Surgical News

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

Features our latest up and coming researchers

The College of Surgeons of Australia and New Zealand

A new *focus*

Working to deliver skills to the next generation of Sumba doctors

contents

REGULAR PAGES

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ON THE COVER:
Dr Mark Ellis and eye care trainee Nefry Radenna providing post-op care to a cataract patient. P16

President's Perspective

Surgical Education

Creating a pathway for the best Trainees

The role that the College has in Surgical Education continues to evolve and at times dramatically. Fellows would be aware that this College was built on the tradition of being the examining body for surgeons. However, over the decades this traditional role has significantly evolved to being the accredited provider of Surgical Education and Training in the post-medical-school vocational training space. The robustness of our programs that are delivered in partnership with the 13 Specialty Societies continues to attract both attention and admiration.

However, the model that we are familiar with in Australia and New Zealand is quite different from other parts of the world. The College of Surgeons in Edinburgh continues to run their Fellowship Examinations around the world with limited input into the required educational program. Universities in America conduct the training with the American Examining Boards undertaking the assessment process. The American Colleges and various Surgical Associations are far more focused on lobbying and advocacy. The models are all different and they are all valid in the context of the educational and health sectors in which they are based. They all continue to change, at times dramatically.

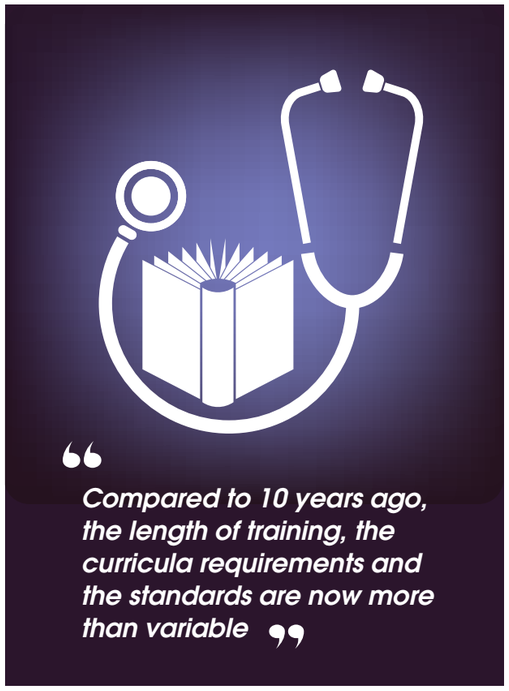
Nor is surgical training built on the fundamentals of a medical graduate qualification. In the US, osteopathy and podiatric are recognised as "medical" qualifications. Indeed the Medical Board of Australia now regards a Doctorate of Medicine and Doctorate of Osteopathy from US as comparable. In Canada, streaming into a surgical program is encouraged from within the medical school program itself.

In Australia and New Zealand we are challenged in that the requirements within a medical school curriculum have changed significantly. With the opening of many more medical schools and now having twice the number of graduates compared to 10 years ago, the length of training, the curricula requirements and the standards are now more than variable. There is much less emphasis on surgery and its contribution to the undergraduate curriculum is decreasing. The same applies to subjects we consider intrinsically surgical, such as anatomy.

The College dealt with this variability over previous decades by having the Basic Surgical Training program. Over a number of years, surgical Trainees worked in different units including ICU and A&E. They were exposed to a variety of surgical disciplines, completed a number of courses and had the opportunity to act as a junior registrar before entering definitive training. The introduction of SET (Surgical Education and Training) tried to streamline entry into the desired training program, to decrease the length of training and be responsive to concerns raised about many Basic Surgical Trainees not being successful in establishing a career in surgery.

However, what has evolved is regarded by some as a lack of direction and a disconnect between the standard of the entry level Trainee and those surgeons training them. Equally, how do we ensure we always attract the best possible Trainees into surgery? Trainees are no longer prepared to spend years accruing a variety of surgical experience before commencing training. This pre-vocational space is recognised as being increasingly important and the College is now responding significantly to this demand.

Our College is now developing a Pre-Vocational Training and Education Program that is particularly focused on the first three post-graduate years. We need to encourage surgical aspirants – who are usually highly motivated self-directed learners – into key areas that we expect of potential surgical Trainees. We have included core surgical scientific knowledge like anatomy and physiology and courses that provide surgical skills and also skills in communication, counselling and team work. Many of these can be provided through the College or the various Specialty Societies.



> *"Compared to 10 years ago, the length of training, the curricula requirements and the standards are now more than variable"*

Many could be provided by universities or indeed other Colleges with the standards being credentialed by RACS. Courses will be provided at cost so this initiative will not impact on subscriptions.

With the substantial investment that the College has made in Information Technology over the past few years, we are now poised to be able to provide these online or via 'internet-based technology'. These can then be accessed and completed at times that are suitable to the surgical aspirant themselves. Their involvement can be crafted to suit their demands – a key change as the surgical aspirants juggle the demands of work, family and their ongoing career development. Although there are some similarities with the previous Basic Surgical Training model, the 'ownership' of hospitals or training opportunities will not be by the College. Our aim is to engage with, and provide opportunities for, surgical aspirants as they begin to engage more fully with their chosen career.

I must admit that I viewed the move away from Basic Surgical Training with some trepidation at the time. Now is the time for our College to re-engage in this space. We want the best Trainees, so we need a state of the art entry portal to our profession.

Mike Hollands
President

Regional meetings

In the Spring a Fellow's fancy lightly turns to thoughts of their regional annual meeting (with apologies to Alfred, Lord Tennyson)

Over the coming months, the Regional Committees across Australia and New Zealand will host their annual opportunity for Fellows, Trainees and IMGs to gather and consider issues of concern to surgeons, discuss advances in the practice of surgery and take some time to catch up with friends and colleagues away from the hospital setting and the pressures of work. This is truly what collegiality is all about.

The 'meeting season' began in Cairns, where Queensland Fellows gathered at the Shangri-La Hotel on Friday, August 2, for the QHealth Forum. The forum focused on the productive operating theatre. These sessions are an excellent opportunity for Fellows to engage directly with a government health instrumentality and to influence change from a clinical perspective.

The meeting proper followed on Saturday with a broad session on issues such as the use of audits as a teaching tool and the role of the Academy of Surgical Educators. Following this is the competition by surgical registrars for the Neville Davis prize.

This year is the 30th anniversary of the prize named for Neville Davis, who was a senior surgeon at the Brisbane General and Princess Alexandra hospitals. The prize is named in his honour in recognition of his high standards in writing and research, as well as his views and influence in surgical education.

A highlight from the Queensland meeting must be the presentation of the David Thiele lecture by the 2006 Australian of the Year, Professor Ian Frazer.

David Thiele held many positions within the College, including Chair of the Queensland Regional Committee, Vice President and President. He was also instrumental in the College securing funding for the Pacific Islands Project and the subsequent growth and reach of the College's aid programs.

David Thiele is also remembered as the only Australian to win consecutive gold medals for backstroke, doing so at the 1956 and 1960 Olympiads.

From the tropics of Cairns to the snow covered Remarkables, the New Zealand annual meeting has just been held in picturesque Queenstown on August 8 and 9. Their theme was "Influencing the Future of our Surgical Services".

With sessions covering topics such as 'Equipping Surgeons to Lead and Challenge Change', 'Learning from Innovation' and 'Bold Suggestions for the Future' the program proved to be a stimulating look at the challenges surgery will face into the future in New Zealand.

New Zealand also boasts its own registrars (and Fellows under 40) prize, the Louis Barnett. Not to be confused with the College's singular award, the Sir Louis Barnett Medal, which is awarded for outstanding contributions to education, training and advancement in surgery, the Louis Barnett Prize recognises young investigators carrying out surgical research.

Sir Louis Barnett was of course the College's first Vice President and later President between 1937 and 1939 and was instrumental in the foundation of our College. What is perhaps less well known is that Sir Louis was considered a pioneer in hydatid's research and was influential in the establishment of the College's hydatid register. The Ralph Barnett Chair in Surgery at Otago Medical School was endowed in memory of his son, Ralph, who was a member of the Lancashire Fusiliers, 8th Battalion and was killed in Belgium on 6 September, 1917.

The tripartite SA/WA/NT regional meeting also has a focus on the future. Set in one of Australia's premier winemaking districts, the Barossa Valley, 'Future Directions in Surgery' offers a stimulating program.

From the futurist Dr Kristin Alford who opens the meeting, through the debate on the future of surgery and winding up with discussion centred on new technology and Telehealth, the meeting program will challenge and stimulate many Fellows.

As it is a tripartite meeting, there is also a strong WA element, no better exemplified than by the Hanrahan Oration, which is the keynote presentation after the formal dinner. The oration is named for the College's first Western Australian president, John Hanrahan from 1991 to 1993. An accomplished photographer, the former President's book, '*Shark Bay Patterns of Nature*' is presented to the orator.

With further meetings later in the year in Victoria, Tasmania and the ACT, there truly is something for most Fellows and in most locations.

As Vice President I am often invited to attend the regional meetings and I try to get to as many as I can. Last year I managed all but for the SA/WA/NT meeting, which I am making up for this year by getting to the Barossa Valley this month. Adrian Nowitske is the Chair of the Board of Regional Chairs and he has assumed much of my responsibilities in this regard. I am sure the regional chairs would attest that he has injected new vitality.

I am always impressed by the organisation of regional meetings and the work that is put in by the convenors to develop interesting and engaging programs. Coupled with the many attractive locations on offer, what more could a Fellow want? More importantly I have made many new friends – easy to do in a relaxed convivial and collegiate environment. It reminds me of what one of my mentors once told me – "surgery is a great club!"

I look forward to meeting you at your regional annual meeting.

Michael Grigg
Vice President

Spreading the smile

Qld surgeon Richard Lewandowski is leaving an important legacy in the Philippines and Vietnam thanks to his work with the Australian arm of Operation Smile.

Mr Lewandowski has been travelling to the countries since 1995 and performed a number of key surgeries for deformities.

Operation Smile treated its 34th surgical patient in June, though Lewandowski is most proud of the teaching of health practitioners within the countries they visit.

"We're not only teaching them to fish, but teaching them to teach others to fish," Mr Lewandowski said.

***Courier Mail*, July 6**

Help from afar

Hope of a new life has been ignited for a young Indonesian woman who underwent life-changing surgery.

Ani Budjen lived with a debilitating tumour covering half her face before she met two Kiwis, Peter and Stacee Honey. The Honeys were inspired to change Ani's life and wrote hundreds of letters to organisations for help.

Help came from Takapuna Surgeon Mark Izzard, who offered to do the surgery free of charge.

"It's really improved my life," Ms Budjen said.

"No-one can judge me anymore."

***New Zealand Herald*, July 5**

Call to save lives

The College is increasing pressure on the NT Government following its move to scrap speed limits in the territory.

They have released figures that show 10 lives are saved each year when capping the speed limit.

Dr David Read has renewed calls for a backflip on the "utterly irresponsible" plan.

"It seems madness to invite 10 people to kill themselves, leaving devastated family and friends behind," he said.

***Northern Territory News*, June 3**

Band of white collar workers

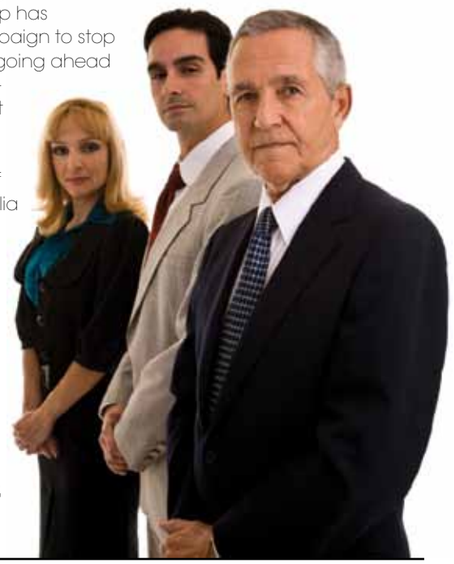
Professional groups have banded together to increase pressure on the Australian Federal Government to 'scrap the cap'.

Led by white collar workers including lawyers, architects, accountants, engineers and doctors, the group has launched a campaign to stop the government going ahead with capping self-education fees at $2,000.

At the launch, Chief Executive of Universities Australia Belinda Robinson has said that the cap is a "tax on learning".

"This is going to have a very profound impact on national productivity," she said.

***Australian Financial Review*, July 9**



Finding a home base

Professor Swee Tan's research team now have somewhere to continue their work

After a tireless 15-year campaign to raise funds and support, Professor Swee Tan – Plastic and Reconstructive Surgeon, research pioneer and founder of the Gillies McIndoe Research Institute – finally has a permanent base for his scientific endeavours.

Later this year, Professor Tan and his team will move into a refitted, state-of-the-art facility in what is now disused laboratory space located in a building that also houses the New Zealand Blood Service next to the Wellington Regional Hospital.

Until now Professor Tan and his team have had to conduct their ground-breaking research, particularly into the mechanisms regulating strawberry birthmark (haemangioma), in various laboratories made available to them which he described as being akin "to cooking in someone else's kitchen".

He said work at the new Institute would concentrate on expanding their findings relating to haemangioma to seek novel, less invasive and more effective treatments for cancer.

Professor Tan and his team won international recognition for their discovery in 2010 that haemangioma, a disfiguring and sometimes life-threatening vascular tumour, is caused by stem cells arising from the placenta.

The team then went on to discover that the renin-angiotensin system, hitherto known only for its regulation of blood pressure and body fluids, controlled these stem cells.

These discoveries underscore the new treatment approach for haemangioma by manipulating the renin-angiotensin system, using beta-blockers and angiotensin converting enzyme inhibitors that leads to dramatic regression of these tumours.

The team and their collaborators successfully transformed haemangioma stem cells into fat cells and bones cells. Their demonstration of the ability to transform these stem cells into red blood cells won the team the top science prize at the International Confederation of Plastic, Reconstructive, and Aesthetic Surgery in Vancouver, Canada in May 2011.

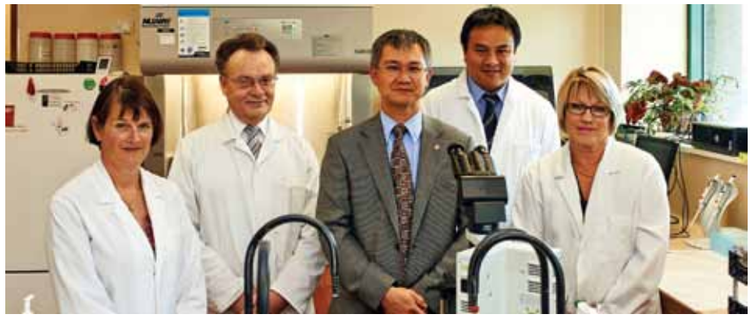
Professor Tan said he believed these discoveries – which won prestigious international science awards – have enormous implications for the treatment of cancer and regenerative medicine.

