member saving is $3,000[1]. Call us today for a quote.

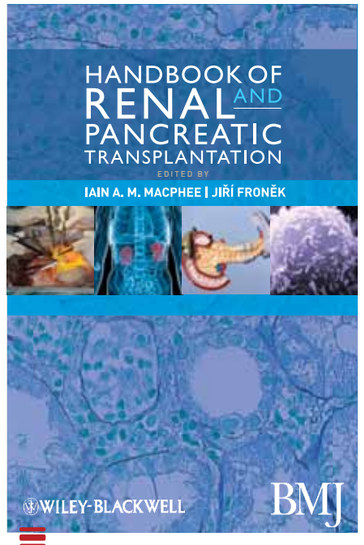
For further information on these benefits, please contact Member Advantage:
Call 1300 853 352 or visit www.memberadvantage.com.au/racs
NZ Fellows and Trainees call +61 3 9695 8997

1) Average member saving off the cost of a new vehicle for the period 2011 to 2012.

Welcome to the Surgeons' Bookclub

ALL BOOKS NOW 25% DISCOUNT

25% Discount



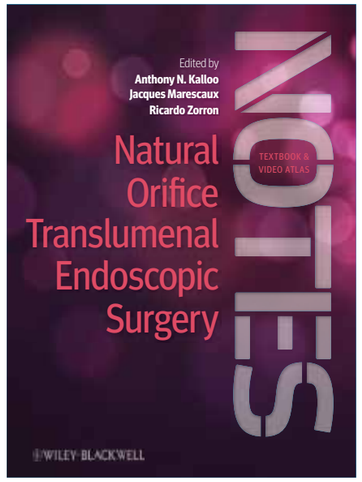
Handbook of Renal and Pancreatic Transplantation

Iain MacPhee (Editor),
Jiri Fronek (Editor)
9780470654910 | Pbk | 504 pages
June 2012

~~AU$105.00~~ | AU$78.75
Member Price

This book is designed to fill the need for a contemporary handbook for the practice of renal and pancreatic transplantation that is focussed on a European rather than North American approach.
There are significant differences in transplant practice internationally and there is a need for a practical guide to application of the current evidence base.

25% Discount



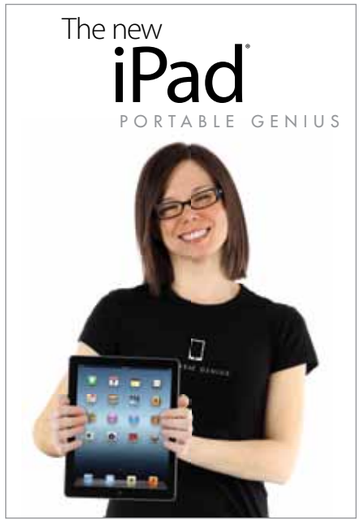
Natural Orifice Translumenal Endoscopic Surgery: Textbook and Video Atlas

Anthony N. Kalloo, MD, Jacques Marescaux, Ricardo Zorron, MD, PhD (Editors)
9780470671030 | Hbk | 328 pages
June 2012

~~AU$190.00~~ | AU$142.50
Member Price

Natural Orifice Translumenal Endoscopic Surgery (NOTES) has the potential to change the practice of surgery as we know it. Proponents say advantages over laprascopic surgery include lower anesthesia requirements, faster recovery and shorter hospital stays, avoidance of transabdominal wound infections, less immunosuppression, better postoperative pulmonary and diaphragmatic function, and the potential for "scarless" abdominal surgery. In this text/video set, the leading world expert in NOTES shares his experience. Three sections cover fundamentals, current clinical applications and techniques, and future perspectives.

