SURGICAL NEWS

THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS
VOL 15 NO 7
AUGUST 2014

The College of
Surgeons of Australia
and New Zealand

What do we expect in a surgeon?

The pressure to live up to a role

2014

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

workshop

August-November

Preparation for Practice

23 to 24 August, Melbourne; 25 to 26 October, Brisbane

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 proudly supported by the Bongiorno National Network, mlcoa, Rooms With Style and MDA National.

Management of Acute Neurotrauma

24 August, Darwin (the day after the Provincial Surgeons of Australia ASC)

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

Safer Australian Surgical Teamwork

3 September or 4 September - Darwin, NT
12 September - Albany, WA
2 October - Bega, NSW

The Royal Australasian College of Surgeons (RACS) with the Australasian College of Anaethetists (ANZCA), the Australian College of Nursing (ACN) and Australian College of Operating Room Nurses (ACORN), is offering a combined workshop for surgeons, anaesthetists and scrub practitioners working in rural and regional Australia. The workshop focuses on non-technical skills which can enhance performance and teamwork in the operating theatre thus improving patient safety.

Keeping Trainees on Track (KTOT)

9 September, Melbourne; 18 October, Newcastle; 22 October, Wellington

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.

Polishing Presentation Skills

25 September 2014 - Sydney

The full-day curriculum demonstrates a step-by-step approach to planning a presentation and tips for delivering your message effectively in a range of settings, from information and teaching sessions in hospitals, to conferences and meetings. Key learning outcomes are to explore how to conduct a needs analysis for your target audience, to develop an effective presentation structure and to develop and use visual aids.

Supervisors and Trainers for SET

18 October, Newcastle; 21 October, Wellington; 20 November, Melbourne

The Supervisors and Trainers for Surgical Education and Training (SAT SET) 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.*

Training Standards: Interpretation and Application (TSIA)

24 October, Melbourne; 29 October, Brisbane

Training Standards: Interpretation and Application (TSIA) is a new course offering. This three-hour workshop expands on the in concepts outlined in the Becoming a competent and proficient surgeon booklet developed by the College in 2012. The course aims to provide a baseline standard for College educators in Competency Based Education, ensure that College educators know the required standards for Competent and Proficient performance across the nine RACS competencies and increase awareness of Training Standards in the workplace, including the ability to interpret standards and use them to assess own and other's performance.

Clinical Decision Making (CDM)

24 October, Melbourne; 29 October, Brisbane

Clinical Decision Making (CDM) is a three hour workshop designed to enhance a participant's understanding of their decision making process and that of their Trainees and colleagues. The workshop provides a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling Trainee or as a self-improvement exercise.

Building Towards Retirement

15 November, Sydney

Work is an important part of life so when you stop full time surgery or are approaching retirement, you need to take time to plan for the next stage. It's crucial that as much thinking and planning are undertaken for life after surgery as was given to building your career in the first place. Surgeons who attend can expect to receive information about retirement and motivation to plan for retirement, share the experience of retired Fellows to stimulate interest in alternative careers and lifestyles and gain financial and legal management information and resources. This activity is proudly supported by proudly supported by the Bongiorno National Network and mlcoa.

ACT

10 October, Canberra
Keeping Trainees on Track (KTOT)

NSW

5 to 7 September, Sydney
Process Communication Model Part II
25 September, Sydney
Polishing Presentation Skills
2 October, Bega
Safer Australian Surgical Teamwork
18 October, Newcastle
Keeping Trainees on Track (KTOT)
18 October, Newcastle
Supervisors and Trainers for SET (SAT SET)
23-25 October, Sydney
Surgical Teachers Course

NT

24 August, Darwin
Management of Acute Neurotrauma
3 September, Darwin
Safer Australian Surgical Teamwork
4 September, Darwin
Safer Australian Surgical Teamwork

NZ

23 September, Auckland
Non-Technical Skills for Surgeons (NOTSS)
21 October, Wellington
Supervisors and Trainers for SET (SAT SET)
22 October, Wellington
Keeping Trainees on Track (KTOT)

QLD

25 to 26 October, Brisbane
Preparation for Practice
28 October, Gold Coast
Non-Technical Skills for Surgeons (NOTSS)

SA

13 November
Academy of Surgical Educators Forum

TAS

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

VIC

23 to 24 August, Melbourne
Preparation for Practice
6 September, Ballarat
Foundation Skills for Surgical Educators
9 September, Melbourne
Keeping Trainees on Track (KTOT)
29 September, Melbourne
Academy Educator Studio Session
24 October, Melbourne
NHET Sim
24 October, Melbourne
Clinical Decision Making (CDM)
24 October, Melbourne
Training Standards: Interpretation and Application
15 November, Melbourne
Communication Skills for Cancer Clinicians

WA

7 August, Perth
Management of Acute Neurotrauma
16 August, Perth
Supervisors and Trainers for SET (SAT SET)
16 August, Perth
Keeping Trainees on Track (KTOT)
12 September, Albany
Safer Australian Surgical Teamwork
25 September, Perth
Foundation Skills for Surgical Educators

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

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ACTING ON OUR CONCERNS

Don't be a bystander

MICHAEL GRIGG
PRESIDENT

There are frequently confronting stories in the media where our gut-level response is, "how could that happen". It could be racial vilification, public transport abuse or even health care disasters over many months. And removed from the immediacy of the situation, one wonders on why there was not a stronger response from the people involved or where were the leaders of that organisation while this was happening.

I remember being in New York in the 1970's. It did not feel like a safe place and indeed it was not with frequent muggings and a terrible homicide rate. I returned more than 10 years later – it was a totally different environment – I felt safe walking the streets late at night. Who would have believed that a "zero tolerance" policy would work. Who would have believed that attacking littering and shop-lifting would dramatically reduce the homicide rate, but it did.

The NHS disasters of Mid Staffordshire Hospital and then more recently the Colchester Hospital have highlighted the issue of why people fail to act in situations that appear to have been crying out for a response. Unfortunately these are not issues that only occur in the NHS. They are occurring in every health system across the world, including our own. So what does the research evidence provide as the key obstacles to overcome before people speak up and action can follow?[1]

These are:

1. **Someone needs to notice that something is wrong.** There is an increasing trend that in a pressurised workplace, when people are already overwhelmed they will tend to unconsciously try to 'make normal' the things that conflict with their preferred reality.
2. **The bystander effect.** The greater the number of witnesses, the less likely someone will intervene as the diffusion of responsibility provides uncertainty about taking action.
3. **How the organisation signals what matters and how they deal with unpleasant messages.** If the organisational leaders 'shoot' the messenger, then it is much less likely that further issues will be raised.
4. **Knowing that when concerns are raised, they are acted upon.** It needs to be important that successes are highlighted to ensure we do not underestimate the likelihood of achieving a good result.
5. **People weigh up the pros and cons of taking action.** Despite the difficulties of reporting minor issues, it is most important that the culture of reporting them and addressing them is encouraged.