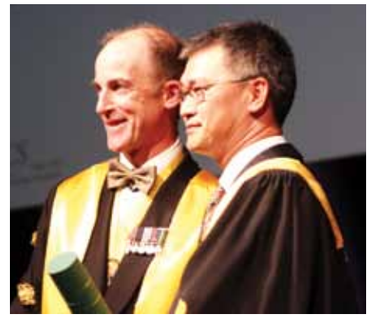
"We believe the knowledge we have gained can be used to further our understanding of cancer. In the past two years we have found parallels in a number of types of head and neck cancers," Professor Tan said.

"Even though an enormous amount of money has been poured into cancer research we believe there is a need to look in a new place, from a different perspective if we are to find more effective, less invasive and debilitating treatments.

"To have our own state-of-the-art facility, staffed by skilled researchers means that we can bring fresh eyes to the problem of cancer and hopefully to come up with novel approaches toward treatment.

GILLIES McINDOE RESEARCH INSTITUTE
Pioneering future treatment of cancer





"We speculate that cancer is a disease of stem cells, regulated by very primitive systems that regulate cell multiplication, maturation and suicide."

Professor Tan said he first dreamed of creating a dedicated cancer research institute in 1996 after his return from Oxford working under Professor Michael Pool and later, in Boston, under the mentorship of Professor John Mulliken who got him interested in vascular birthmarks.

When he returned to New Zealand in 1996, he established the Centre for the Study and Treatment of Vascular Birthmarks, a national centre, now with more than 1,600 patients on its database. He assembled a research group at the outset, realising that most of these conditions are poorly understood and believing that only through basic research could more effective treatment be found. He enrolled to do a part-time PhD study with the University of Otago and was awarded a PhD degree in 2001 for his work in haemangioma.

In 1998, he founded a charitable trust to raise funds for his work – with the ultimate vision to establish a dedicated research institute – which attracted wide support from government, charities, corporate and individual donations.

He said the new laboratory would cost several million dollars to fit out and equip and that he hoped to be able to expand his team from the current six positions to have up to 30 scientists, post-doctoral and PhD researchers working there within the next 10 years.

"Our challenge from here is to ensure that it is sustainable," said Professor Tan.

Professor Tan is the Director of the Gillies McIndoe Research Institute – named after two New Zealand pioneers in plastic surgery – while continuing in his role as a consultant plastic and cranio-maxillofacial surgeon at Hutt Hospital.

He said he was excited about the work the team could achieve when they were finally able to work in their own dedicated space.

"For some time now we have been operating from different sites and while we have been grateful for people's generosity in allowing us to do that, it's like cooking in someone else's kitchen where you have to work around other people," he said.

"When I first became involved in this field of enquiry, I realised that better treatment for such tumours would only come about through basic research and this also applies to cancer. Innovation is underpinned by radical concepts which lead to paradigm shifts.

"We believe that our radical concept about cancer is worth exploring because there is the potential that we could come up with something quite radically different than what we have been doing for the past 100 years.

"For a number of years we had difficulty getting our work published until we won the science prizes and I can remember presenting our work at an international conference when the leader of a world-renowned laboratory stood up at the end and said: 'I don't believe a word of it'.

"But medicine is a very conservative profession in which people often hang onto the things they know, so we just had to have thick skin and have the deep conviction to keep going forward.

"While it has taken us so long to get this far, the results have been enormously rewarding, because of the commitments and efforts many people have put into this project."

So much public support and recognition has Professor Tan won for his work, particularly with children with vascular birthmarks and those suffering from head and neck cancer, that he was one of the three finalists for 2013 New Zealander of the Year Award.

Originally from Malaysia, he completed his medical training at the University of Melbourne before being required to leave because of his foreign student visa.

He then took up a house surgeon position on offer in New Zealand where he fell in love with the country and became fascinated with the life-changing nature of Plastic Surgery.

He said he felt it a great privilege to be involved in this field of medicine and the opportunities to work with colleagues from all disciplines and that he was humbled by the nomination and selection as finalist.

"I think there are many other people more deserving of this recognition than me," Professor Tan said.

"I see myself primarily as a catalyst. It has been a great privilege to work with a team of committed people who think creatively, coming up with radical concepts and having the courage to test new ideas."

With Karen Murphy

Left: The new facility next to Wellington Regional Hospital. Above left: The team: Dr Helen Brasch, Dr Paul Davis, Prof Swee Tan, Dr Tinte Itinteang, Ms Liz Jones. Above right: Swee Tan receiving his award for Excellence in Surgical Research from past-President Ian Civil at the ASC in Adelaide in 2011

In Memoriam

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

Oliver Ross Nicholson,
New Zealand Fellow

Richard Dunstan,
South Australian Fellow

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org**

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
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TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
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Erratum: In the July issue of Surgical News, WA Fellow Bernard Catchpole was attributed to the article 'On the Shard End' (Page 45). This was an error and the article was a contribution from a Fellow who wishes to remain anonymous. *Surgical News* apologises for the inaccuracy.

Not a flight of fancy

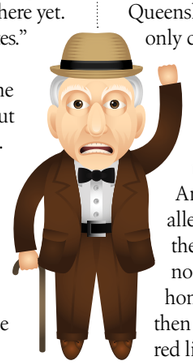
Time the airlines pulled their socks up!

There is one thing that really annoys me and that is airlines – well not all airlines all of the time, but all airlines some of the time. I recently travelled interstate and arrived suitably early for the 7.25am flight. We curmudgeons don't do 6.05am flights as we are too grumpy at that hour of the morning. Ten minutes after the scheduled boarding time there was an announcement that the boarding would be delayed by 10 minutes. Being restless I wandered from the Qantas lounge (that gives you a clue as to which airline is in my sights today) and at gate 25 there was no plane. What the announcement really should have been is, "We have no hope of leaving on time as the plane isn't here yet. Give us at least another 30 minutes."

On the flight there is another annoyance – the in-flight magazine has the crossword already filled out and it is only the 3rd of the month. Don't other passengers realise that there are others who like doing crossword puzzles? We curmudgeons like crossword puzzles as we often say cross words so we should have priority in doing the puzzles in the in-flight magazine.

As for the breakfast – there wasn't any. I had forgotten that the low cost subsidiary was really a no service subsidiary. Why would you want to buy (yes, BUY) a chicken wrap at 8am for $6 and then a cup of awful coffee for $4? Then there were the other passengers. At least Mother Qantas has businessmen and women in respectable clothes, but this airline had characters with pierced eyebrows and noses and goodness know what else; grizzly children and grumpy mothers and twitty teenagers.

We were, of course, late arriving for which the pilot offered his profuse apologies blaming a generalised delay in the network due to bad weather in Queensland. Now this plane had only come from Melbourne and was going back again so how did Queensland affect Melbourne so early in the day? I know about the chaos theory of the butterfly in the Amazon flapping its wings and allegedly causing a hurricane in the Caribbean. This is Australia not the Amazon! I was glad to fly home with the other bunch – but then why do you call an airline with red livery, "Virgin Blue"?



Poison'd Chalice

Pick yourself up ...

I am on holidays – a much deserved break from the demands from Health Ministers wanting to have the 'cure' for their current waiting list crisis and the Hospital CEO who never stopped asking me when I was going to be in the hospital providing the solution to theirs... Yes, I know, fame is difficult to deal with.

But at the moment, I am in a warm, somewhat balmy clime and like many others transfixed by the daily updates of the health of the ailing Nelson Mandela. There is no doubt that he personifies so much of what we need and seek in our leaders. Decades in a prison cell and still the ability to forgive and lead a people to a life of freedom – incredible.

One can only hope and pray that the post Mandela period identifies more leaders who can live his words: "The greatest glory in living lies not in never falling, but in rising every time we fall."

Words from the great leaders like Mandela bring us all back to the reality and even the banality of our everyday existence.

It was interesting that Shakespeare used similar words in 'Henry VI', part 3, Act 5, Scene 4 "Great lords, wise men ne'er sit and wail their loss, but cheerly seek how to redress their harms."

I had been using these very words just a few days before. I had been asked to review the Surgical Services of a pre-eminent hospital, which had 'lost its way'. It was interesting to talk to the affected and disaffected. Absent surgeons, invisible on-call commitments, hostility in the clinical environment, arguable morbidity and mortality meetings, poor training for the registrars – it had all been there.

The Hospital Chief Executive had called me in because he had heard me on the 'speakers circuit' – how to lead a surgical service. I asked a bit more about the 'surgical leadership group' – a bit like a 'football club leadership group'. It needs to be full of common sense, respect and agreement in what needs to be done. It also needs to stand up in those moments of 'peptide confusion' and know what is wise. There was a struggle to identify the group or the wisdom.

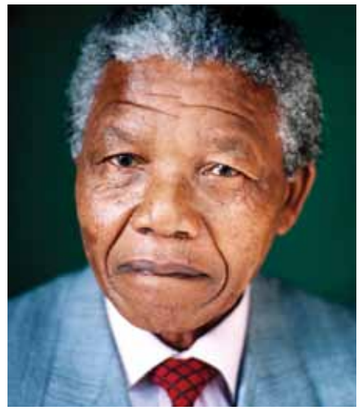
And there it was, another quote from the Bard: "See first that the design is wise and just; that ascertained, pursue it resolutely." I asked the CEO and the senior surgeons about the leadership group of the hospital.

I am a firm believer that a unit based structure in hospitals is critical. These are quite literally both the leaders and the glue of the hospital. They do not wail their loss, but attempt to redress whatever ails the organisation. They are not the juniors who are struggling to build up a private practice and may have time on their hands. They are the esteemed, senior and experienced surgeons who collectively know how it should be. They have demonstrated that they have the capacity to rise from a fall.

The CEO looked at the surgeons and the surgeons looked at the CEO. There had been no leadership – not for quite a while. The 'head' surgeon had taken the role because all others – were 'too busy'. The 'head' position was designed to be a rotating position – the arrangement brought to mind the game of musical chairs. Not only that, but there had been no advertisement, no degree of 'chasing' the right person. It was almost as if leadership was not an expectation. So, when the difficult discussions were needed, they were more than difficult – they simply could not happen. This was hospital governance by pseudo democracy inevitably creating a disaffected minority.

Over the years I have become a firm believer in consensus management, but this can only be achieved with strong leadership. A disaffected minority has to be avoided if at all possible. Not always easy, for when it comes to surgeons, there is no exception to the rule that every surgeon thinks they are an exception to the rule.

And on the rare occasions that a degree of alienation is necessary, I always fall back on the wise words of Casey Stengel, a very successful American baseball manager: "The key to good management is to keep those who hate you away from those who are still undecided."



"The greatest glory in living lies not in never falling, but in rising every time we fall"

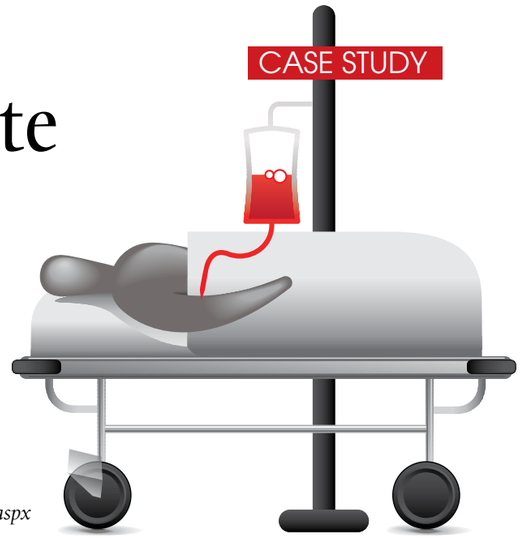
– Nelson Mandela

So how do I know the 'design is wise' – I live and breathe hospital surgical services. I am a believer in leadership – those men of reputation. Leaders are vital. As Mowbray stated in 'Richard II', Act 1, Scene 1: "The purest treasure mortal times afford is spotless reputation – that away, men are but gilded loam, or painted clay." The heads of the surgical units are vital – they have the reputation and the ability to be wise men or women. They seek how to redress the harms.

The Hospital CEO and senior surgeons had looked at each other. It was going to be a long path back. But they had started, had risen from a fall.

Professor U.R.Kidding

Case Note Review



A complication of arterial puncture for coronary angiography

Log in to the College website to join the discussion: http://www.surgeons.org/180673.aspx

Case Summary

An elderly patient presented to Hospital A with breathlessness and was admitted under a medical team. Comorbidities included hypertrophic cardiomyopathy, hypotension, atrial fibrillation and hyperlipidemia. Shortly after admission, the patient became hypotensive and developed chest pain. Clopidogrel and enoxaparin were started. One week later, the patient was transferred to Hospital B for coronary angiography which was performed via a puncture of the right femoral artery.

Following the procedure, bruising and tenderness were noted in the right groin. The patient was transferred back to Hospital A. The next day, the bruising and swelling in the right groin increased. There was no further clinical concern recorded until nearly a week later when the patient complained of severe right groin pain. Examination revealed a large tense swelling in the upper right thigh. An ultrasound was performed. The formal results were not included in the notes although a provisional diagnosis of ruptured pseudoaneurysm was recorded.

Several hours later, the patient became hypotensive and unresponsive. A medical emergency call was made. There was a massive expanding haematoma in the right groin. Transfer to Hospital C for specialist vascular care took several hours during which time resuscitation started with blood products and coagulation factors.

A CT scan showed a large haematoma in the right groin, extending up the anterior abdominal wall. Nearly half a day after admission to the ICU in Hospital C, surgery was performed to stop the bleeding from the femoral artery. The pathology appeared to be a ruptured pseudoaneurysm. Following surgery, hypotension persisted despite inotropes and the patient died nearly a day later.

Assessor's comment

Pseudoaneurysm is a complication of angiography and is a surgical emergency.

Applying pressure to the groin to control bleeding is an effective initial manoeuvre to control blood loss from an artery. Immediate surgery is required to control blood loss. Ultrasound is an effective diagnostic tool for pseudoaneurysm. This complication may be treated using endoluminal techniques which may be preferable to an open operation.

Guy Maddern
Chair, ANZASM

Australian Telehealth: on the rise

Use of the new telehealth system is being driven by patients

Funded by the Australian Government's Telehealth initiative, the Royal Australasian College of Surgeons has championed the Telehealth cause for the past year, creating a suite of online resources and retaining a support officer. The College has worked hard to promote uptake and these efforts are now bearing fruit.

As more Fellows see how Telehealth can work for them, there is evidence showing a strong increase in the numbers who are using it.

In the nine months to March 2013, the number of urologists using Telehealth had jumped from 1 in 10 to 1 in 4 and the number of both plastic and otolaryngological surgeons to 1 in 10.

Similarly, surgeons using the free to subscribe Telehealth Provider Directory run by the Australian College of Rural and Remote Medicine, have risen from two in April 2012 to 111 today. Some of these represent practice entries, so the actual number of surgeons participating is higher. Of course, not all Fellows want to grow their practice in this way, but the directory is there for those who do.