25% Discount



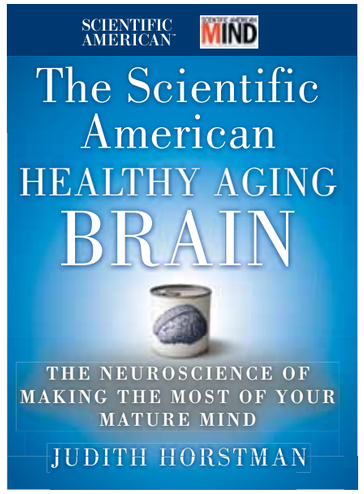
The new iPad Portable Genius

Paul McFedries
9781118173039 | Pbk | 336 pages
April 2012

~~AU$29.95~~ | AU$22.46
Member Price

The popularity of the iPad is seemingly unstoppable and if you've decided to get in the iPad game, this handy guide is must-have reading. This easy-to-understand resource shares tips, tricks, and advice, to help you get the most out of your ultraportable tablet device. You'll learn how to maximize features of The new iPad such as the beautiful Retina display, multitouch screen, 5MP camera, Bluetooth and Wi-Fi +4G capability, eReader functionality, and much more.
Shows you how to surf the web, watch movies and TV, listen to music, read books, play games, create presentations, edit documents, manage contacts, organize photos, update spreadsheets, and more Covers how to use and troubleshoot the latest iOS. Features Genius icons to show you the smartest way to do things Helps save you time and avoid hassles as you get up to speed
The new iPad Portable Genius presents you with accessible, useful information so that you can start confidently using your new iPad today!

25% Discount



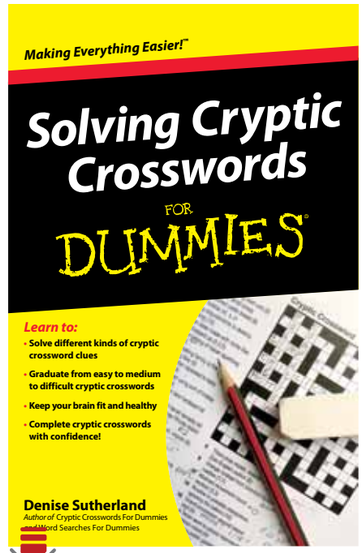
The Scientific American Healthy Aging Brain: The Neuroscience of Making the Most of Your Mature Mind

Judith Horstman, Scientific American
9780470647738 | Hbk | 280 pages
May 2012

~~AU$32.95~~ | AU$24.71
Member Price

Good news about getting older from *Scientific American* and *Scientific American Mind* . *The Scientific American Healthy Aging Brain* taps into the most current research to present a realistic and encouraging view of the well-aged brain, a sobering look at what can go wrong—and at what might help you and your brain stay healthy longer. Neurologists and psychologists have discovered the aging brain is much more elastic and supple than previously thought, and that happiness actually increases with age. While our short-term memory may not be what it was, dementia is not inevitable. Far from disintegrating, the elder brain can continue to develop and adapt in many ways and stay sharp as it ages. With hope and truth, this book helps us preserve what we've got, minimize what we've lost, and optimize the vigor and health of our maturing brains.

25% Discount



Solving Cryptic Crosswords For Dummies

Denise Sutherland
9781118305256 | Pbk | 216 pages
June 2012

~~AU$19.95~~ | AU$14.96
Member Price

Even expert crossword-solvers struggle with cryptics. The clues can often seem nonsensical, mysterious and infuriating, but finally cracking them is immensely satisfying. *Solving Cryptic Crosswords For Dummies* is designed to help even the most casual crossword lover master these mental feats of gymnastics. Packed with clear explanations, helpful hints, and practice crosswords, the book explains how to approach these problems in a clear and logical manner, providing hints on identifying the different kinds of clues and tips on how to solve them.
Using worked examples and clear explanations, the book guides the reader through the common and not-so-common clues that can be used to decipher even the most confusing cryptics, and includes practice puzzles to put your new skills to the test. Cryptic crosswords have emerged as one of today's most popular brainteasers, and *Solving Cryptic Crosswords For Dummies* is the one-stop resource for becoming a puzzle pro.

WILEY-BLACKWELL

To Order

RACS Members can now access the **25% discount*** by following the instructions:

Log on to the RACS website

Go to College Resources then Member benefits – then Wiley-Blackwell

Follow the steps on the website to ensure your **25% discount** on all Wiley-Blackwell books*

If you have previously ordered from the RACS Landing Page, then you can purchase direct from www.wiley.com by selecting the book of choice and then logging on.

Place your order – no discount code needed

Postage is charged on all orders:

AU$7.50 within Australia and AU$25.00 to New Zealand

*Excluded from discount are School (Jacaranda) titles.

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

Not all books promoted in Surgical News will appear on the RACS/ Wiley Landing Page.

You can still order these, as with any other book, by finding it within **wiley.com**, after logging in.

*Excluded from discount are School (Jacaranda) titles.