It is important that we take action as individuals and also as a professional organisation when things do not appear quite right, when the standards are not at the level that is required. I am frequently quoting Lieutenant General David Morrison, Chief of the Australian Army, who addressed the entire rank and file of the army in a video clip that has gone 'viral' on YouTube. The quote of importance is "the standard you walk past is the standard you accept". (I seem to remember Prof UR Kidding 'adopted' this quote!)

But the standards we need to address are at many levels. It is important we do not shirk from addressing them within our hospitals, particularly when it relates to patient safety. It is important that we address them within our peer groups and our professional organisations when it relates to professionalism. One of the biggest issues undermining professionalism at the moment is a growing trend among Fellows and anecdotally among younger Fellows in charging fees to patients that are unreasonably high – even excessive or extortionate fees.

I am deliberately raising this to provoke discussion across the broader Fellowship as to what the College and Specialty Societies need to do to address this incredibly damaging issue. It is a key concern to the public as well as to the individual patient. I am receiving responses from "it is a market out there and my private practice does not involve the College" to "whole-hearted agreement with College involvement in this regard as these particular surgeons damage the reputation of our profession as a whole".

It will be an emotive issue, but I go back to the issues raised by the research about what makes people not do things. When standards are not at the level we can accept, we cannot just walk past. The College as our professional organisation and ourselves as individual surgeons cannot be the bystander to this discussion. Our professionalism and the reputation of our profession are too important.

1. *Darley, J. M. & Latané, B. (1968). 'Bystander intervention in emergencies: Diffusion of responsibility'. Journal of Personality and Social Psychology 8: 377–383.*

HEALTH ADVOCACY

DAVID WATTERS
VICE PRESIDENT

Informing smokers of their surgical risks and encouraging them to quit

In 2012, Australia became the first country in the world to enact legislation mandating plain packaging for all tobacco products. New Zealand has agreed in principle to plain packaging legislation and, after a long consultation process, looks poised to enact the legislation by the end of the year. Plain packaging essentially takes away the colourful and alluring branding of the tobacco companies, increases the size of graphic health warnings and displays telephone numbers for Quitline in prominent positions on the packets.

In recent weeks, some Australian government ministers have been calling for a repeal to the plain packaging legislation, arguing the legislation was introduced even though "it would not work" and pushes us further into a "nanny state."

Additionally, one cigarette manufacturer is proposing to introduce a 25-pack of cigarettes for $13 – considerably less than the traditional $20-$25 per pack. In response to this, legislation is proposed to ensure a minimum floor price of at least $20 for cigarettes.

When this came to the attention of the College, we were quick to act, along with colleagues from CPMC (Committee of Presidents of Medical Colleges). College President Michael Grigg has said, "Everything that can be done, must be done if it assists our attempts to help people stop smoking and to stop people from starting. Tobacco is an insidious drug and we cannot let our guard down for a moment."

As a College, we believe it is important that the government resist lobbying against anti-smoking measures such as plain packaging. A recent study in the 'Medical Journal of Australia'[1] clearly shows an association between plain packaging and an increase in calls to Quitline.

After adjusting for a number of confounders including seasonal trends and anti-tobacco advertising, the study found a 78 per cent increase in the number of calls to the Quitline after the introduction of plain packaging. They also compared the number of calls during this period to the number of calls after the introduction of graphic health warnings in 2005-06. The higher number of calls was sustained for a longer period after the introduction of plain packaging than after the graphic health warnings.

The prevalence of smoking in the community is declining. Over the decade, 2001-2 to 2011-12, smoking levels declined from 27 per cent to 20 per cent in males and 21 per cent to 16 per cent in females. Further progress is reflected by recent figures released by the Australian Bureau of Statistics (ABS) showing that total consumption of tobacco and cigarettes in the March quarter 2014 was the lowest ever recorded, with tobacco clearances (including excise and customs duty) falling by 3.4 per cent in 2013 compared with 2012, the year tobacco plain packaging was introduced.

Much to the angst of tobacco companies, other countries are now taking note of the impact of plain packaging, even though Australia and New Zealand are only small markets for the tobacco industry.

I also believe we as surgeons, ought to do everything we can to encourage our patients to stop smoking before undergoing surgery. An increasing number of peer-reviewed papers have reported that a proportion of patients are unaware of the increased surgical risks of smoking, but when so informed are more likely to stop smoking on the advice of their surgeon, someone in whom they have placed great trust.

Two recent papers in our own 'ANZ Journal of Surgery' provide regional evidence on these issues. Webb, Robertson & Sparrow[2] reported that, while on a waiting list, 44 of 177 smokers reporting quitting at least 24 hours before surgery whilst a further 42 attempted quitting. They concluded that when a patient's understanding of perioperative risks is better informed and where the advice to quit is given emphasis by physicians and surgeons, cessation rates are improved. Quit-packs sent to surgical patients at the time of waiting list placement also improved perioperative quitting[3]

Simple as ABC?

In New Zealand, patients in public hospitals are routinely given the smoking ABC by the admitting nurse or doctors. That is Ask, give Brief advice, and Cessation. Patients are provided with a Quit Pack and a notation made in their records that this has been done. Most are referred back to their primary care physician.

The topic of plain packaging for tobacco products and the issue of smoking cessation before surgery was discussed during June Council week at the Governance and Advocacy Committee meeting. Whilst as Councillors there was complete agreement on the adverse effects of tobacco, the discussion ensued as to how surgeons should advocate effectively on this issue.

The College advocates for the wellbeing of the patients to whom surgeons provide services. We also promote the best in surgical standards. Patients who smoke and continue to smoke have a higher rate of respiratory complications, poorer wound healing and increased number of cardiovascular events. Stopping for even two weeks prior to elective surgery results in better outcomes. We should all ask our patients if they smoke, provide brief advice, encourage cessation by providing Quit Packs and document in the patient record that we have done so. At a national level we should continue to apply pressure on the governments of both countries. Plain packaging has been successful and should be here to stay.

The College is developing a position paper and an information sheet for patients on the perioperative risks of smoking and the value of quitting. I am pleased to report that new Councillor, Dr Sally Langley, a Plastic and Reconstructive Surgeon from New Zealand is taking the lead in this.

We welcome further dialogue and your ideas on this topic.