To ground these statistics in reality, the College has since run a survey to assess Fellows' use, awareness and opinion of Telehealth. Respondents came from all sub-specialties and included both Fellows and Trainees.

For those surgeons who said they were Telehealth users, the main drivers for adoption were patient demand, and the desire to accommodate their wishes to provide a more convenient service. One paediatric surgeon noted that while they achieved higher throughput in standard outpatient clinics, they used Telehealth because it provides equitable access for rural patients to healthcare.

The Department of Human Services has released the following data for five of the nine surgical sub-specialties:

Sub-specialty	No. of Surgeons using Telehealth as at May-12	No. of surgeons using Telehealth as at Mar-13	% of total no. of Australian surgeons in that specialty
Urology	34	108	26
Otolaryngology	11	58	12
Plastic	13	49	11.5
Orthopaedic	35	113	9
General	53	105	5.5

Source: Department of Human Services

The long term follow up consultation was the most common occasion on which to use Telehealth (according to three quarters of the replies). Meanwhile, initial consultations tied for second place with billable post-op appointments in nearly 60 per cent of replies.

Of those who said they hadn't used Telehealth, most said that it was simply because no one had asked them. This should be less of an issue as the Royal Australasian College of General Practitioners continues to support uptake among GPs. Indeed, the latest figures suggest that there are now more than 5,000 Telehealth active GPs.

A little less than half the surgeons who responded said they didn't know enough about Telehealth to implement it in their practice or their workplace wasn't properly equipped for Telehealth consultations. As mentioned before, the College has addressed this by creating a suite of online resources and retaining a support officer to advise on Telehealth matters.

Interestingly, only around 10 per cent of surgeons were concerned about technical or privacy issues. While a similarly small number believed it might impact on their efficiency. This is heartening because it suggests that the main barriers to uptake are potentially user-education and need. The former can be easily addressed and the latter is a logical determinant anyway.

In conclusion, the recent evidence supports a solid uptake in the use of Telehealth among Australian Fellows in the last year. It also suggests a greater awareness of its value amongst non-users. That usage amongst most Telehealth adopters is small is not actually a concern. It points to the fact that Telehealth may not necessarily be the Holy Grail, it's just a tool to be available for when the surgeon decides it is needed.

Professor Julian Smith
Chair, eHealth Reference Group

New developments for eye care in Sumba

Cover Story

Eye care improves in Sumba with the teaching of a new generation

The commitment and determination of an Australian Ophthalmology and Optometry team to reduce avoidable blindness and improve eye health care for the people of Sumba has shaped exciting developments for eye care services on the island.

The Sumba Eye Program, led by Ophthalmologist Dr Mark Ellis FRACS AM and optometrists Mr Peter Lewis and Mr Peter Stewart, has delivered annual outreach clinics in West Sumba in Nusa Tenggara Timur, the eastern province of Indonesia since 2008. The volunteer teams of ophthalmologists, optometrists and nurses conduct screening clinics to test vision and provide corrective spectacles, and referrals to the ophthalmologists for surgery, including small incision cataract surgery.

With the endorsement of the Indonesian Ophthalmology Association and the Indonesian College of Ophthalmology, two Indonesian ophthalmologists and one Trainee from Hassanudin University in Makassar, Sulawesi, were invited to work alongside the Australian team in September, 2012. This was the start of a collaboration effort between the program and the Faculty of Ophthalmology, Hassanudin University (UNHAS).

In June this year, Dr Habibah Muhiddin, Head of the Department of Ophthalmology at UNHAS participated in the program accompanied by one of her younger faculty, ophthalmologist Dr Hasnah Eka and final year resident, Dr Abrar Ismail. Both Dr Hasnah and Dr Abrar worked closely with the optometry and ophthalmology team for the full week.

The Indonesian team members are experienced in small incision cataract surgery, and on top of their regular workload, they undertake monthly outreach clinics in Sulawesi and West Papua, so they were well versed in the obstacles of outreach work and were able to hit the ground running with the Australian team on the first day.

The Australian team had high praise for the young Indonesian doctors' skills and attitude. Reflecting on their involvement, Dr Ellis commended Dr Habibah: "If Dr Abrar and Dr Hasnah represent the calibre of your Trainees and young ophthalmologists, then your training program has a bright future."

Dr Habibah has confirmed that her university is enthusiastic to continue the partnership.

Left: Dr Habibah Muhidden, Head of Ophthalmologyy at Hassanudin University with one of the patients.
Top to bottom:
The Indonesian team providing post-operative care to a cataract patient;
Optometrists Peter Lewis and Peter Stewart with the eye care trainees;
Dr Hasnah Eka looks on as Dr David Workman attends a patient.

> *"If Dr Abrar and Dr Hasnah represent the calibre of your Trainees and young ophthalmologists, then your training program has a bright future"*

"Reducing blindness in Indonesia, especially in the eastern part is our responsibility. And having friends to do it together with is really wonderful.

"I am really happy that we are involved in the program, because the collaboration also widens education, knowledge sharing, skills and experiences. See Hasnah and Abrar learn from the Australian team was amazing."

Having two operating tables meant that the surgical team was able to provide training and support for the young Indonesian doctors, while achieving a good throughput of patients over the course of the week. The benefit of the collaboration was significant.

The involvement of the Indonesian ophthalmologists is a significant step for the Program, which has been seeking opportunities to engage regional doctors and develop its training component, with the aim of eventually transferring the program to local ownership.

The program successfully recruited two Sumbanese (with the assistance of the Sumba Foundation a local NGO) and sponsored their training as eye care workers in order to set up a permanent eye care service in the main the town of West Sumba.

Nefry Radenna and Serly Yiwangnana, who have qualifications in public and environmental health and general nursing respectively, completed a basic eye care training program at the John Fawcett Foundation in Bali earlier this year. Shortly after completing the training program, they joined the Sumba Eye Program's optometry clinic for intensive one to one training with the Australian optometry team in June.

The Program received a grant from Optometry Giving Sight (OGS) to fund the initial training program and purchase motorcycles for the eye care Trainees to enable them to travel out to the districts to screen and inform the more remote communities about eye health care, which might otherwise not be reached.

OGS is also sponsoring the travel for the Australian optometry team members for the next three years, so they can continue to conduct their annual visits to the island to provide ongoing training and reinforce the skills learnt.

With the majority of Sumbanese unable to afford treatment in Bali or overseas, the delivery of ophthalmic and optometry services through the Sumba Eye Program has been one of the only ▸

Royal Australasian College of Surgeons

Nominations invited for the

SURGEONS INTERNATIONAL AWARD

The Surgeons International Award provides for doctors, nurses or other health professionals from developing communities to undertake short term visits to one or more Australian or New Zealand hospitals to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's country.

The Award may cover a return economy class airfare, necessary accommodation costs and living expenses for the recipient. The value of the award varies up to a total amount of AU $12,000, depending on the requirements of the candidate's program.

Fellows participating in the RACS International Development Program or international outreach work are encouraged to nominate worthy individuals they have identified while undertaking outreach work.

Fellows who nominate worthy individuals with whom they have had contact must be willing to accept the responsibility for arranging a suitable program and acting as a personal host to the award recipient.

NOMINATIONS MUST INCLUDE

- Personal and professional information concerning the nominee;
- Objectives of the proposed visit;
- Anticipated benefits to the nominee and their home country;
- Names of the International Development Program team members responsible for organising the visit (including accommodation, training program and travel within Australia);
- An outline of the proposed training program and activities; and
- Letters of recommendation from the nominee's hospital and/or Health Department with an indication of the local importance of any upskilling resulting from the Award.

Dr Malemo Luc Kalisya from the Democratic Republic of Congo was supported to participate at the RACS ASC 2013 in Auckland, and undertook a four week hospital attachment at Princess Alexandra Hospital under the mentorship of Dr Neil Wetzig. Dr Wetzig has been working with Dr Luc and his colleagues during annual visits to the D.R. Congo for over 10 years.

CONTACT INFORMATION

For further information or to submit an application

International Scholarships Officer
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 – 290 Spring St, East Melbourne VIC 3002, Australia

Or by fax or email to:

Telephone: +61 3 9249 1211 Fax: +61 3 9276 7431
Email: international.scholarships@surgeons.org

Dr Abrar (UNHAS trainee) with a post-op cataract patient.

options for treatment for the majority of the population of West Sumba. Now with the local eye care workers on board, they will be able to conduct regular clinics to provide screening and basic treatment, as well as provide follow-up care to patients after the team's departure.

The Sumba Foundation plans to set up a permanent eye care clinic within the malaria training centre in the town centre, where the eye care workers will provide a full time service for the community. The team left behind all of the necessary optometry equipment including trial sets, eye charts, drops and a large supply of spectacles for the eye care workers to continue to conduct eye clinics on the island throughout the year.

Fellows of the College have been delivering volunteer specialist medical and surgical services and training support to communities in Indonesia since the 1960s. The College's work has recently been formalised, with the Indonesian Government accrediting the College to work as a registered development agency in the country. The next decade will see the Indonesia Program continue in its much needed service delivery component, but also concentrate on expanding its training and capacity building initiatives.

Although the lack of infrastructure on Sumba means that the establishment of a local specialist ophthalmology service is not likely in the short-term, the vision of the program is a situation where regional Indonesian institutions take ownership and promulgate the program, to encourage local ownership and sustainability.

Ideally, the regional ophthalmologists would provide regular outreach services on the island, with the Australian component visiting intermittently for teaching and to consult on specific cases when required.

The Sumba Eye Program is supported by Glenferrie and Kew Rotary Clubs (in Victoria, Australia), the Sumba Foundation and Sumba Foundation Australia, Optometry Giving Sight, Mondottica and private donors with logistics support from the Royal Australasian College of Surgeons.

Phil Carson
Chair, International Development

If you would like to donate to the Sumba Eye Program, please contact Stephanie Korin on stephanie.korin@surgeons.org or phone + 61 3 9249 1211.

Red-faced or Rouge?

Be sceptical about the ingredients of the skin care you use

A fit and energetic surgeon consulted me some months ago due to persistent, red, itchy lines above and around the eyes and down the nasolabial fold. Nothing applied seemed to relieve them, not even hydrocortisone.

Was it due to sweating a lot in the gym or an infection acquired from a towel? Was it some partial butterfly lupus type rash or were they cutaneous manifestations of an underlying connective tissue disorder?

So many of my medically qualified patients self medicate *in extremis* and never consult until they are desperate. This surgeon was no exception. But the advantage of being a GP is that we do have experience of common medical conditions.

"It looks like MI," I stated, eliciting a startled response – "but not the MI you're thinking of," I hastened to add. After a detailed history, including generalised inflammatory conditions, and failing to find any other reddening on the rest of the skin surface, I asked about face creams, lotions and cosmetics.

This evoked an admission to using '*healthy ozone oil mist*', a face cream discovered late last year, during an overseas trip. The said cream/moisturiser advertised its efficacy was based on Vitamin E, other anti-oxidants, and lavender plus an antibacterial action with a long shelf-life. Its other contents hadn't been scrutinised, but suddenly it became apparent that use of this cream preceded the red tramlines, though not immediately.

"You are suffering from contact dermatitis; you are allergic to something in the cream or some other product you are applying. It is likely to be MI or Methyl iso-thiazolone, if you'd rather hear its full name. We googled '*healthy ozone oil mist*' – and yes, lo and behold, it contained the culprit MI.

It's not surprising a surgeon would never have heard of it (those of you who read this column who are offended by this are welcome to write and tell me off, even if you only read the article in the Australian on July 8).

The isothiazolones are a chemical family of biocides (i.e. they kill things) and so lengthen the shelf life of cosmetic products through their antibacterial and thus preservative action. They are present in low concentrations in rinse-off products like shampoos and conditioners, body washes, laundry detergents and liquid hand soaps and also in leave-on products like cosmetics and face creams. In addition to *methyl iso* there are also *chloro, benzyl, octyl* and *dichloro* versions of the iso-thiazolinones.

The European Scientific Committee on Cosmetic Products and Non-Food Products intended for Consumers (SCCNFP) unwittingly recommended companies limit the maximum concentration to 100 parts per million (ppm) or 0.01 per cent.

However, this may be far too high for MI on its own. Formerly when used in combination with chloro methyl iso [MCI} in concentrations of 1:3, only 7.5 ppm was permitted for leave-on products and 15 ppm for rinse off. Thus MI exposure has greatly increased in recent years.

MI is the Allergen of the Year, 2013, as announced by the American Contact Dermatitis Society. An allergic reaction can be confirmed by patch testing providing MI is specifically included in the range of potential allergens. An article published in the Journal of Dermatitis early in 2013 reported that, "in Europe, several groups have documented the frequency of allergy to this preservative to be approximately 1.5 per cent (in those tested)."

The Information Network of Departments of Dermatology (IVDK) reported a consistent figure for MCI/MI sensitivity of around 2.1 per cent from 1998 to 2009, but this increased to 3.9 per cent in 2011, paralleled by an increase in the frequency of allergic reactions to MI from 1.9 per cent in 2009 to 4.4 per cent in 2011.

> ***"This evoked an admission to using 'healthy ozone oil mist', a face cream discovered late last year, during an overseas trip"***

In July 2013, the president of the British Society for Cutaneous Allergy put wind to the sails of adverse publicity, announcing rates of MI sensitivity to have increased to almost 10 per cent (of those tested). These are only the "tip of the iceberg", he claimed.

The *BMJ* published a Danish study (*BMJ* 2012; 345:e8221) showing airborne exposure to MI may also cause sensitivity resulting in allergic skin reactions, particularly in those with eczema. MI is in paints so painters are also affected. An Australian study highlighted contact dermatitis in the hands due to moist nappy wipes. *In vitro* studies on rat brain cell cultures showed MI is highly toxic, raising concerns about long term exposure in humans.

Contact dermatitis can be due, not only to preservatives, but also fragrance components, antioxidants, natural ingredients (herbs) as well as and excipients, emulsifiers, and surfactants.

I am pleased to report that this surgeon's dermatitis soon resolved – the red lines were not rouge, but an allergic reaction to MI! And there's a special mention for anyone who can make one word out of healthy ozone oil mist.

Dr BB G-loved

A briefing note from Brisbane

The Queensland state committee further drives its presence among policymakers

This month marks the halfway point in my two year stint as the State Chair of the College for Queensland.

I moved my family of six away from the NHS and the English Lake District to tropical Queensland in 2005 in order to take up a full time area of need specialist position in ORL/H&N surgery at Princess Alexandra and Logan Hospitals. My parents and sisters had made the move to Brisbane some 20 years before me.

As an IMG, I followed the pathway, was deemed substantially comparable and after a period of oversight was awarded the Australasian Fellowship (Section 19) which was subsequently conferred at the Christchurch ASM the following year.

Having left my existing medical network behind in the UK, I felt that becoming active in the college was an excellent way of establishing contacts and getting immersed in the Queensland way of doing surgical business. I would strongly recommend this approach to other IMGs upon arrival in Australia and encountering a new foreign health care system.