THANK-YOU
for donating to the Foundation for Surgery

VICTORIA
ANZCA
Dr Monica Cosgrove
Mr John Fliegner
Mr John Gribbin
Mr William Heape
Mr Victor Mar
Assoc. Prof. Helen O'Connell
Mr Brian Randall OAM
Mr Harry Ross
Professor David Scott AM

NSW
Mr Russell Aldred
Mr Brian Casey
Dr Michael Donnellan
Dr Hayder Ridha

QUEENSLAND
Mr Ian Colledge
Mr Kenneth Pettit

SOUTH AUSTRALIA
Assoc. Prof. Robert Atkinson AM, RFD

WESTERN AUSTRALIA
Mr Peter Bath
Mr Steven Lai

NEW ZEALAND
Dr Mathew DeWall

TOTAL
$45,374

Your passion.
Your skill.
Your legacy.

Your Foundation.

Yes, I would like to donate
to our Foundation for Surgery

Foundation for Surgery
Passion. Skill. Legacy.

All donations are tax deductible

Name:

Address: Telephone:

Email: Speciality:

Enclosed is my cheque or bank draft (payable to Foundation for Surgery) for $ ☐☐☐☐.☐☐

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

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

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

Card Holder's Name - block letters | Card Holder's Signature | Date

I would like my donation to help support:

☐ General Foundation Programs ☐ International Development Programs
☐ Scholarship and Fellowship Programs ☐ Indigenous Health Programs
☐ I have a potential contribution to the Cultural Gifts Program
☐ I do not give permission for acknowledgement of my gift in any College publication

Please send your donation to:

AUSTRALIA & OTHER COUNTRIES
Foundation for Surgery
250 - 290 Spring Street
East Melbourne , VIC 3002
Australia

NEW ZEALAND
Foundation for Surgery
PO Box 7451
Newtown, 6242 Wellington
New Zealand

The 9th Cowlishaw Symposium is coming

Saturday 27 October 2012
9.30am

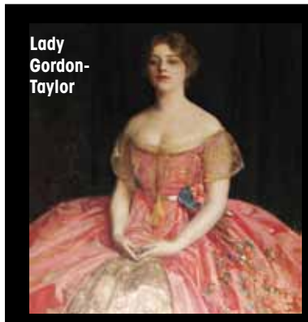
Registration will be available closer to the date.

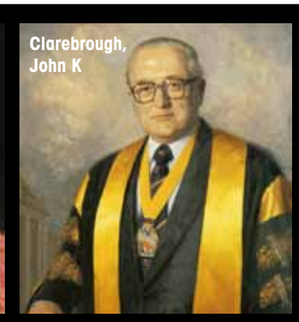
Royal Australasian
College of Surgeons,
250-290 Spring St,
East Melbourne
Hughes Room

Fee: $130.00 inc. GST

per person covers morning tea,
lunch, afternoon tea
and cocktail reception

For further information contact geoff.down@surgeons.org +61 3 9276 7447





THE HERITAGE GROUP
Presentation: Portraits
Friday 19 October at 12pm

at The Royal Australasian College of Surgeons, 250-290 Spring Street, East Melbourne

$30 inc. GST per person and lunch.
For further information contact geoff.down@surgeons.org or phone: +61 3 9276 7447

PLEASE RETURN THIS SECTION WITH PAYMENT TO:
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Megan Sproule, Resources Division
College of Surgeons Gardens,
250-290 Spring Street, East Melbourne, VIC 3002
Alternatively fax completed form to +61 3 9249 1219

DELEGATE INFORMATION (Please print in BLOCK LETTERS)

Title / Given Name:

Surname:

Mailing Address:

Postcode:

Ph: E-mail

Dietary Requirements:

PAYMENT OPTIONS
1. Pls make all cheques/bank drafts payable to the Royal Australasian College of Surgeons (payable $AUD)
2. The following Credit Cards are acceptable

☐ Amex ☐ Diners Club ☐ MasterCard ☐ Visa card

Card No:

Expiry Date ..... /.....
MONTH YEAR

Card Holder's Name

Card Holder's Signature

Amount (inc. GST) $

Date..... /..... /.....

GAMMEX® Non-Latex range minimises the risks of type IV allergies and skin irritations, but some chemicals contained in GAMMEX® Non-Latex gloves may cause allergic reactions or irritations in some users.

Ansell, ® and ™ are trademarks owned by Ansell Limited or one of its affiliates.
© 2012 Ansell Limited. All rights reserved.

WWW.MEDICAL.ANSELL.COM.AU

Ansell