References:
1. MJA, 2014, Jan 200 (1) 20
2. ANZJS, 2013, 83:753-757
3. ANZJS, 2014;84: 12519

SALLY LANGLEY
PLASTIC AND
RECONSTRUCTIVE SURGEON

2014 Queens Birthday Honours

AUSTRALIA

Officer (AO) in the General Division

Emeritus Professor John Miles Little AM, AO FRACS

Professor Michael Kerin Morgan AO FRACS

Member (AM) in the General Division

Dr Gary Raymond Speck AM FRACS

Professor James Tatoulis AM FRACS

Medal (OAM) in the General Division

Dr Francis Poh Gwan Cheok OAM FRACS

Dr Peter Dalton Hughes OAM FRACS

Dr Alastair Alexander Mackendrick OAM FRACS

Growing risk for obese

An increasingly obese population is leading to more risky surgery, Queensland surgeons say.

Despite advances in technology, the weight of a person can still be an impeding factor to reading diagnosis. Neurosurgeon Sarah Olsen has said that surgery on the obese also takes longer, delaying other people's surgery.

"It means somebody else potentially misses out on an operating slot in the public sector."

***Sunday Mail*, 27 July**

Technology cutting stays

A new cutting edge theatre recently opened at Launceston General Hospital will cut patient stay times to days rather than weeks.

Although Hobart patients are expected to travel to the new unit for certain procedures, it is hoped that savings generated will be transferred to frontline services.

Director of Surgery Brian Kirkby has said the theatre will make a big difference.

"It is important that we can put patients through less trauma and less pain, and an older style operation has a lot greater morbidity," he said.

***Hobart Mercury*, 28 July**

Slow Telehealth delivery

The Telehealth system introduced to encourage specialists to use video consultations has failed to hit its mark.

The Labor-introduced program has only spent one-fifth of its budget, despite its push to assist the rural health crisis.

Despite a fast uptake of initial services, consultations have not reached expected targets, though a Department of Health spokesperson has said that Telehealth services are on the increase.

***Cairns Post*, 28 July**

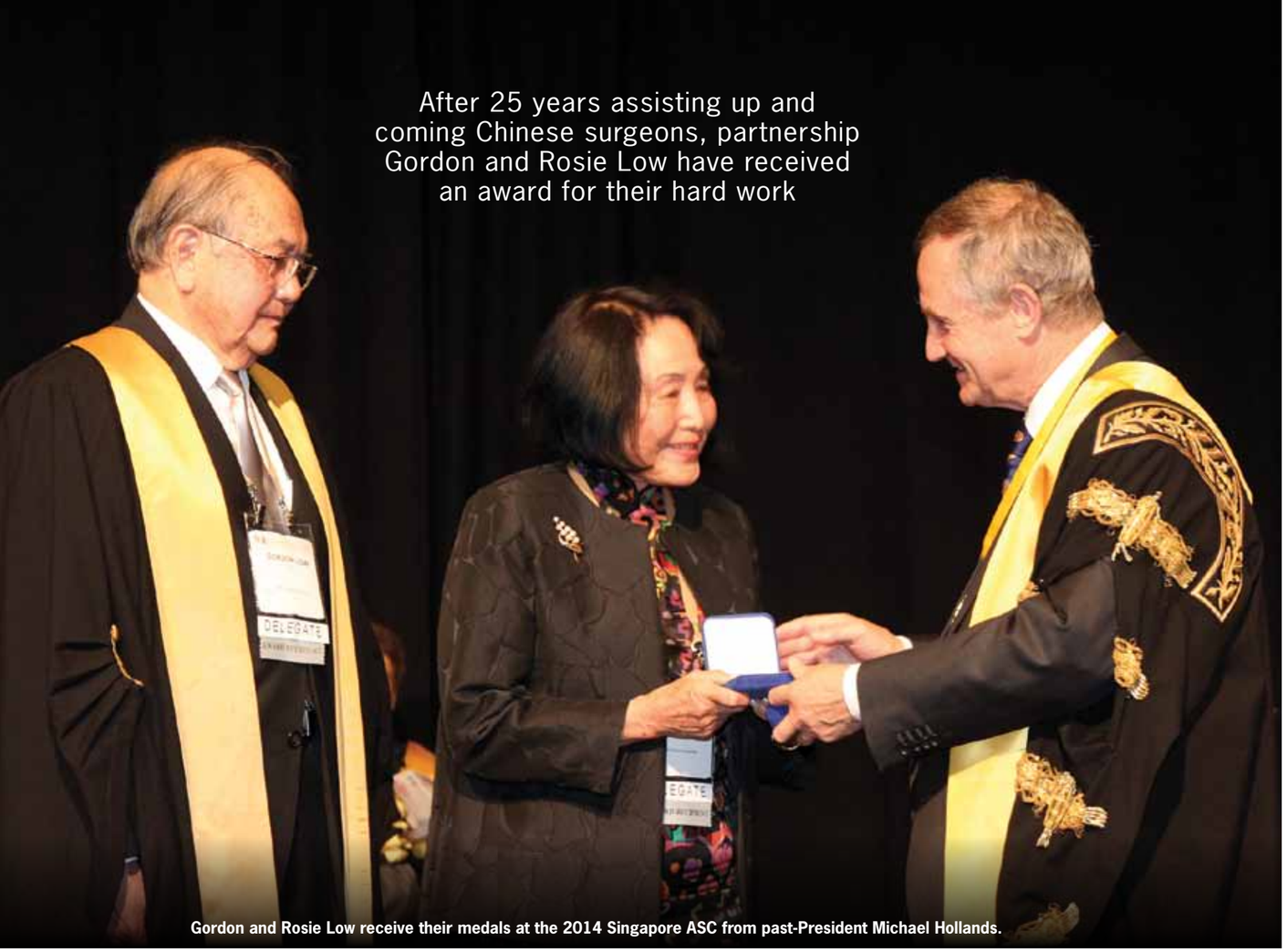
Big fees by small number of surgeons

The College has responded to reports that some surgeons are charging 'extortionate' fees, with President Michael Grigg saying that the news is damaging the profession.

The conduct of these surgeons has been branded as unethical and breaches the College's Code of Conduct.

"Hopefully, the current Senate Committee reporting on out-of-pocket costs will highlight the imperatives of better disclosure of all fees in the health sector," Professor Grigg said.

29 June



Gordon and Rosie Low receive their medals at the 2014 Singapore ASC from past-President Michael Hollands.

RECOGNITION FOR
PROJECT CHINA FOUNDERS

General surgeon Mr Gordon Low and his wife Rosie have received one of the College's most prestigious awards for their tireless efforts over 25 years to advance surgical and medical exchanges between Australia, New Zealand and China through their self-funded program called Project China.