I was proud to be elected to the State Chair in July, 2012, which coincided with the move to Leckhampton House, the new, leased, fit for purpose headquarters for the College in Queensland.

The Queensland state election in March, 2012, gave a massive mandate for change to the incoming government and health issues were high on the agenda. February, 2013, saw the launch of the LNP Blueprint for Health Care in Queensland which is now being implemented. The core messages from the blueprint were partnerships (PPP) with the non-government sector in health care delivery, increased transparency and accountability with the public access online and in the press for wait times, access to surgery and KPIs concerning the performance of hospital networks.

Meaningful engagement by the College to seek to influence the changes was established soon thereafter. Scheduled meetings with Queensland Health Minister Lawrence Springborg are held bimonthly with John Quinn EDSA in attendance. We stressed that the College and not the Queensland AMA is the voice of surgeons in Queensland.

In addition, the Queensland Committee of Medical Specialists (PCSW Chair elect) questions the minister twice yearly. Further college and strategic surgical input is provided by the Surgical Advisory Committee chaired by Professor Ian Gough.

This financial year is shaping up to be a good one for the patients of Queensland. Many of the major capital infrastructure hospital builds initiated by the Federal and previous Labor regime are due for completion this year. It is, however, worth remembering that over a building's 30 year life cycle, the capital costs to build the facility are only a small percentage of the overall bill. Hence, the need for a different way of doing business should be considered to maximise "bang for bucks" for the taxpayer.

> ***"I would strongly recommend (becoming involved with the College) to other IMGs upon arrival in Australia and encountering a new foreign health care system"***

Queensland Regional Chair Bernard Whitfield with his wife and children taking part in the Guinness Book of Records, world's biggest orchestra at Suncorp Stadium.

Starting with Far North Queensland and working down the coast, Cairns Base Hospital will open more beds, theatres and a radiation oncology centre. Townsville and Rockhampton Hospitals are also adding further surgical capacity and new fit for purpose redevelopments. Mackay received a brand new future proofed hospital which opened in December, 2012.

Close ongoing collaboration between the Mackay clinicians and hospital architects have delivered a first class facility. Morale has rocketed upwards and for the first time ever there are no specialist vacancies across all departments. The Ipswich and Logan Hospitals have also benefitted from significant redevelopments, thereby increasing beds, procedure units and theatres.

Gold Coast University Hospital opens in October, 2013. The existing Southport campus surgical activity will be absorbed fully, but the 'redundant' capacity, potentially up to 10 operating theatres plus surgical wards, is likely to go to PPP tender process in a move to maximise the Queensland Health dollar purchasing capacity.

The Queensland Children's Hospital (QCH) will open in 2014. This is the largest capital build hospital infrastructure project to date. The salutogenic approach to the built environment design principle was recognised this week as Brisbane hosted the 9th World Congress in Design and Health at the recently expanded Brisbane Convention and Exhibition Centre.

The Sunshine Coast Private Hospital at Kawana opens in December, 2013, with a three year Queensland Health block contract with Ramsay Health Care to deliver surgical care for public patients and achieve NEST targets. Thereafter, in 2016 the new Sunshine Coast University Hospital will be fully operational and ground works commenced for this last month.

This is a PPP arrangement and it remains to be seen whether the managing rights for this new facility will be partially or fully within the non-government sector. The Health Minister has agreed to facilitate meetings between the Sunshine Coast Private Hospital (with public contract) and the Gold Coast Hospital Health Service and the College to ensure that training opportunities for the SET registrars are embedded into the modus operandi.

The Gold Coast Griffith University Dental and Oral Health School and Hospital opened this week with a large similar facility at Herston, Brisbane, provided by the University of Queensland, due to open its doors in late 2014.

This year also heralded the fruition of the Diamantina partnership between Princess Alexandra Hospital, University of Queensland, Queensland University for Technology and the Mater Hospital group, led by Professor David Thiele, together with the Translational Research Institute headed by Professor Ian Fraser.

This science medicine industry hot spot campus co-located with Pharmacy Australia Centre of Excellence is well placed to delivery potent new biological agents from the lab to the bedside and to the world, as well as firmly placing Brisbane on the global innovation map.

So what's happening now? The current QH funding for Queensland Audit of Surgical Mortality over the next three years has been confirmed this week and will now cover all costs from the private sector hospital groups, hopefully ensuring that they participate fully in future surgical audit within Queensland.

The Queensland Auditor General's Report into 'The Right of Private Practice in Queensland Public Hospitals' was released on July 11. This report was concerned with full time SMOs, including surgeons employed by hospital health services within Queensland (VMOs were not considered).

Essentially, the existing salary option arrangements dating back 20 plus years, initially brought in to enable recruitment and retention of full time public doctors, are no longer fit for purpose. It is very likely that individual contracts with specific KPIs regarding to public and private interactions will be promulgated this year to take effect from July, 2014. ▶

The Health Ombudsmen Bill 2013 was introduced to the legislature on June 4 and will be passed through the parliamentary process into law by October. The implications are as follows:

"The medical complaints roll of AHPRA and HQCC Queensland will be subsumed into the new Health Ombudsmen office. All complaints will be triaged at a high medical level. Complaints will be dealt within a prescribed short time frame. The complainant will know that he or she is being investigated which is a new feature and the need to respond timeously to produce a definitive outcome is enshrined within the law. Parliamentary oversight of the Health Ombudsmen office is also enabled."

The roll of the Health Ombudsmen Queensland is critical and RACS Queensland continues to lobby for an appropriately skilled person to be appointed to the role. We also seek to influence the composition of the adjudicating medical group's setup within the ombudsmen legislation.

The College is also well represented by Professor Ian Gough as chair of the Clinical Advisory Committee of IHPA. I am also a member of the CAC together with the Teaching, Training and Research working group, as well as the Pricing for Safety and Quality group of IHPI and the AHQCC. When there is full national implementation of activity based funding from July, 2014, we will all have to deliver according to the funding determined by the national efficient price.

Queensland is a seriously large state. This year David Watson, Regional Manager for Queensland at the College, and I have undertaken a series of visits to cover all the surgeons practicing within the public sector throughout Queensland.

To date, we have visited Rockhampton, Gladstone and Mackay. Cairns; Townsville and Mt Isa are scheduled for early August and thereafter Gold Coast, Sunshine Coast, Toowoomba and Ipswich to follow. The voice of the College and its Fellows in the regional locations needs to be promulgated.

In October, 2013, the first medical student orientated surgical skills competition, in conjunction with Johnson and Johnson and the Royal College of Surgeons of Edinburgh will occur at the Leckhampton house in Brisbane.

Finally, as an example of what team work can achieve, I congratulate the 7,223 Queenslanders, including my wife and our youngest two children, who achieved the Guinness Book of Records award for the World's Biggest Orchestra Performance at Suncorp Stadium on July 13.

I wish to continue serving the interests of surgeons within Queensland and as such will be putting my name forward for the College council elections when my current term is finished.

Bernard C S Whitfield
Chair, Qld Regional Committee

55th Victorian Annual Surgeons Meeting (VIC ASM)

"Surgical Practice and Training - confronting and tackling the regional issues"

FRIDAY 18 - SUNDAY 20 OCTOBER 2013

Novotel Forest Resort, Creswick / Friday 18 October
Welcome Dinner and Show - Sovereign Hill
(Families are encouraged to attend)

Saturday 19 October; Meeting Dinner - Novotel Forest Resort, Creswick

PRIZES

There are prizes for the following categories:

2013 DR Leslie Prize – Best clinical registrar paper
2013 RC Bennett Prize – Best laboratory based research paper presented
DCAS Scholarship – Best presentation appropriate to academic surgery.
Medical Student Prize – Best presentation by a Medical Student
Audio visual instructions will be sent to all successful authors.
Please note that single case reports will not be accepted for presentation or poster

MEETING ORGANISER

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Royal Australasian College of Surgeons

2013 Workshops & Activities

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

Supervisors and Trainers for SET (SAT SET)

2 August, Cairns

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.

Preparation for Practice

24 - 25 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. This activity is proudly supported by The Bongiorno National Network, mlcoa and ROOMS WITH STYLE.

Keeping Trainees on Track (KToT)

18 October, Annual Scientific Meeting Hobart

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.

Non-Technical Skills for Surgeons (NOTSS)

18 October, Annual Scientific Meeting Hobart

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.

Management of Acute Neurotrauma

26 September, Sydney

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.

Surgical Teachers Course

24 - 26 October, Perth

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

Writing Medicolegal Reports

28 October, Melbourne

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

bongiorno network | ROOMS WITH STYLE | mlcoa | Avant

NSW

13 August, Sydney
Supervisors and Trainers for SET (SAT SET)
26 September, Sydney
Acute Neurotrauma
12 November, Sydney
Keeping Trainees on Track (KToT)
22-24 November, Sydney
Process Communication Model

QLD

2 August, Cairns
Supervisors and Trainers for SET (SAT SET)
26-27 October, Brisbane
Preparation for Practice
29 October, Gold Coast
Non-Technical Skills for Surgeons (NOTSS)

SA

12 September, Adelaide
Polishing Presentation Skills

TAS

18 October, ASM Hobart
Non-Technical Skills for Surgeons (NOTSS)
18 October, ASM Hobart
Keeping Trainees on Track (KToT)

VIC

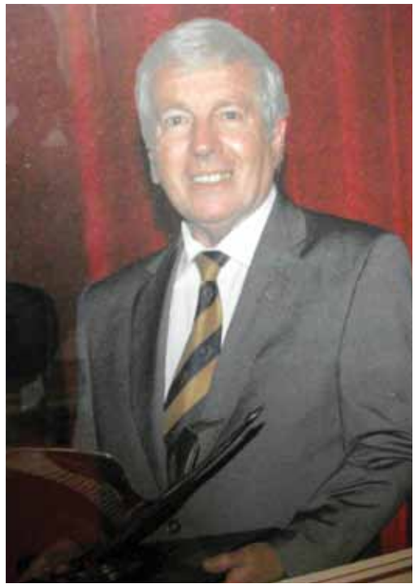
24 - 25 August, Melbourne
Preparation for Practice
10 September, Melbourne
Keeping Trainees on Track (KToT)
9 October, Melbourne
Supervisors and Trainers for SET (SAT SET)
11 October, Melbourne
Strategy and Risk for Surgeons
28 October, Melbourne
Writing Medicolegal Reports
16 November, Melbourne
Building Towards Retirement
16 November, Melbourne
Communication Skills for Cancer Clinicians
22 November, Melbourne
Non-Technical Skills for Surgeons (NOTSS)
27 November, Melbourne
AMA Impairment Guidelines

WA

24 - 26 October, Perth
Surgical Teachers Course

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.

> *They simply accept the risks they faced during the war, and partly because of their experience we may not expect to see the same results in years to come*



A lifetime of service

Associate Professor Robert Pearce uses his military experience to relate to his own patients suffering the after-effects of national service

When the young men of Australia and New Zealand were deployed to fight under the unforgiving sun of Africa and the Middle East during WWII, few understood that danger lay not only in the bullets and bombs and fire of war.

As many of us have seen in the slowly fading photos of our ANZAC ancestors taken during periodic breaks in fighting, many coped with the unrelenting heat by stripping down to their boots and shorts unaware that by so doing they were exposing themselves to a different, but no less lethal danger.

By the 1960s, however, returned veterans began presenting with skin cancers in numbers that outstripped that of the general population to such a marked degree that it became clear they were a by-product of military service and therefore deserving of state-funded medical care.

Plastic and Reconstructive Surgeon Associate Professor Robert Pearce has spent much of his professional life treating the diggers of WWII as well as Vietnam Veterans and other peacetime personnel for skin cancers and melanoma.

An Associate Professor of Surgery at the University of Western Australia, Professor Pearce has been a Colonel in the Medical Corps of the Australian Army Reserve until his recent retirement, having joined in 1968 to help treat the returning casualties from the war in Vietnam.

"I was initially called up for National Service but was allowed to defer while I completed my medical training," he said.

"I was appointed to RMO and Registrar posts at Princess Alexandra Hospital in Brisbane and worked some night shifts and weekends at 1 Military Hospital in Yeronga which was a receiving centre for sick and injured troops returning from Vietnam.

"After that I completed my surgical training in Edinburgh, Glasgow and Oxford and returned to Perth, in 1973 as Senior Registrar at Royal Perth Hospital.

"In 1975 I was appointed consultant Plastic Surgeon to the Department of Veterans Affairs at Hollywood Repatriation Hospital and was also consultant surgeon to the Australian Defence Force so I've been treating soldiers for most of my working life."

Professor Pearce said he became interested in melanoma research through his association with the Queensland Melanoma Project. Melanoma is also very common in Western Australia and he has treated many veterans with this disease. He established the Perth Melanoma Clinic and was a foundation member of the Western Australian Melanoma Advisory Service.

He has also worked to develop a melanoma research program at Edith Cowan University investigating biomarkers for early detection and prognosis under the leadership of molecular biologist Associate Professor Mel Ziman.

"I have supplied hundreds of cases to this research project and many strong papers have come out of our research team at Edith Cowan University," he said.

Professor Pearce has himself completed two tours of active service with the Australian Army, on each occasion as Consultant Surgeon with the multinational Bougainville Peace Monitoring Group sent in to help a community ravaged by civil war.

In an image straight out of the TV series "MASH", Professor Pearce said the group set up a hospital and operating theatre in tents. While they were not permitted to carry weapons, members of the group were sometimes targets of the less-disciplined rebels.

"I was shot at a few times during that deployment, once in a helicopter that I remember quite vividly, but we all made it through," he said.

"In Arawa on the island of Bougainville all the doctors had fled, much of the population were in hiding and what little infrastructure was once there had been utterly destroyed, including a substantial hospital and their local ambulances.

"We did what we could for the people, including a number of amputations for injuries caused by motor accidents and I treated head injuries, burns, a few cleft lips and a number of Caesareans, so it was an interesting experience."

Professor Peace has spent his career outside his military involvement pursuing a number of research interests, particularly into the biology and genetics of Dupuytren's Disease which is a painful and debilitating contraction of the fibrous tissues in the hand.

In 2003, he presented research of 1,000 cases to a surgical congress in Paris, after which he was made an honorary member of the Academy of Surgeons.

Yet, still it seems his clinical interests remained focused on the needs of Australian war veterans.