In May, Gordon and Rosie Low were presented with the College International Medal at the ASC in Singapore, an honour only bestowed for outstanding contributions to the international work of the College.

Established at a time when China was still comparatively isolated and economically sluggish from the effects of the Cultural Revolution of the seventies, Project China was designed by the Lows to advance surgical and medical knowledge in all three countries by linking the skills and technology of the West with the vast amount of clinical material in the Chinese population.

"Coming from Hong Kong, we observed the great discrepancy between the medical care being offered in China, particularly in the poorer country areas, and the care available in Australia at that time," Mr Low said.

"We thought it would be great if a bridge could be built so that the knowledge and experience could be shared to the benefit of the patients of all countries.

Former Councillor Vincent Cousins on a trip for Project China in 2012.

"In the late 1980s, the College decided to cease its involvement in conducting Fellowship Examinations across South East Asia and there was the possibility that some contact with our neighbours in the region may be lost. We thought our plan to establish this bridge would help to retain these relationships."

Having decided to create such a project, the Lows spent the first five years from 1988 travelling to China periodically to cultivate personal relationship with Chinese medical leaders in spite of some major political interruptions.

Then with the guidance of a neurosurgeon and close friend from Hong Kong, and with the unstinting support from College Presidents Tom Reeve and John Hanrahan, and also President LU Guang-qi of the Sun Yat-sen University of Medical Sciences, the Lows organised and financed the first visit by Australian surgeons in 1993 when two spinal surgeons from Melbourne spent one month at the Second Affiliated Hospital of the Sun Yat-sen University in Guangzhou.

From that modest beginning Project China grew to include visits by other disciplines such as anaesthetists, pain management specialists, ophthalmologists, dentists, theatre nurses and other allied health professionals.

Responding only to requests from Chinese hospitals, Project China has now sent more than 110 Australian and New Zealand surgeons and medical specialists to China across 64 visits and supported more than 90 surgeons, nurses, anaesthetists and other specialists from China to undertake hospital placements in New Zealand and Australia. The first Chinese surgeon who visited Australia under the program was in 1994.

Speaking after receiving the International Medal, both Gordon and Rosie Low said they were delighted to be so honoured by the College, particularly because they had never expected their initial plan – to work with surgeons in one hospital in Guangzhou – to grow into Project China.

"Although the College was able to provide administrative support through its External Affairs Department, no additional money was available to sponsor Chinese surgeons to come to Australia/New Zealand, or to provide fares for our own Fellows to travel to China.

"As a 'labour of love' we had to find the money to finance our objectives and we were most fortunate to have many generous relatives and friends in Hong Kong, Britain, Canada and Australia who willingly donated money to the RACS – Project China to support our work.

"Still, even with this backing, it's hard to believe that our first tentative step in sending two orthopaedic surgeons to one hospital in one city could ever have grown into Project China."

In the past 25 years that the program has been running, the Lows have assisted Dr Alex Konstantatos to start a Pain Management Course, and encouraged Dr John Reeves to conduct courses in Intensive Care at the Sir Run Run Shaw Hospital in the east China city of Hangzhou. Also in the same hospital, Melbourne plastic surgeons helped to develop a program for training Chinese surgeons in Reconstructive and Plastic surgery. The Lows also supported the development of medical research in China by funding doctors to visit Australian research centres and helped other Fellows establish their own training programs in China.

To further enhance the exchange of knowledge, Gordon and Rosie raised funds to bring Chinese surgeons and medical personnel to Australia and New Zealand for advanced training and also to hold clinical meetings to foster friendship between Chinese and Australian and New Zealand colleagues. Together with the Tumour Hospital and Cancer Centre of the Sun Yat-sen University in Guangzhou, they established a series of biennial conferences called the Sino-Australia/New Zealand Conference on Surgical Oncology. First held in 2000, the next meeting will be held in Melbourne in October this year. ▶

"We also learned very quickly that many Chinese surgeons felt isolated from the rest of the world, and we heard many stories of highly qualified Chinese surgeons applying for training positions in other countries who never even received a reply," Mr Low said.

"Yet while some of this was driven by geopolitics, it was also about language barriers. In 2006, we established the Oral English program in a few hospitals to aid Chinese medical personnel to go overseas for training or placement."

Mrs Low said, "We approached a retired teacher of English as a Second Language, Mrs. Bronwen Ronan, to help us provide courses for doctors and nurses wishing to become proficient in spoken English and she then went on to recruit other teachers for us.

"This not only allows the Chinese doctors and nurses to gain the most from visiting specialists or to reap greater benefit from their visits to Australia, but also gives them confidence when applying for overseas medical and hospital appointments.

"Under Project China, each teacher spends three months in the designated hospital and their work has been invaluable, not just in terms of helping individual students, but by subtly working to break down unnecessary and unhelpful barriers between China and the west."

For all these achievements Mr Low was made a Member of the Order of Australia in 2003 in recognition of his services to medicine and to international relations while both he and Rosie were presented an Excellent Contribution Award from the Tumour Hospital and Cancer Centre in Guangzhou and a Distinguished Service Award from the Sir Run Run Shaw Hospital in Hangzhou.

Rosie Low is the lynch pin of the project. During the years when Mr Low worked in a multi-disciplinary surgical practice in Melbourne with honorary public appointments at the Box Hill and Alfred Hospitals, she took on the role as administrator, fund raiser and coordinator.

She said some of the keys to the success of Project China were their language skills, their understanding of the Chinese culture and the time they invested to develop personal relationships with medical leaders in China.

Gordon and Rosie Low at the recent Singapore ASC

Mrs Low said that they had taken more than 50 trips to China over the years for Project China, to meet medical leaders and to discuss and plan the exchange visits of specialists from all countries involved.

"It is hard to imagine how difficult it was to even get into and around China when we first began, given how open it has now become," she laughed.

"Then, there were very few direct flights from Australia to China and often when we went, we had to go through Hong Kong, and then enrol family members to purchase the rail tickets ahead of arrival in Hong Kong for ourselves and for the visiting surgeons – so this has been quite a family affair."

Now retired, both Gordon and Rosie Low say the aims of Project China have been realised and the need for financial assistance largely obviated given the extraordinary economic transformation of China in recent years.

"At the beginning, we had to support Chinese surgeons and medical personnel, but now they have the financial backing to train where they wish," Mr Low said.

"At first, we used to send some equipment to various hospitals, but now they have access to technology that is more advanced than ours.

"In the early years, we worked to advance the training of surgical specialists but now they have units in many hospitals and universities that are among the best in the world.

"I think it is fair to say that we have achieved what we set out to achieve, thanks to the support of the College and Fellows from across Australia and New Zealand, and the enthusiasm of the Chinese administrators, the doctors and nurses. Last, but not least, it was the munificence of philanthropists whose donations made all these programs possible."