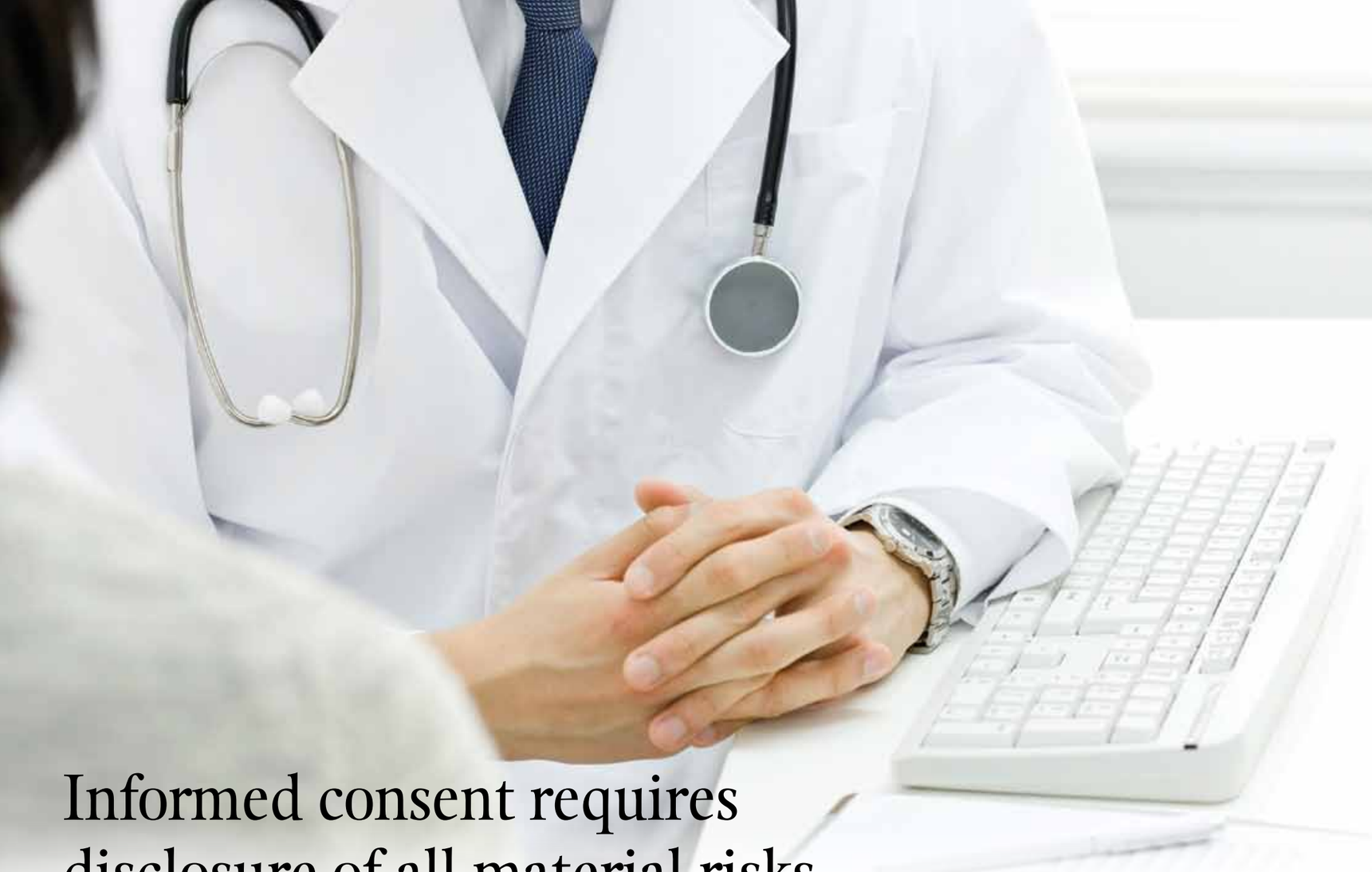
"I do enjoy treating these patients; perhaps because of my own military involvement they relate very well to me," he said.

"As a group, the WWII veterans are a very tough, very stoic group, probably more so than later generations.

"They simply accept the risks they faced during the war, and partly because of their experience we may not expect to see the same results in years to come affecting our soldiers who have served in Iraq or Afghanistan.

"So in a way you could say they are still serving their country."

With Karen Murphy



Informed consent requires disclosure of all material risks

A recent High Court decision (*Wallace v. Kam (2013) HCA 19, 8 May 2013*) produced an interesting scenario.

The neurosurgeon allegedly failed to provide information on the material risks of two specific risks – neurapraxia and the risk of paralysis. The surgical procedure was unsuccessful, and the first risk occurred, with the patient sustaining neurapraxia, which left the patient in severe pain for some time.

Notably, the Court accepted that if the patient had been warned of the risks of neurapraxia, the patient would still have proceeded with the operation, and a claim for lack of informed consent would have failed. However, the Court also accepted that if the patient had been warned of the risk of paralysis, the patient was, on the balance of probabilities, unlikely to have proceeded with the operation. In fact paralysis did not occur. In other words, the risk which the patient would have avoided was not the risk that actually materialised.

The High Court nonetheless determined that there was, of course, the general obligation of the medical practitioner to advise of all the material risks of the proposed treatment. This is the standard requirement of informed consent. The Court accepted that the surgeon failed to advise of the two particular risks, and accordingly was in breach of his duty to advise.

The Court concluded that the failure to advise of all of the "inherent material risks" led to the patient proceeding with the operation. It concluded that if the surgeon had warned of the risks, particularly the risk of paralysis, the patient would have avoided the operation, and therefore not suffered the neurapraxia. (Even though if warned of the neurapraxia alone, the patient would probably still have proceeded with the operation.)

The decision does not substantively alter the legal obligations of informed consent. It serves as a reminder that liability can accrue when any of the inherent material risks have not been advised to a patient. It reinforces that doctors will not be liable where, even where they have failed to warn of the material risk, it is likely the patient would still have proceeded with the operation.

In this case, the Court accepted that the patient was not warned of all of the material risks, and if warned of one of the particular risks, would have chosen not to proceed with the operation, even though that material risk was not the one which materialised.

The Court confirmed: "The duty of a medical practitioner to warn the patient of material risks inherent in a proposed treatment is imposed by reference to the underlying common law right of the patient to choose whether or not to undergo a proposed treatment."

> ***"In other words, the risk which the patient would have avoided was not the risk that actually materialised"***

Medical Board of Australia undertakes National CPD Audit

The Medical Board of Australia (MBA) has indicated that it will, for the first time, be conducting a CPD audit to ensure compliance by all medical practitioners of their obligations under the MBA CPD Standard.

Medical practitioners will be selected randomly and will be "required to provide evidence to support the declarations made at renewal", which are declarations that they met all of the requirements of the CPD Standard during the previous year.

It is hoped, therefore, that medical practitioners will have retained sufficient records to be able to demonstrate that they met their CPD obligations. If in doubt, medical practitioners should review the MBA CPD Standard requirements, and be aware of the activities required, including practice based reflective elements such as clinical audits, peer review or performance appraisal. This would be in addition to other activities such as seminars, professional meetings, etc.

Under the MBA CPD Standard, compliance with the CPD requirements of the medical colleges is usually sufficient, and medical practitioners should check their requirements either under the MBA Standard, or with their appropriate medical college.

CPD evidence should generally be recorded and retained for at least a period of three years.

End of limited registration for retired doctors

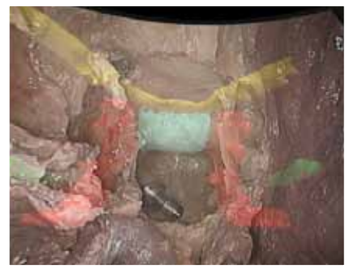
When the new National Scheme commenced in 2010, approximately 1,000 medical practitioners were granted special registration "public interest – occasional practice", mainly for retired doctors who held a similar type of registration under the old arrangements. Because of that, "grandfathered" registration arrangements were permitted three renewals, and those retired doctors cannot continue with that registration after three renewals. The registration of approximately 600 of these medical practitioners will expire on 30 September, 2013, and the registration of the remaining medical practitioners will expire after a final renewal on 30 September, 2014.

Limited registration allowed doctors to issue scripts and referrals and provide "occasional" practice in very limited circumstances. Those doctors will now have to seek alternative registration arrangements, either for general registration or non-practising registration. Under non-practising registration, doctors cannot issue scripts or write referrals. An application for general registration implies that the medical practitioners have currency of practice, will be delivering service on a more regular basis, and will need to meet CPD and professional indemnity insurance requirements. The MBA has indicated that these changes occur because of the public safety aspects involved.

Michael Gorton,
College Solicitor

Research for virtual reality

Recipient of a Foundation for Surgery Research Scholarship Ben Dixon looked into how to take up new technology in the theatre



Ben Dixon in the lab; below right; a close-up of his work.

While computerised innovations such as advanced navigation displays with real-time image guidance may have the potential to improve surgical accuracy and efficiency, more research must be undertaken to ensure that the extra data provided does not impair, rather than enhance, surgical safety, according to Head and Neck Cancer Surgeon Mr Ben Dixon.

The recipient of a Foundation for Surgery Research Scholarship in 2012, Mr Dixon conducted PhD research into the benefits of 3D "virtual views" and augmented reality for use by surgeons through a Research and Clinical Fellowship at the Guided Therapeutics Program based at the University of Toronto, Canada.

Augmented reality is a live, direct or indirect view of the physical world, the elements of which are augmented by computer generated sensory input such as sound, video or graphics.

The technology was expected to improve surgical accuracy and patient care, but Mr Dixon instead found that increased data and sensory input could cause surgeons to become distracted.

Mr Dixon conducted his research with the cooperation and support of scores of senior surgeons who gave up their time to use the high-tech equipment on cadaver specimens in an operating theatre specifically equipped and designed by Mr Dixon for experimental purposes.

He found that while there was scope for greater integration of computer-assisted technology, trained surgeons were unable to efficiently complete tasks while being presented with additional stimuli, meaning that great caution must be taken in how information was displayed.

"Until I began this work there was very little research looking at the detrimental effects of such technology or why, with such rapid advances in computer technology, it hadn't taken off within the field of surgery as might have been expected," Mr Dixon said.

"People had assumed it was because of slow computer speeds or problems with accuracy, or that junior surgeons could find using such devices made tasks more difficult while senior surgeons didn't need it, but we found something quite different.

"We found, for instance, that if you present a Trainee surgeon with unfamiliar anatomy yet provide them with extra computer-generated information, they cannot use the extra information.

"We also found that experienced surgeons were no more likely to pick up truly unexpected findings than their more junior colleagues.

"This represents a fundamental limitation between how much external information the human brain can usefully absorb and use, which requires significant further research."

With many papers already published and more being assessed, Mr Dixon said that in one study, published in Surgical Endoscopy, surgeons completed tasks on a cadaver model with some salient, but unexpected, findings placed in their field of vision such as a foreign body (a screw) and one critical complication.

He said that just 41 per cent of surgeons recognised additional information using a standard display such as a computer monitor while the group using an augmented reality display showed even poorer results.

"This was an extraordinary finding in that almost everyone missed the unexpected and it suggests strongly that the use of advanced technology provided no gains in efficiency, but did increase distraction," Mr Dixon said.

"This inability to see the unexpected is known as inattentional blindness which is the failure to notice an unexpected stimulus in your field of vision when you are performing attention-demanding tasks.

"Our experiments showed that placing the same information on a sub-monitor, rather than a head-up display mitigated the cost of the surgeons' attention without compromising efficiency.

"It is the same reason that cars have GPS equipment as a monitor on the dashboard, even though head-up "out-the-window" prototypes have been around for years.

"Projecting images into your real-world view competes for attention and becomes dangerous as has been shown in other fields that have developed such technology including the military, aviation and the automotive industries.

"In our field, there has now been enough research done to know that the technology works, but more research needs to be done to fully understand how surgeons interact with the equipment."

Mr Dixon, now a Fellow, conducted his PhD under the supervision of Professor Peter Choong, University of Melbourne and the Department of Surgery at St Vincent's Hospital, and Professor Jonathon Irish at the University of Toronto, Department of Otolaryngology, Head and Neck Surgery.

Now back working at the Peter MacCallum Cancer Institute and St Vincent's Hospital in Melbourne, Mr Dixon said further research would require the input of psychologists, behavioural scientists and software developers to fully understand how humans interact with machine-driven input and whether there are basic limitations to how useful such data can be.

"I went into this field of research very keen to understand how we could better integrate this technology into surgery,

> ***"Until I began this work there was very little research looking at the detrimental effects of such technology"***

Career Highlights

Scholarships

2012: RACS Foundation for Surgery Research Scholarship

2011: RACS Morgan Travelling Scholar

Conference Presentations

Dixon BJ, Daly MJ, Chan H, Vescan A, Witterick IJ, Irish JC. *The hidden cost of enhanced real-time image guided surgery*, 5th World Congress for endoscopic surgery of the brain, skull base and spine, Vienna, Austria, March 2012.

Dixon BJ, Daly MJ, Chan H, Vescan A, Witterick IJ, Irish JC. *Augmented real-time navigation with critical structure proximity alerts for endoscopic skull base surgery*, 22nd annual North American Skull Base Society Meeting, Las Vegas, NV, February 2012.

Dixon BJ, Daly MJ, Chan H, Vescan A, Witterick IJ, Irish JC. *Augmented real-time image guided surgery reduces task workload during endoscopic sinus surgery*, 57th meeting of the American Rhinological Society, San Francisco, September 2011.

Dixon BJ, Daly MJ, Chan H, Vescan A, Witterick IJ, Irish JC. *Pre-clinical assessment of various technological aids for anterior skull base endoscopic navigation. Augmented image guidance in skull base surgery: improved navigation and reduced task workload*, NASBS annual meeting, Scottsdale AZ, February 2011.

Ben Dixon enjoying the Canadian snow with his family

but the more involved I became the more problems I found," he said.

"One of the more surprising results was that while more experienced surgeons run through a larger check list of issues to be aware of and things to look out for, when something truly unexpected occurs they have the same chance of picking it up as a novice.

"This means that experience has no impact on the unexpected, but very few senior surgeons believe me when I tell them this."

Mr Dixon said it had been a wonderful experience working with such a diverse group of people as those attached to the Guided Therapeutics Program which included surgeons, IT experts, radiologists and engineers; he also thanked the College for its support.

"During the last part of my PhD work in Canada I received incredible support from highly trained and experienced surgeons and at one stage had 70 surgeons give up their time to do endoscopic surgery, some using this technology and some not," he said.

"It is always very difficult to get very experienced surgeons, skilled in a particular surgery, working together on a research project, so I was extremely grateful for their support.

"I am also very appreciative of the support given to me by the RACS and I hope my work goes some way to helping us as a profession understand which technologies to embrace and which to approach with caution."

With Karen Murphy

The Section of Academic Surgery Annual Meeting of Academic Departments will be held in Adelaide on Thursday 14th November 2013

This year Day 1 of this meeting will consist of two workshops. We have excellent and interesting speakers who will be presenting during the day, with time to spend on discussion after each session and during the small group workshops which will occur at the end of the day.