Mr and Mrs Low both said the transformation that had taken place in their country of birth during the past 25 years meant that Project China had now reached its use-by-date.

"Our lives have been enormously enriched through our involvement in Project China," they said.

"We went into this scheme with no concrete aim because China is so large and so complex. Instead, we just took one step at a time, feeling our way forward, so that any success has always been unexpected and delightful.

"We have had the chance to meet a great many wonderful people through this work and we thank the College for bestowing upon us the honour of the International Medal."

With Karen Murphy

NOMINATING FOR COUNCIL

Have a say in your College's decision making!

Fellows are invited to nominate for election to the College Council. Nominations open on Friday 22 August and close on Friday 12 September, 2014.

You will receive an email on Friday 22 August with a link to enable you to complete your nomination form. You will need to contact two Fellows to support your nomination.

As a member of Council you become a company director with fiduciary responsibility to act in the best interests of the Fellowship as a whole.

Training by the Australian Institute of Company Directors is provided. You would need to make a meeting commitment of three days three times a year at the end of February, June and October. Your three year term of office would commence at the AGM in May 2015.

There are four vacancies in the category of Fellowship Elected Councillor on the Council of the College.

There are six vacancies among the Specialty Elected Councillors. Fellows in these specialties are invited to nominate:
– Cardiothoracic Surgery
– Paediatric Surgery
– Plastic & Reconstructive Surgery
– Otolaryngology Head and Neck Surgery
– Vascular Surgery
– General surgery

Fellowship Elected Councillors

The current Fellowship Elected Councillors are:

Members of Council who wish to retire:
> Sean Guy Hamilton (Plastic & Reconstructive) WA
> Simon Alan Williams (Orthopaedic) Vic

Members of Council who are eligible for re-election and wish to stand:
> Phillip James Carson (General) NT
> Lawrence Pietro Malisano (Orthopaedic) QLD

Members of Council not due for re-election on this occasion:
> John Charles Batten (Orthopaedic) TAS
> Spencer Wynyard Beasley (Paediatric) NZ
> Ian Craig Bennett (General) QLD
> Graeme John Campbell (General) VIC
> Catherine Mary Ferguson (Otolaryngology) NZ
> Sally Jane Langley (Plastic & Reconstructive) NZ
> Barry Stephen O'Loughlin (General) QLD
> Richard Edward Perry (General) NZ
> Julian Anderson Smith (Cardiothoracic) VIC
> Philip Gregory Truskett (General) NSW
> Marianne Vonau (Neurosurgery) QLD
> David Allan Watters (General) VIC

Specialty Elected Councillors

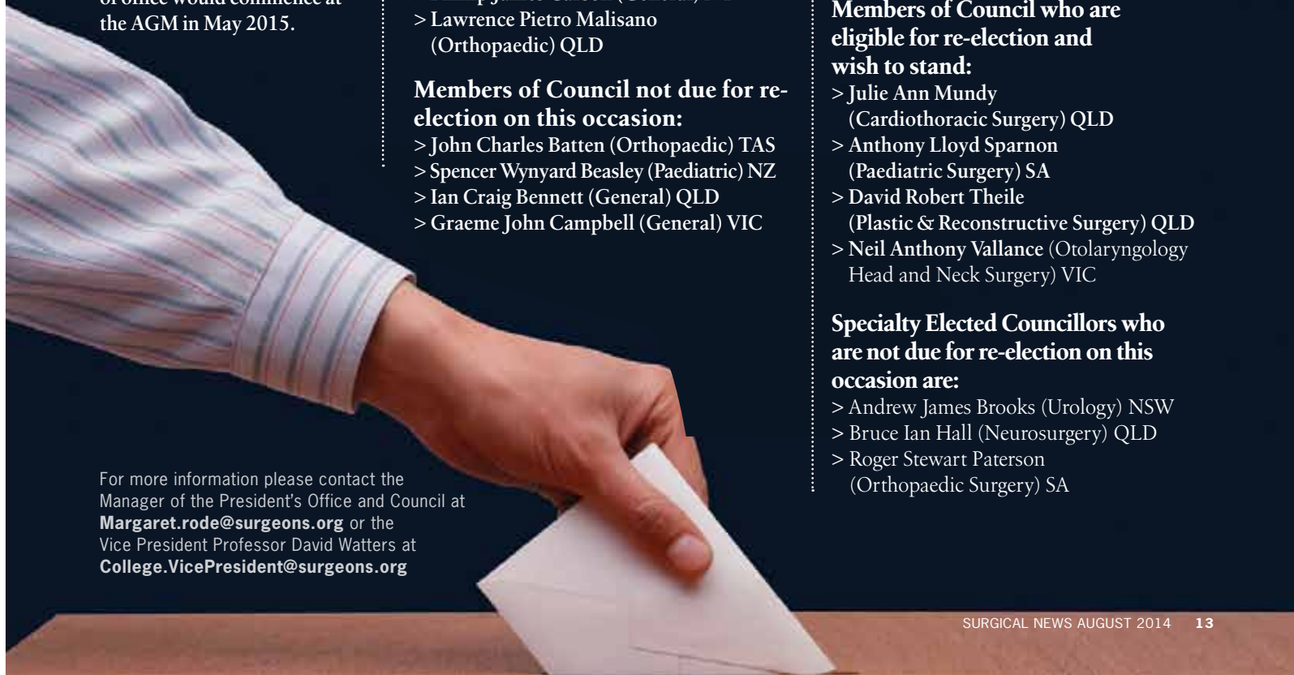
The current Specialty Elected Councillors are:

Member of Council who is retiring
> Michael John Grigg (Vascular Surgery) VIC

Member of Council who is eligible for re-election but is retiring as General Surgery representative:
> Alan Charles Saunder (General Surgery) VIC

Members of Council who are eligible for re-election and wish to stand:
> Julie Ann Mundy (Cardiothoracic Surgery) QLD
> Anthony Lloyd Sparnon (Paediatric Surgery) SA
> David Robert Theile (Plastic & Reconstructive Surgery) QLD
> **Neil Anthony Vallance** (Otolaryngology Head and Neck Surgery) VIC

Specialty Elected Councillors who are not due for re-election on this occasion are:
> Andrew James Brooks (Urology) NSW
> Bruce Ian Hall (Neurosurgery) QLD
> Roger Stewart Paterson (Orthopaedic Surgery) SA



For more information please contact the Manager of the President's Office and Council at **Margaret.rode@surgeons.org** or the Vice President Professor David Watters at **College.VicePresident@surgeons.org**

SOCIAL MEDIA IN MODERN MEDICINE

Is social media a help or a hindrance in modern medicine? Dr Edwin Kruys, a GP from Queensland's Sunshine Coast, provides a personal perspective on the subject

Social media is here to stay. A lot of registrars and young doctors have one or more social media accounts, and I have yet to meet a medical student who is not on Facebook. Patients are already sharing online (health) information via Facebook, Twitter and other social media accounts – so sooner or later health professionals will need to decide whether or not to participate.

What are the potential benefits of using social media in the medical profession?

Social media is increasingly used for medical education, and sharing knowledge and information such as tips, resources, literature and links.

It's also useful to build an online community. Clinics can share health information and other practical information. Social media is more interactive than a website and you can reach a wider audience in real time. Another benefit is the value of health promotion and lifting the profile of a medical practice or organisation.

I'd like to mention the use of blogs, pictures and videos. I find they are a great way to communicate a message, and I use my social media accounts to let my followers know when I've posted something new.

How can doctors make the most of social media?

You need to be prepared to put aside time to manage your online presence, and there is no easy way out here. It takes time to post useful material and interact with others. Social media is a two-way street and not just another promotional channel. If you use social media for branding or promotional purposes only, you may lose followers.

Your online presence should have a consistent approach. Too many organisations set up a Facebook account without first developing a clearly defined strategy. It is recommended to take some time to plan and figure out the purpose of the social media campaign, which medium to focus on, and how to keep it sustainable and current. This usually requires a motivated person within the organisation.

Preparation is key, and implementing a social media policy should be part of the preparation. Some things to include in the policy are, for example, how to respond to negative feedback and/or complaints received via social media; and how to comply with AHPRA regulations.[1] The AMA has a useful document[2] that outlines the risks. I also felt that the social media workshops organised by MDA National are an excellent way to become familiar with the common pitfalls.

Is social media for you?

Due to the time commitment, and the effort it takes to set up and maintain social media accounts, it may not be ideal for everyone. For those who want to contribute to online health promotion or interact and share health information with their patients or other health professionals, social media is not without risks, but it can be an effective tool if used wisely.

Dr Edwin Kruys is a practising GP who blogs at doctorsbag.wordpress.com.

Useful links

- For information on social media workshops run by MDA National in 2014, visit our What's On page at mdanational.com.au or email events@mdanational.com.au.
- A new 'Social Media Policy' has just been published by the Medical Board of Australia. It was developed jointly by the National Boards to help registered health practitioners understand their obligations when using social media. Available at medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

Medical practitioners should only post information that is not in breach of their obligations by:

- complying with professional obligations, including the Medical Board of Australia's Code of Conduct and Advertising Guidelines;
- complying with confidentiality and privacy obligations, e.g. not discussing patients or posting pictures of patients, procedures, case studies or sensitive material which may enable patients to be identified, without having obtained consent in appropriate situations;
- presenting information in an unbiased, evidence-based context;
- not making unsubstantiated claims.

References

1 Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia and Medical Guidelines for Advertising Regulated Health Services. 2010. Available at: medicalboard.gov.au/codes-guidelines-policies.aspx.

2 A Guide to Online Professionalism for Medical Practitioners and Medical Students. Available at: ama.com.au/social-media-and-medical-profession.

This article is provided by MDA National. It was first published in MDA National's Autumn 2014 edition of Defence Update. MDA National recommends that you contact your indemnity provider if you have specific questions about your indemnity cover.

The Full Brazilian

Watching sport may be bad for you and supporting your team may be worse

Sport watchers in Australia and New Zealand have suffered a bleary-eyed winter. The overlapping spectacles of the FIFA World Cup, Wimbledon, and the Tour de France resulted in late nights, disturbed sleeps and early rises. If any antipodean hour can be regarded as 'ungodly' it has to be 2am (4am in NZ) – the time beyond which a competitive five-set men's singles final extended, or a Brazilian quarter final began.

During the World Cup the Netherlands Coach, Louis van Gaal, even went on his national television (recycled on SBS and Fox Sports) recommending parents to let their children stay up late to watch – so that Dutch children wouldn't have a restless night wondering about the result. More about that advice later.

Unfortunately during the semi-final with Argentina van Gaal's team then couldn't get even 'van goal' in what proved to be their most dull and unenterprising performance that saw them deservedly exit on penalties.

We know that physical exercise is strongly associated with good health. For that, there is overwhelming evidence. But what are the benefits of watching others exercise? How does someone with a dicky heart withstand the adrenergic surges associated with great shots and incredible misses? Adjusting to the stressors of triumphs and tragedies?

I have been consulted by patients about almost every imaginable and some unimaginable situations during my career, but no one has ever asked me whether they should stay up late to watch sports events on the other side of the world. However, it is always good to have considered the evidence, and with such a topic on my mind I decided to be ready; if and when that question might ever be asked.

In preparation for the 2014 World Cup there was a full Brazilian study of the impact of the 'world game' on myocardial events. Analysing hospital admissions during World Cup years from 1998-2010, there was a statistically increased risk of acute coronary syndrome during World Cup matches, with even more events during Brazil matches. Although the coronaries did not translate into an increased in-hospital mortality, the study was performed using only hospital admission data so that deaths that never made it to hospital would not have been recorded.

The authors went on to conclude that football matches are associated with an increased risk of acute coronary syndrome. In Brazil where they are very passionate about their football, each gender was affected equally. It would be interesting to read any follow up study on the rate of acute coronary syndrome during and after Brazil's semi-final 7-1 drubbing by the Germans.

The Deutsch will also suffer for football. A German study conducted during the 2006 German-hosted World Cup, and published in the NEJM, found the rate of acute cardiovascular events doubled on the days the German team played.

However, there may be other cultural factors to consider. In the French-hosted 1998 World Cup which France won, the acute coronary syndrome rate dropped in France (?Les Blues red wine effect) but rose in French speaking areas of Switzerland (the Swiss are very serious).

Yet perhaps this is not true downunder. The health effects of Australia's penalty shoot-out with Uruguay in the World Cup qualifier of 2005 was studied in NSW, but was somewhat underpowered with only 28 myocardial events on the day of the match, and a further 43 on the two subsequent days. The AFL Grand Final, won that year by the Sydney Swans also had no impact on acute coronary rates. Rather cruelly, the authors concluded NSW spectators just didn't care enough (motivational deficiency).

We also have to consider the effects of sleep deprivation on the human metabolome. Sleep deprivation is associated with metabolic syndrome, obesity, insulin resistance and a lack of personal physical activity. During a World Cup, adults take less exercise, have less sleep, and suffer the emotional and performance consequences. Children watching games late at night will exhibit the effects of lack of sleep in their behaviour with impaired ability to concentrate or learn at school.