- **9.00am – 12.30pm**
  MID-CAREER WORKSHOP FOR SURGICAL LEADERS

  SESSION 1: Being an Academic Surgeon
  SESSION 2: Academic Surgery and the World

- **1.30pm – 5.00pm**
  WORKSHOP: UNIVERSITY HOSPITALS AND SURGICAL SERVICES

  SESSION 1: Models of Care – Academic Strengths and Weaknesses
  SESSION 2: General Workshop on Academic Health Centres

After these workshops you are invited to attend the

- **SURGICAL RESEARCH SOCIETY 50TH ANNIVERSARY DINNER**
  The Adelaide Club
  7.00pm.

- **THE SURGICAL RESEARCH SOCIETY ANNUAL SCIENTIFIC MEETING**
  Friday 15 November 2013
  You are encouraged to stay overnight and attend Day 2 of this meeting which will be held at the same venue in Adelaide. This meeting is open to those involved in or interested in research, including surgeons, surgical or medical trainees, researchers, scientists and medical students.

- **CONTACT**
  For further information, please telephone Sue Pleass on +61 8 8219 0900 or email academic.surgery@surgeons.org .

PRELIMINARY NOTICE – SURGICAL RESEARCH SOCIETY ANNUAL MEETING

The Surgical Research Society 50th Annual Scientific Meeting will be held in Adelaide on Friday 15th November 2013

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 Guy Maddern

Dept Surgery, Queen Elizabeth Hospital, Woodville, South Australia
"50 years of the Surgical Research Society"

ASSOCIATION FOR ACADEMIC SURGERY GUEST SPEAKER:
Dr Chris Breuer

Professor of Surgery and Director of the Tissue Engineering Program Nationwide Children's Hospital, Columbus and Ohio State University
"The development of tissue engineered vascular grafts for use in children"

SOCIETY OF UNIVERSITY SURGEONS GUEST SPEAKER:
Professor David J Hackam, MD, PhD FACS

Professor of Surgery, University of Pittsburgh School of Medicine Children's Hospital of Pittsburgh of UPMC
"Small cells for small patients: The interaction of the innate immune system with intestinal stem cells in necrotizing enterocolitis"

CALL FOR ABSTRACTS:
The call for abstracts will be open on Monday 29 July 2013 and must be submitted no later Monday 23 September 2013. 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

A dinner commemorating the 50th anniversary of the SRS will be held the evening prior to the SRS Meeting at the Adelaide Club on Thursday evening, 14 November 2013.

CONVENOR:
Professor Guy Maddern

CHAIR, SRS
Professor Leigh Delbridge

FOR FURTHER INFORMATION CONTACT:
Mrs Sue Pleass | Tel: +61 8 8219 0900 | Email: academic.surgery@surgeons.org | Web: www.surgeons.org/academic-surgery

Resolutions – 2020 Vision Zero

To share or not to share the way, November 21

The Trauma week workshop held at the College in November 2012 explored ways to make the roads safer – for all road users. The Trauma Symposium '*2020 Vision Zero: to share or not to share the way*' attracted a wide range of participants and experts in road safety. I thank and congratulate the conveners, orthopaedic surgeons, Mr Garry Grossbard, and Assoc Prof Robert Atkinson; and also Prof Danny Cass and Monique Whear who made up the working party.

The President's opening address highlighted past successes of the College with the active advocacy role the Trauma Committee played with regard to mandatory seat belts, bicycle helmets and driver blood alcohol limits. The College continues to advocate for trauma prevention and supports all initiatives to 'drive down road trauma'.

We were delighted to welcome the Hon Catherine King, Federal Member for Ballarat, Parliamentary Secretary for Health and Ageing and Parliamentary Secretary for Infrastructure and Transport [now newly appointed member of Cabinet and Federal Minister for Regional Australia, Local Government and Territories] who spoke of her involvement, experience and her political obligations and aspirations surrounding road safety.

We were privileged to have among the speakers Professor Fred Wegman, international road safety research expert who provided an excellent perspective from the Netherlands – one of the best performing countries in terms of road safety.

Prof Wegman has been at the forefront of 'safe system' developments around the world. Other presenters included road safety engineers, data analysts, road advocacy groups – as well, each road user group was represented – heavy vehicles, motorists, motorcyclists, cyclists and pedestrians.

The resolutions of the meeting have been collated into a paper with expert advice from road safety engineers. These resolutions include application of available technology (such as compulsory introduction of 'black box' technology in both heavy vehicles and motor cars and the fitting of rear vision cameras in all new vehicles), pathway separation and speed control.

The resolutions are supported by the many College trauma position papers on road trauma that include topics such as – licensing, speed, motor cycling, pedal cycling, vehicle safety, quad bikes and alcohol and drugs. The papers carry the imprimatur of the College and have aided road safety advocacy groups in lending support and expertise. The College trauma position papers and the resolutions paper can be found on the College website.

Excellent media interest was generated from the meeting, particularly with Lindsay Fox – always an interesting and entertaining speaker – who asked for support of black box technology for trucks.

> *"The College continues to advocate for trauma prevention and supports all initiatives to 'drive down road trauma'"*

The other main item capturing media interest was the proposed cessation of speed limits on Northern Territory roads – a sure thing to increase road trauma! This is a worrying issue and close to the hearts of the trauma surgeons in Northern Territory. We must stand united in support of our hard-working colleagues.

We have, fortunately, come a long way since the 1960s when the number of fatally injured road users in Australia between 1960 and 1970 was only 388 lives less than the total number killed during World War 2. Fatality and injury rates per head of population exceeded those of the US and were double those of the UK [Trinca, G. 'Anstey Giles Lecture' 1991].

While it is unlikely we will see a return to the dramatic reduction in road fatalities that occurred in the 1970s following the introduction of mandatory seat belts and drink driving legislation, even a small shift in road trauma trends can have a remarkable effect on the capability of saving multiple lives and reducing serious injuries.

'Vision Zero' refers to an understanding that no road death is acceptable. Government policy needs to support this expectation by introducing tough initiatives that will save lives and lessen injuries. Let us follow the example of the airline industry that demands 100 per cent air safety records.

How many people would take to the air if the risk assessment was equivalent to road trauma numbers in this country? That would mean more than 1,200 people would be killed in Australia each year as a result of plane crashes. This would surely be the death knell of the airline industry.

"If we strive for the impossible, the possible may emerge." – Abdul Kalam ex-President of India

Daryl Wall
Chair, Trauma Committee

Opposite: Trauma Committee Chair Professor Daryl Wall, Hon Catherine King and President Mike Hollands at the 2012 Trauma Meeting

> *Caring for our shared heritage is an important task and by becoming accredited, the College of Surgeons Museum has proven to be a leading museum in Victoria*

After hard work and diligence, the highly regarded College Museum gains its certificates.

College Museum
gains accreditation

On 5 July the College of Surgeons Museum officially gained accreditation from Museums Australia (Victoria). This is the result of three years' work by the curator and other staff. In the citation, Elizabeth Marsden, Manager of the Museum Accreditation Program (MAP), said:

> *"We are delighted to recognise the hard work demonstrated by the team at the College of Surgeons Museum. Caring for our shared heritage is an important task and by becoming accredited, the College of Surgeons Museum has proven to be a leading museum in Victoria."*

The museum was opened on 27 February, 2007, by then President Russell Stitz. But under the rules of MAP, a museum has to be operational for at least two years before it can apply to join the Program. So the museum had to wait until 2009 to submit an application. When the application was accepted the MAP managers came to inspect and talk about the program. They provided a kit, including a workbook, which had to be completed within a given timeframe.

Because it has only one full-time staff member, the museum was put into the small museum category, and allowed three years to complete the workbook. Much of the work involved in this comprised the development of policies, procedures and practices to meet recognised museum industry standards, in particular the *National Standards for Australian Museums and Galleries* (Version 1.2, November 2011). The submission date was set at 28 August, 2012, and this deadline was achieved.

As well as policy development, improvements were made to the principal areas of the museum. A new ceiling was installed above the exhibition space, along with new adjustable track lighting to museum standards. Three new upright showcases and four low-level island cases were ordered and installed. The workroom was rearranged and new high-grade racking was installed to improve storage and handling efficiency. Long-line racking was installed in the storage area, so that permanent storage of the collection can be arranged in a more systematic and logical order.

A Review Panel was convened to assess the workbook, and finally a site visit was arranged. Due to staff changes and workloads at Museums Australia, this visit did not take place until 5 June, 2013. A group of four museum professionals, including the MAP managers, a curator and a conservator inspected the museum, its exhibition space, workroom and storage area. They commended the museum and the College for:

- The significant investment in collection conservation and in the refurbished museum space.
- The significant works undertaken in the past 12 months, especially in relation to the storage and work areas.
- The uncluttered and attractive displays in the museum space.

The final report included a small number of requirements and recommendations. Some require immediate action, while others have a six-month or 12-month timeframe in which to attend to some outstanding issues to bring the museum fully into line with the National Standards and the International Council of Museums' (ICOM) *Code of Ethics*.

Museums Australia (Victoria) was established in 1994 as the peak body for museums in Victoria. The Museum Accreditation Program (MAP), now in its 20th year, is a framework used by museums to improve museum standards and increase profile.

There are currently 54 organisations accredited, including galleries, historical societies, botanic gardens, archæological monuments and historic houses and another 25 are working towards this goal. Accreditation is reviewed every five years, and is renewed if standards have been maintained and progress made in furthering the museum's aims.

The College of Surgeons Museum is the first surgical museum to gain accreditation and it joins an eclectic group of organisations including Museum Victoria, the Old Melbourne Gaol, the Gold Museum (Ballarat), the Victoria Police Museum, the Victorian Jazz Archive, Buda Historic House & Garden (Castlemaine) and the Queenscliffe Maritime Museum, to name just a few. The museum has now attained a leadership position in the museum sector in Victoria, which it will retain through continuous improvement and commitment to maintaining standards over the next five years.

Marianne Vonau
Treasurer

The redesigned museum layout including new lighting and display cabinets. The entrance proudly displays the accreditation sign.

Research with heart

Cardiothoracic Trainee Dr Arjun Iyer is working on research to provide more hearts for transplantation

Research being conducted by cardiothoracic Trainee Dr Arjun Iyer from the Victor Chang Cardiac Research Institute and St Vincent's Hospital in Sydney could lead to an increase in the number of donor hearts suitable for transplantation.

Dr Iyer is undertaking PhD research into the viability of using hearts from 'Donation after Circulatory Death (DCD)' by investigating the impact of varying periods of warm ischaemia on cardiac function and evaluating pharmacological strategies to limit ischaemic injury.

He said that between 60 to 70 heart transplants were performed in Australia each year, but that the limited number of suitable organ donors resulted in a 10 per cent mortality rate for those patients on waiting lists.

While the lungs, kidneys, liver and pancreas were all able to be harvested and transplanted from DCD donors, until now hearts had been unsuitable because of the detrimental effects of warm ischaemia – referring to the hypoxic period between extubation of the donor and flushing of the organ with protective preservation solution.

Now through the twin research streams of developing an enhanced cardioplegic preservation solution and refining the use of a portable ex-vivo perfusion system, Dr Iyer has shown complete functional recovery of DCD hearts after 30 minutes warm ischaemic time (WIT).

"Based on our preclinical work we can say that hearts from DCD donors achieve complete recovery after up to 30 minutes WIT, but remain unsuitable with irreversible damage sustained beyond this mark," Dr Iyer said.

"Ex-vivo perfusion technology offers a superior method of preservation, as well as allowing an avenue to resuscitate these organs. The heart starts beating once perfused with oxygenated blood, which restores aerobic metabolism thereby preventing any further ischaemic injury, something that is sustained with cold storage beyond three hours.

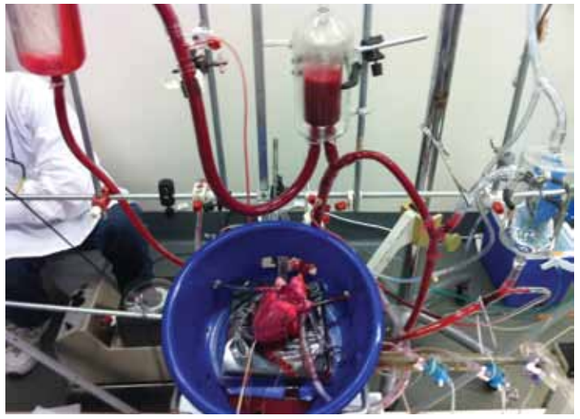
"Additionally, we supplement the Celsior preservation solution that we use to flush the organ with Post Conditioning Agents which pharmacologically mimic the endogenous phenomenon of ischaemic post-conditioning and work to minimise the reperfusion injury – reperfusion injury occurs to any organ that is re-perfused following an ischaemic insult, and can be as damaging as the ischaemic insult itself.

"These agents have been developed over the past decade, with this phenomenal research being conducted by scientists at the Victor Chang Cardiac Research Institute under the guidance of Professor Peter Macdonald, and this work that has been pivotal to the advances we are making now.

His findings come after two years of conducting animal trials, with assessment of porcine hearts on ex-vivo working heart circuits and in an orthotopic transplant model involving separate donor and recipient animals. The positive results have paved the way for application of these findings to human hearts – the past few months he has spent investigating the effects of WIT on the hearts of DCD patients, the families of whom had kindly agreed to organ donation for scientific research.

"We have now been given the opportunity to take hearts from DCD patients, and reperfuse them in an ex vivo perfusion system based on the Transmedics Organ Care System device which is clinically approved and designed for donor heart preservation in brain-dead donors. The hearts are perfused and stabilised to a rhythm, following which they are transported back to the laboratory. Here, the hearts are made to contract varying loading states for a period of up to 10 hours, during which time we measure functional output, assess metabolic profiles and biochemical parameters and sample myocardium for histological changes.

"This work is at its initial stages, and we are hoping to demonstrate the promising animal study findings in the human hearts. If we can show viability of human DCD hearts after 30 minutes of warm ischaemia, this has the potential to change the profile of heart transplantation in Australia."



Dr Iyer receiving his award; in the lab.

Dr Iyer received an inaugural $50,000 scholarship from medical defence organisation Avant with broader project funding provided through the NHMRC and JT Reid Foundation Grants. He has also been supported by University of New South Wales scholarships.

He said the research program at the Victor Chang Cardiac Research Institute and St Vincent's Hospital was one of only three such programs in the world investigating the viability of DCD hearts for donation. Although conducted through different approaches, research in this area is being done at the Baker Medical Research Institute in Melbourne through Professor Rosenfeldt and another group based through a combined UK and Canadian research collaboration.

In April, Dr Iyer presented his findings to the Annual Scientific Meeting of the International Society for Heart and Lung Transplantation held in Montreal, Canada.

He told the meeting that using various factors of predictability including past experiences with DCD lung transplantation, donor demographics, using a WIT of 30 minutes and donors less than 50 years of age, clinicians estimate the number of heart transplants could potentially increase by 15 per cent using hearts from such donors.

Since he began his work in 2011, Dr Iyer has not only conducted the porcine trials and the successful animal orthotopic transplantations that have led to the human DCD heart research trial, he has also turned his ingenuity to designing his own equipment.

"When I first took this on, as a result of the large cost of the commercial OCS device and the need to understand and develop ex-vivo perfusion technology, I spent some time designing and building from scratch an ex-vivo perfusion rig using custom made glassware and specialised tubing to conduct our porcine experiments. This in itself was a practical lesson in cardiac physiology and perfusion science, an invaluable experience for a cardiothoracic surgical Trainee.

"Using this lab working heart circuit construct, we looked at the various challenges faced with utilising DCD hearts including their physiology, applicable time limits for use, optimum storage pre-transplant and then transplantation, and all of this work has yielded very positive results."

He said the research team, which is led by his PhD supervisors Transplant Cardiologist Professor Peter McDonald and Cardiothoracic Surgeon Dr Kumud Dhital, would spend the next few months accessing and studying a dozen human DCD donor hearts with a WIT of less than 30 minutes.

"Now we are in the process of conducting a series of human experiments and all going well, we'll hopefully be in a position by next year to achieve the 'holy grail' of this research by putting a DCD heart into a patient on the waiting list".

So far, Dr Iyer has won the President's Prize for Research and several Young Investigator Awards from the Transplantation Society of Australia and New Zealand, the Trainee Research Prize in Cardiothoracic Surgery at the College's Annual Scientific Congress held this year and the Young Investigator Award from the Australian and New Zealand Society of Cardiothoracic Surgery.

"I have been very lucky in having some inspiring clinicians and researchers that have guided this work in Professor Peter McDonald and Dr Kumud Dhital, and am very grateful for the mentorship from the cardiothoracic surgeons at St Vincent's Hospital, Dr Paul Jansz, Dr Emily Granger and Dr Phil Spratt.

"It was fantastic to get the scholarship from Avant because cardiothoracic transplantation is a dynamic area with enormous scope for research and development, and such financial support provides the opportunity for surgical Trainees to pursue important research, so I am very grateful to Avant for their support," Dr Iyer said.

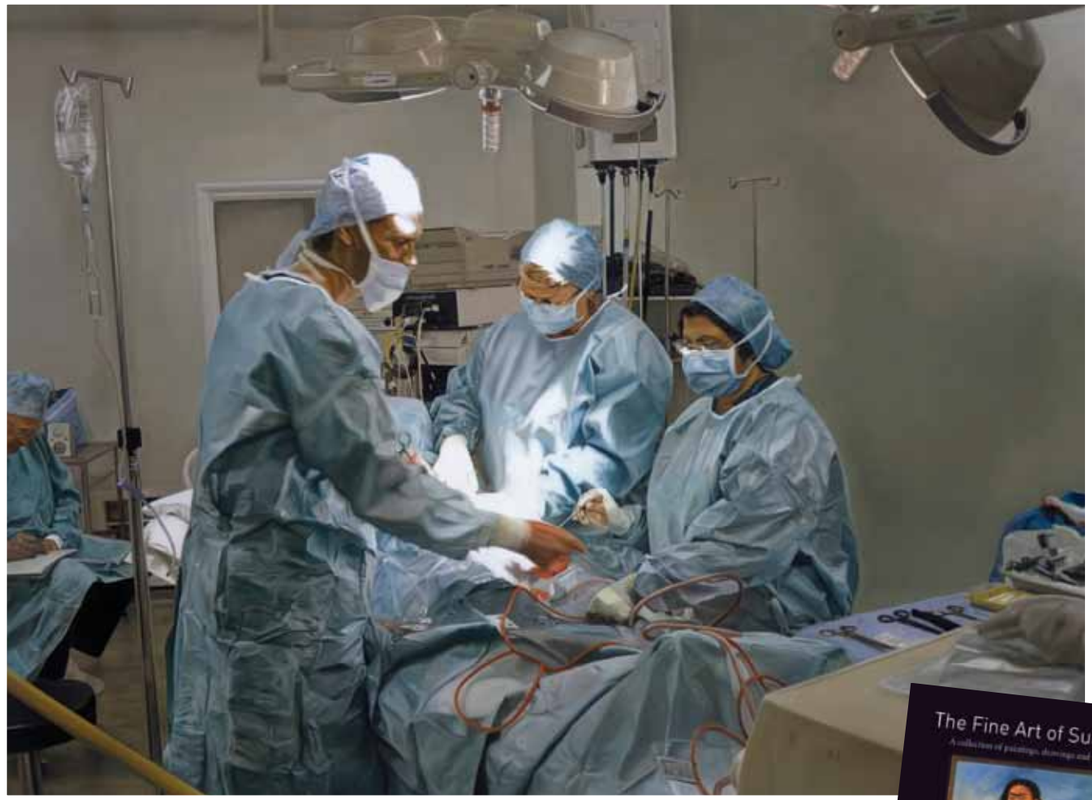
"Although overall research funding is limited in Australia, especially in comparison to what is available to scientists and researchers in North America, we still punch well above our weight with our scientific output and ground breaking discoveries. Scholarships like this from Avant will no doubt continue this trend."

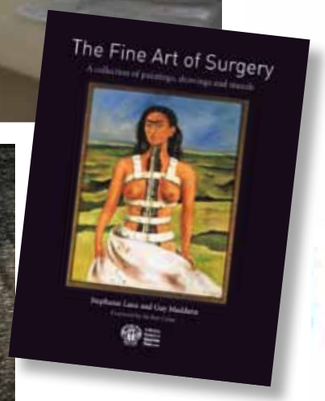
Dr Iyer is due to complete his PhD at the end of this year, and return to full-time clinical work and training next year.

With Karen Murphy

The Fine Art of Surgery

One to add to your library





A chance meeting between Professor Guy Maddern and Stephanie Lane who had worked in commercial contemporary art galleries in Salzburg, London and New York has led to the development and co-authorship of *'The Fine Art of Surgery'*.

The images in the book have been collected from over 4,000 years and from every continent and they reflect the privilege and trust placed in surgical hands. By bringing together images recorded over the ages, the similarities and evolution of surgery can be appreciated. *'The Fine Art of Surgery'* attempts to represent a selection of styles, situations and techniques used to capture one of the most feared and celebrated of human interactions.

Sir Roy Calne in his forward to the book states: "This book will be of interest to all surgeons but also to the public in general, giving some idea of both the practice and the intense emotions that are involved in surgery."

Published by the Royal Society of Medicine Press, it is available online at: www.amazon.co.uk or contact Guy Maddern at guy.maddern@adelaide.edu.au

> ***"By bringing together images recorded over the ages, the similarities and evolution of surgery can be appreciated"***

The categorisation of intra-operative laparoscopic surgical movements

The Academy of Surgical Educators would like to congratulate Dr Esra Kilavuz for taking out this year's Surgical Education Research Prize at the College Annual Scientific Congress. The following is her presentation.

The teaching method 'see one, do one, teach one' is a commonly used algorithm implemented by many apprenticeship programs; however, in high risk fields such as surgery, it would be wiser to implement a 'see one, practice one on a simulator, do one' approach to optimise surgical competence and patient safety.

As surgical competence is the result of a dynamic construction of finite and definable series of microskills that are rehearsed and practiced as a whole, one could potentially optimise training and assessment methods by incorporating the more frequently used microskills into the curricula.

A single-centre study on laparoscopic cholecystectomies (key-hole gallbladder removal operations) was conducted at Nepean hospital in 2010/2011 with the aim of creating a database of microskills for a commonly performed operation, and investigating the frequencies of these microskills among surgeons of varying experience.

Initially, a taxonomy list of all potential microskills was devised with each instrument and its action being assigned a code. Laparoscopic video was captured and recorded onto DVD, and the footage underwent transactional analysis whereby every five seconds the action being performed by an instrument was recorded. In previous studies that used transactional analysis, only one action was recorded for every five seconds of video footage; however, with multiple instruments each performing their own action, we decided to capture all the instruments' actions concurrently. This method of categorising movements is more comprehensive, and provides a larger number of datapoints.

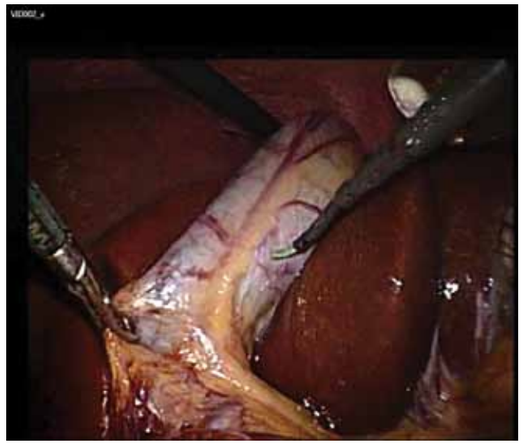
Seven sequential elective laparoscopic cholecystectomies (LCs) were recorded in this study. The surgeon participants varied in surgical training level (two consultants, one SET 5, three SET 4) and in experience (one had performed less than 100 LCs, four 100-250, one 250-500 and one greater than 500). Gall bladder disease severity was mostly minimally inflamed with only one empyematous and one mild chronic disease.

It was discovered that in all seven operations, the same set of microskills were performed, regardless of training level. The most commonly performed microskill was grasping with an average of 60.8 per cent operating time, with 50.7 per cent of the time concurrently pulling while grasping. 'Nothing', a non-specific waiting time was the second most common action, followed by diathermy and moving or lifting. Blunt dissection took 1.2 per cent of operating time, however, was performed by eight different instruments including diathermy, irrigator, graspers and scissors, suggesting the ability to multitask with a single instrument is customary.

The study also looked at which instruments were used more often and for which action. The most commonly used instruments were the grasper, forceps, diathermy, irrigator and clippers. The clippers, however, were the most versatile instrument performing seven actions including positioning, palpating, milking cystic duct and blunt dissecting. The diathermy spent 64 per cent of its use cauterising, 20 per cent positioning, 8 per cent blunt dissecting, 5 per cent palpating and 4 per cent moving/lifting, which shows that an instrument is not limited to its primary function.

Comparing expert surgeons with Trainees did show a difference in microskill frequency. Consultants performed less grasping; however, when grasping, were more likely to be pulling while grasping (70.2 per cent vs 49.7 per cent). They also performed less diathermy (1.9 per cent in experienced surgeons vs 7.5 per cent in those who had performed less than 100 LCs) and placed less clips per operation (6 in total vs 8.5). These differences present novel avenues of research, which with further validation studies could be used to predict a surgeon's level of competence.

Left: Dr Esra Kilavuz who presented at this year's ASC.
Below: an example of her research.



This study also investigated the use of ports during a LC, whereby the main actions performed in each of the four access ports, and their corresponding instruments was examined. Port 1, the umbilical port, was used mainly for laparoscopic video capture, and removal of gallbladder at the conclusion of the intra-abdominal stage of the operation. Port 2, the most lateral port, spent 83 per cent of operating time with the instrument grasping the fundus of the gallbladder with superior traction, an action most commonly performed by the surgeon's assistant. Port 3, the medial port (generally the surgeons left hand instruments) was used mainly for exposing Calots triangle (50 per cent of operating time), and instruments in this port also had a statistically significant higher amount of 'letting go' and moving/lifting. The instruments in Port 4, the sub-xiphisternal port (the surgeon's right hand), were more likely to perform the microskill 'positioning' compared to port 2 or port 3. It was also the port with the highest number of instrument exchanges. Five to eight instruments were used in this port with an average of 33 insertions per operation. There was a linear trend noted with the instrument insertion rate as the more experienced surgeons had an insertion rate of 75 per hour; second most experienced 64 per hour; third most experienced 40.5 per hour; and least experienced 19 per hour.

This study has thus noted many trends on instrument use, as well as statistically significant differences in the microskills' frequencies among surgeons of different experience levels. Most importantly, however, by developing this method of categorising the intra-operative laparoscopic movements, a database of microskills can be created which allows for easy calculation of differences in frequencies of actions. This database presents potential enhancements of training simulators and skills laboratories, by optimising which microskills are rehearsed, and hence increasing surgical competence.

Dr Esra Kilavuz
Resident Medical Officer
Westmead Hospital

> ***"In high risk fields such as surgery, it would be wiser to implement a 'see one, practice one on a simulator, do one' approach to optimise surgical competence and patient safety"***

Congratulations
on your achievements

Members of the Court of Honour are chosen from those who show continuing personal interest in the College. The Court exists both to honour its members and to provide advice to Council.

PROFESSOR MURRAY BRENNAN FRACS (HON)
Court of Honour

Born in Auckland, Murray Brennan commenced a BSc in mathematics at Auckland University before moving to Dunedin and completing his MB ChB in 1964. He received his surgical training in Dunedin, where he was Assistant Lecturer in Physiology and Surgery at the University of Otago. On the basis of his research during this period he was invited to a position at the Harvard Medical School commencing advanced laboratory and clinical work at Peter Bent Brigham Hospital, Harvard Medical School and the Joslin Research Laboratories in 1970.

After completing his residency, Murray joined the National Cancer Institute where he became head of the surgical metabolism section. In 1981 he commenced work at New York's Memorial Sloan-Kettering Cancer Center as Chief of the Gastric and Mixed Tumor Service. He chaired the Department of Surgery from 1985 to 2006 and he currently holds the Benno C. Schmidt Chair in Clinical Oncology.

Throughout his career, Murray's clinical and research interests have focused on surgical oncology, endocrinology, metabolism and nutrition. He has designed and conducted numerous clinical trials, contributing to the management of patients with soft tissue sarcomas and pancreatic cancer.

Together with his colleagues, he was involved in the creation of the world's largest database of more than 8,000 sarcoma patients and the subsequent development of a computer program that is highly effective in predicting patients' chances of surviving soft tissue sarcoma.

Murray has been an invited guest lecturer throughout the world and authored or co-authored more than 1,000 scientific papers and book chapters, as well as a book on soft tissue sarcoma. He has served on the editorial board of more than 20 significant journals and publications, including the Australia and New Zealand Journal of Surgery.

Murray has held many leadership positions including Director of the American Board of Surgery, Chairman of the American College of Surgeons Commission on Cancer, President of the Society of Surgical Oncology, Vice President of the American College of Surgeons, and President of the American Surgical Association.

His significant contributions have been recognised internationally through the award of numerous honorary Fellowships and in 1995 he was honoured with membership of the Institute of Medicine of the National Academy of Sciences. More than a decade ago he received the American College of Surgeons' highest award, the Distinguished Service Award.

Although Murray has lived and worked in the US since 1970, he has maintained very strong links with New Zealand. He completed both his MD and ChM through the University of Otago, and received an honorary doctorate in science from the University in 1997. Throughout his career Murray has been a significant contributor to College activity.

Professor Murray Brennan is an outstanding surgeon, contributing significantly to surgical knowledge and practice. Professor Brennan's election to the Court of Honour is fitting recognition of a Fellow who has represented our College with distinction at the highest level.