There is no doubt that watching soccer matches poses a health risk. That risk is increased if you care about who wins. Louis van Gaal might be someone you would trust to manage a soccer team, but he's most certainly not qualified to comment on what's best for children, nor what's best for the health of football fans.

The World Cup is over, congratulations to Deutschland (über alles)! Some of you may have cried for Argentina. Dr BB G-loved has decided that for the full Russian in 2018, my bleary-eyed spouse, Mr BB G-loved, would be better off moving time zone, should pass a pre-World Cup cardiac check-up, have normal blood pressure and ensure his ball watching does not disturb my sleep. Fat chance of that!

PLAYING THE MAN

Clinical roles were played out on stage in the closing session of the ASC

One of the highlights of the ASC in Singapore was the first live theatre production written by doctors for doctors to be staged at an Australasian medical conference.

Amusingly titled "There is no 'I' in blame (but there is 'me')", the play was the brainchild of anaesthetist Dr Stavros Prineas with collaborative input from orthopaedic surgeon Mr Angus Gray, colorectal surgeon Professor John Cartmill and fellow anaesthetist Dr Suyin Tan.

Based on a near catastrophe in theatre, the play explores the issues of communication, situational leadership, blame-shifting and the emotional impact of dealing with the unexpected in the operating theatre.

Professor Cartmill, who acted as MC and narrator, said the work aimed to both entertain and educate surgeons and anaesthetists about human factors, a modern field of research relating to the relationship between humans and the systems within which they work.

Human factors training has long been part of the aviation industry and an increasing number of medical leaders are now pushing for the introduction of similar training in medicine in a bid to reduce adverse events.

Professor Cartmill has had extensive involvement in this emerging field of study and some years ago established an educational company called ErroMed, now run by Dr Prineas, to train medical staff in the underlying dynamics of human factors.

He said he was delighted to work with Dr Prineas on the play as a way to both entertain and educate the audience about the need to understand the human reactions that come into play when the unexpected arises.

"The adverse event dramatised in the play was an on-table resuscitation of a prone adolescent having surgery for scoliosis," Professor Cartmill said.

"The surgeon and anaesthetist are shouting at each other, at times playing to stereotypes, but in an amusing way so as to draw the audience into the serious underlying issues explored.

"The near-catastrophe scenario allowed us to explore such concepts as the pre-surgery briefing, the need to take time-out to think how best to deal with a crisis, root cause analysis, the relationship between administrators and clinicians and post-crisis debriefing.

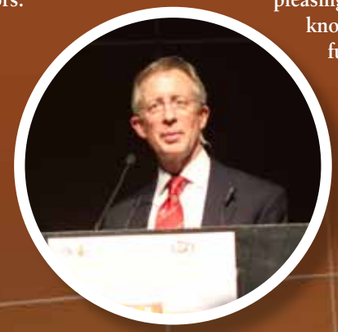
"How to manage disasters or near disasters has long been taught in the aviation industry and there is now a great deal of research to support the value of such training in the medical environment.

"Obviously, the scenario presented in the play is very unlikely, but similar unlikely things happen in theatre often enough."

Professor Cartmill described the production as a form of edutainment which had particular value given that it was written by doctors for doctors.

He said he would now approach the College to see if there was funding available to film the work for use as a training tool for surgeons, anaesthetists and junior doctors.

"The turn-out at the conference was very pleasing, partly because Stavros is well known as being a very entertaining, funny man and afterwards we opened the session for questions and discussion which is a useful way of embedding awareness of the ideas explored," he said.



Clockwise from left: Anaesthetist Stavros Prineas and Fellow Angus Gray take workplace relations to the stage; Fellow and Chair of the session John Cartmill; John Cartmill with the discussion panel.

> *The surgeon and anaesthetist are shouting at each other, at times playing to stereotypes, but in an amusing way so as to draw the audience into the serious underlying issues explored*

Prineas and Gray with Anaesthetist Suyin Tan as the Hospital Administrator.

"As surgeons and anaesthetists we are educators as much as we are doctors and all of us involved would love to do more of this work because it is such a useful, entertaining form of training."

Sydney Orthopaedic surgeon and College Examiner Mr Angus Gray, a long-time friend of Dr Prineas and amateur thespian, played the role of the surgeon in the production.

He said the two had been friends since their university days and had performed together in university review productions so that when he was approached by Dr Prineas to collaborate, he did not hesitate.

"We had great fun working on this in the lead up to the ASC," he said.

"We Skyped a few times, given that Stavros is now in the UK, and traded insults, barbs and witticisms back and forth via email for inclusion in the script.

"Then we kind of threw it together in the days leading up to the performance with the script only finalised hours before, but that was fine because both he and I have a background in improvised theatre and theatre sports."

Mr Gray, the head of the Orthopaedic Unit at the Sydney Children's Hospital, said that he believed the play was an engaging way to raise issues surrounding leadership and communication skills and inter-personal dynamics.

He said that as an examiner for the College, he believed that more structured education should be offered to Trainees in communication, command and control skills, leadership and teamwork.

"These skills are not innate but have to be learned, either informally as we progress through our careers or through dedicated, targeted training," he said.

"Medicine is changing for the better, but I believe that we as surgeons and anaesthetists need to keep up with those changes and take on leadership roles.

"I think most Fellows have felt this loss of control and the rise of the bureaucrat and we have to get involved in the administration and politics of medicine if we are to change that and that involvement requires communication and leadership skills.

"A lot of us are now involved in trying to advocate for this type of training to add to our efforts in teaching registrars the importance of effective communication, not only in times of crisis but in their every-day dealings with patients, colleagues and hospital management.

"Participation in the play, to me, was part of this. It was funny, it was entertaining, but most importantly it raised issues that have now become pressing both for us as doctors and as educators."

With Karen Murphy

THE HUMAN FACTOR

Anaesthetist Dr Stavros Prineas has used his theatre experience for clinical education

Although anaesthetist Dr Stavros Prineas now spends much of his time in the UK, he is well known to NSW surgeons and anaesthetists as a home-grown colleague with a career-long interest in reducing medical error through greater understanding of human dynamics. Now working at Guy's Hospital and Moorfield's Eye Hospital in London, Dr Prineas retains ongoing VMO appointments in Sydney and returns periodically for some sunshine.