Citation kindly provided by Ian Civil

MR IAN CIVIL MBE, KSTJ, FRACS
Court of Honour

Ian graduated in medicine from the University of Auckland in 1976 with prizes in medicine and surgery. Whilst a student, Ian undertook an intern elective at the Cleveland Clinic. Ian completed his surgical training at Auckland Hospital. He passed the Part 1 examination in 1978 and won the Gordon Taylor Prize. He was awarded his FRACS in 1982.

In 1984, he returned to the Cleveland Clinic as a Fellow in Vascular Surgery, and the following year moved to Cooper Hospital in New Jersey. Ian spent three years in New Jersey, first as Fellow and later as Senior Fellow in Traumatology.

In 1987, he returned to Auckland as a general, vascular and trauma surgeon, becoming head of the Trauma Services and Clinical Director of General Surgery in 1992. In 2007, he was appointed Director of Surgery for the Auckland District Health Board and in 2012 was appointed Clinical Lead for the New Zealand Major Trauma Network.

Ian served in the New Zealand Army Medical Corps and saw active service in Bahrain in 1991.

Ian has received many awards for his contributions to surgery including the Gordon Trinca Medal and the RACS Medal from our own College. He is a Knight of Grace of the Order of St John and holds Honorary Fellowships from the Royal College of Surgeons of Thailand and the College of Surgeons of Sri Lanka. He was awarded an MBE in 1992.

Ian has delivered over 120 papers and is a contributing author to over 80 publications in peer-reviewed journals.

Ian was deeply involved in the introduction of Early Management of Severe Trauma Course to Australia and served on its inaugural Board, becoming Chairman of the EMST program in 1996. His contribution to EMST is legendary.

He has instructed on over 100 courses, and continues to do so. For this contribution alone he was recognised with an award by the ATLS sub-committee of the American College of Surgeons Committee on Trauma.

Ian is also deeply involved in the Care of the Critically Ill Surgical Patient and the Definitive Surgical Trauma Care Courses. He was Chairman of the Board of General Surgery in New Zealand from 1996 to 2002.

He is a Member of the New Zealand Medical Practitioners Tribunal and is actively involved in the Order of St John and is Chair of its Clinical Governance Committee.

Recently Ian has served on the Council of our College, from 2003 until 2012. He was Chairman of the Board of Basic Surgical Training, Censor in Chief and, finally, President from 2010 to 2012.

Citation kindly provided by Michael Hollands

MR HUGH MARTIN FRACS
Court of Honour

Hugh Martin graduated from Sydney University Medical School with Second Class Honours in 1964. He became a Resident at Royal Prince Alfred Hospital, a Surgical Registrar at Concord Hospital and then worked in Alice Springs and the United Kingdom before returning as Surgical Registrar at the Royal Alexandra Hospital for Children in 1974. He was appointed as a Paediatric Surgeon at the Royal Alexandra Hospital for Children where he has worked since 1977, transferring to Westmead Children's Hospital when it opened in 1995.

He obtained his Fellowship from the Royal Australasian College of Surgeons in 1969 and his Fellowship of the Royal College of Surgeons of England in 1971. He has been a Demonstrator in Anatomy, Supervisor of Surgical Training, an Instructor in the Advanced Burn Life Support Course and in the Emergency Management of Severe Burns Course. He is an Instructor in the *Assest*_Course and the APLS Course.

He has served on numerous committees at College, Hospital and Department of Health level. He has worked with other learned Colleges including being a member of a working party to revise the Australian College of Paediatricians statement on neonatal male circumcision in 1995. He has been awarded an Excellence in Teaching Award from the Sydney University Medical Program.

He is a Member of the Order of Australia and has a Certificate of Outstanding Service to the Royal Australasian College of Surgeons and was presented with the ESR Hughes Award in 2005. He has published numerous papers in Peer Review Journals and contributed chapters to books and other publications. He is frequently invited as a speaker at clinical conferences.

Hugh has served as President of the Australian New Zealand Association of Paediatric Surgeons from 2007 until 2009. He has been an examiner in paediatric surgery for the Royal Australasian College of Surgeons between 1996 and 2004 and was the Senior Examiner from 2000 to 2003.

He was founding member of the Australian New Zealand Burns Association and has been made an honorary member of that association and was its Vice President from 1994 to 1995. Hugh has served as a Member of the Council of the Royal Australasian College of Surgeons from 2003 until 2012 and was a Member of the Executive of Council in 2006 and 2008. He served as Member of New South Wales Regional Committee from 1988 until 1992 and was the convenor of its State Meeting in 1992.

Hugh Martin's contribution to this college has extended over his entire professional life, training registrars, teaching, serving on committees and being recognised by his Specialist Society and the College for his work. His wisdom and sage advice on Council, coupled with his long contributions to the college make him a worthy member of the Court of Honour.

Citation kindly provided by Michael Hollands

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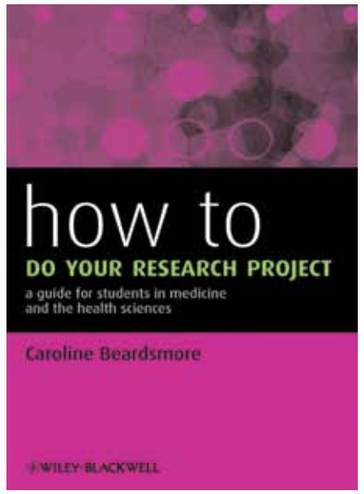

How to Do Your Research Project: A Guide for Students in Medicine and The Health Sciences

Caroline Beardsmore

9780470658208 | Pbk | 152 pages | July 2013

~~AU$37.95~~ | **AU$28.46**

Member Price

This book provides a source of advice and information for students on how to approach, execute, and write up their research and prepare for a viva examination. It points the way to how to get the most out of the experience, both from the perspective of personal development and academic achievement. It is the only short guide available to help with the research project completed as part of a health sciences degree, and takes a practical approach, including key points boxes, practical exercises and further references. Also featuring advice on getting published and how to submit articles and posters to journals and conferences, it even helps students get off to a good start with guidance on assessing the research project and the supervisor!

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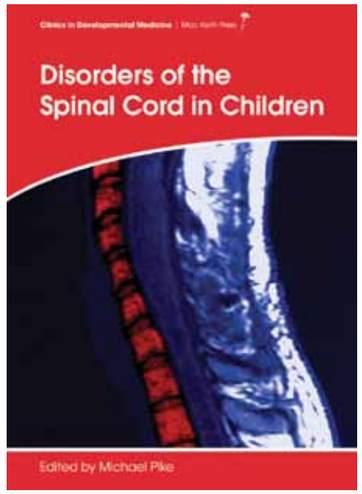

Disorders of the Spinal Cord in Children

Michael Pike

9781908316806 | Hbk | 406 pages | August 2013

~~AU$210.00~~ | **AU$157.50**

Member Price

Spinal cord disorders have tended to be approached as adjuncts to disorders of the paediatric brain or peripheral nervous system. This is partly a function of numbers – specifically spinal pathologies being less frequent than those of the brain and the peripheral neuromuscular system, partly a function of the relatively limited investigation techniques available before the advent of MRI and, at least to some degree, it is because the clinical evaluation of the spinal cord in young children is difficult and may be overshadowed by the manifestations of accompanying brain and peripheral neuromuscular symptomatology. It is likely that the role of the cord, in conditions ranging from neonatal neurological injury to shaken impact syndrome and in inflammatory and neurometabolic disorders and beyond, will continue to become more evident over coming years.

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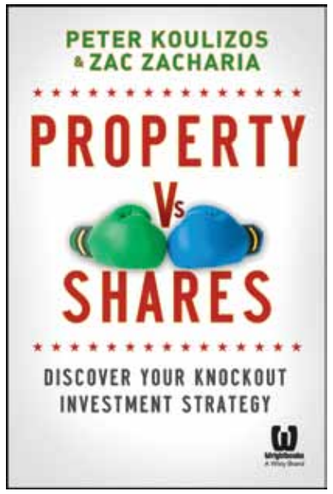

Property vs Shares: Discover Your Knockout Investment Strategy

Peter Koulizos, Zac Zacharia

9781118613139 | Pbk | 224 pages | June 2013

~~AU$24.95~~ | **AU$18.71**

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A comparison of property versus shares and how to find the right mix for a profitable portfolio.

Almost every investor eventually considers the question: which is the better investment, property or shares? The answer isn't as simple as one or the other, since both asset classes offer different benefits and risks. And if the best answer is a mix of the two, how do you strike the right balance for sustained returns? This book takes an unbiased look at these two asset classes, explaining the risks and benefits of each, dispelling stubborn myths, and giving you the facts you need to find what's best for you and your portfolio. Offering a point-by-point comparison of shares versus property, this easy-to-read guide argues that a combined strategy is smartest and safest for most investors. It then goes on to give you the information you need to tailor your portfolio to your own level of acceptable risk versus desired reward.

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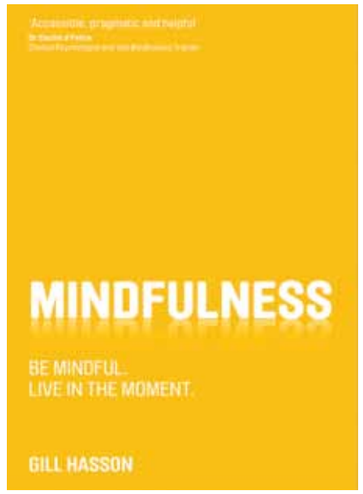

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Gill Hasson

9780857084446 | Pbk | 216 pages | August 2013

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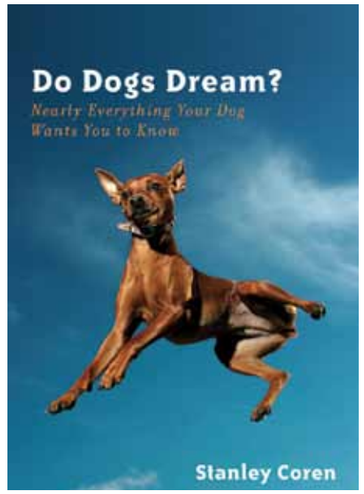

Do Dogs Dream?: Nearly Everything Your Dog Wants You to Know

Stanley Coren, PhD

9780393073485 | Hbk | 160 pages | July 2012

~~AU$29.95~~ | **AU$22.46**

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Do dogs dream? Can they recognise themselves in the mirror or understand what they're seeing on television? Are they more intelligent than cats? People have a great curiosity—and many misunderstandings—about how dogs think, act, and perceive the world. They also wonder about the social and emotional lives of dogs. Stanley Coren brings decades of scientific research on dogs to bear in his unprecedented foray into the inner lives of our canine companions, dispelling many common myths in the process.

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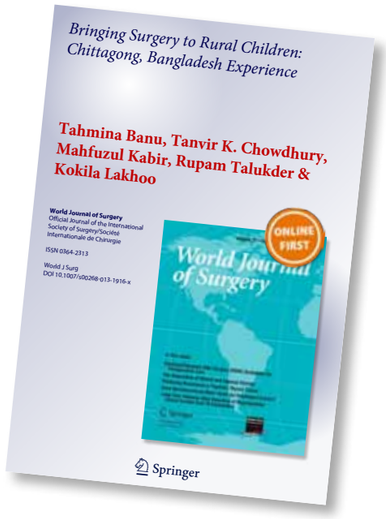
Bringing Surgery to Rural Children: Chittagong, Bangladesh Experience

Tahmina Banu, Tanvir K. Chowdhury, Mahfuzul Kabir, Rupam Talukder, Kokila Lakhoo
Société Internationale de Chirurgie 2013

The following abstract of a paper by Prof Tahmina Banu who was a Rowan Nicks Scholar with Professor John Hutson at the Royal Children's Hospital, Melbourne in 1995 is testimony to the Rowan Nicks Scholarship which helped Prof Banu in her early surgical career in Bangladesh.

Abstract: There is unequal access to surgical health care in underdeveloped countries such as Bangladesh. Bangladesh has a large young population, with 70 % of the population living in rural areas. All of the pediatric surgical services of the country are situated in major cities. We therefore organized an outreach service with the aim of providing surgical services to these rural children by utilizing the existing facilities of primary and secondary care centers. The program originated at the Department of Pediatric Surgery, Chittagong Medical College and Hospital in Sept 2008. The data presented here are from its 2008 beginning to Nov 2011. A yearly plan is sent to the Divisional Director of Health Services for Chittagong Division, who notifies all of the concerned district hospitals

(DHs) and Upazila Health Complexes (UHCs). A member of the outreach team contacts each center via telephone one month prior to the visit to help organize it. Doctors at each participating hospital in which day surgery is possible are informed as to which commonly performed day surgeries are available, and they then select the appropriate patients to be examined at that visit. The local doctors are also advised to choose other pediatric surgical patients as outpatients. The local doctors perform the follow-up. If necessary, patients are referred to our department for further management. During the study period, we made 32 visits to 5 DHs and 10 UHCs. In all, 674 children were seen as outpatients, and 407 underwent surgery, of which inguinal hernia repair was the most common. There were no deaths. Outreach service is a good way to extend curative care to the grass-roots population.

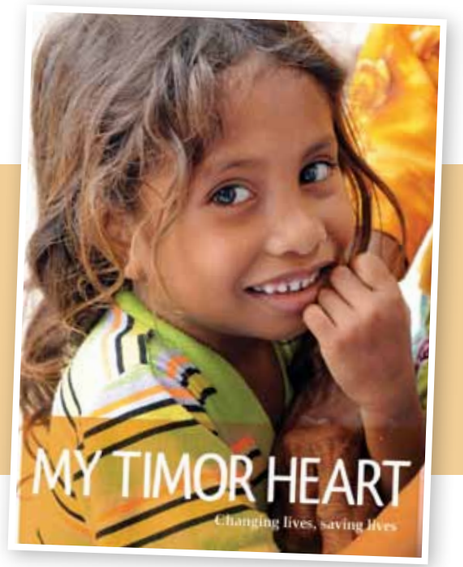


Dr. Graham A E Coupland Rose

'Dr. Graham A E Coupland Rose' developed by Mrs. Robyn Coupland - Graham's widow has strong interests with the Heritage Rose Society and is a member. Bruce Treloar developed the soft pink and white rose.

Many thanks to Tom Reeve for these photos

The College has produced a book, called *My Timor Heart*, to celebrate our achievements in Timor Leste. *My Timor Heart* will recognise the extraordinary efforts of the medical volunteers in Timor Leste, and the life-changing impact their work has on people living in a country that continues to struggle with the legacy of years of civil war and violence.



My Timor Heart

Written by Ellen Whinnett and Ellen Smith

Using striking photographs and volunteers' stories *My Timor Heart* illustrates the profound positive impact of the College's Timor Leste program. Written by Ellen Whinnett, a Walkley award winning journalist and the Head of News at the Herald Sun newspaper. *All proceeds from the sales of My Timor Heart go directly to Foundation for Surgery to fund the Timor Leste Program..*

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