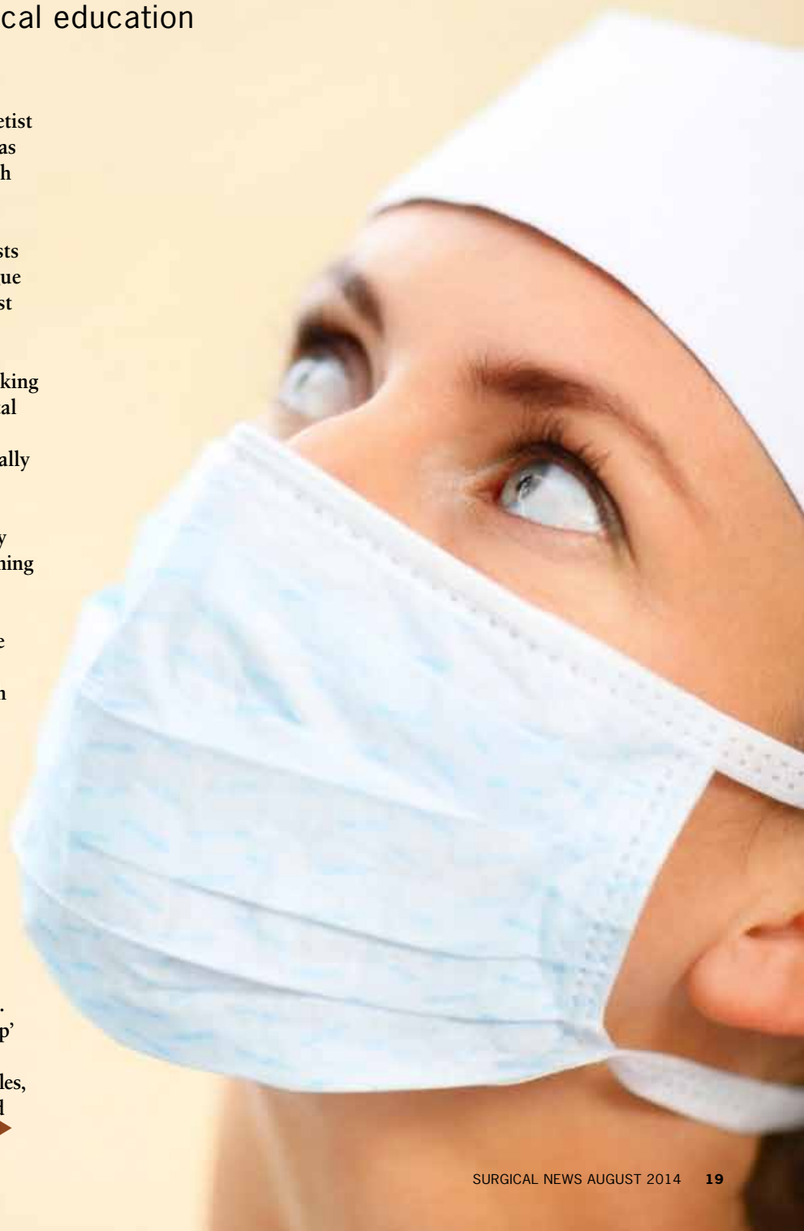
A writer and part-time thespian, he is also a co-founder of ErroMed, an education company which aims to translate the human factors training used in aviation and other industries into the medical setting to reduce adverse events, often using novel non-didactic methods. Recently, he wrote a comedy in collaboration with Fellows Professor John Cartmill and Angus Gray which was performed at the ASC in Singapore. Dr Prineas talks to 'Surgical News'.

What is the play called?

The title in the conference program was "There's no 'I' in Blame (But there is 'Me')".

What are the main themes explored?

There are two broad themes – the decline of leadership in the operating theatre and the rise of algorithmic tick-box thinking in healthcare, which denies the importance of clinical expertise. The concept of the surgeon as 'Captain of the Ship' in the operating theatre is challenged and some practical training concepts such as leadership styles, situational leadership and transferable command are discussed. ▶



FROM THE ASC

How would you describe the characters represented?
The surgeon and the anaesthetist are friends, a bit like an old married couple who bicker but fundamentally depend upon each other. The surgeon is painted as a bit of a boys' own autocrat, although he does think and listen when required. He is the more vulnerable of the two in relation to the near disaster in theatre and the one with more at stake on a personal level.
The anaesthetist is more of an observer and commentator, at times a theorist and at other times a jester. The administrator is more of a cartoon character – a jargon-toting executive for whom checklists and protocols are the answer to everything. I would have liked to have developed her character more, although she did say my favourite line in the piece: "We all make mistakes, didn't you?" That's the new 'no-blame culture' in a nutshell.

What were the aims of the play in terms of sparking discussion and thought?
I wrote it around two main trigger points. Firstly, on a practical level surgeons and anaesthetists need to learn more about basic leadership and command skills, which require specific scholarship and training and cannot just be presumed. They also need to make themselves familiar with concepts and techniques such as human factors for which there is a growing theory and evidence base. This should be part of undergraduate and postgraduate training.

Secondly, at a political level there is an urgent need to rethink clinical leadership in healthcare and for doctors to get back into the driver's seat. As a professional class doctors tend to stand outside healthcare politics which is understandable but misguided, as good leadership is as much a political imperative as it is a practical one. We seem to be struggling to stake a credible claim to lead in healthcare, and meanwhile the resultant power vacuum is being filled by others. Once we lose the ability to be masters of our own practice, we will cease to be a professional class and sometimes I wonder if we have already given up too much ground to regain.

At one point the administrator tells the clinicians: "If you're part of the problem, logically you can't be part of the solution, can you?" This may sound absurd in the first instance, but often newer patient safety initiatives seem to disenfranchise the clinicians and devalue their input. Many professional managers naturally take their policy cues from the commercial corporate world, which seems to me the wrong place to be looking for inspiration on leadership if you want patient-centred care and clinical standards to be the 'bottom line'.

But this situation is – at least in part – one of our own making. We need to reinvent ourselves as a profession who can rightly assume a leadership role because we are trained specifically to be ethical, compassionate and – above all – competent leaders in healthcare.

Are there major differences between how surgeons and anaesthetists deal with adverse events?
I'm not sure if one should make tribal generalisations. They say "physicians kill in weeks, surgeons kill in days, anaesthetists kill in minutes," so maybe there is an immediate instinct of professional self-preservation behind the reason why anaesthetists seem to have embraced human factors so readily. Having said that, there are many surgeons interested in human factors, and working with like-minded colleagues like John Cartmill and Angus Gray has been brilliant. Indeed it was a surgeon – John – who started ErroMed.

Was it difficult to collaborate and write given that you live in England?
We discussed the original storyboard about a year ago, and gestated a number of themes over ensuing months, each of us doing our own preparation. But it wasn't really until the last few weeks before the conjoint congress that the details of the script became clear, and much of the dialogue arose from discussions and rehearsals at the conference.

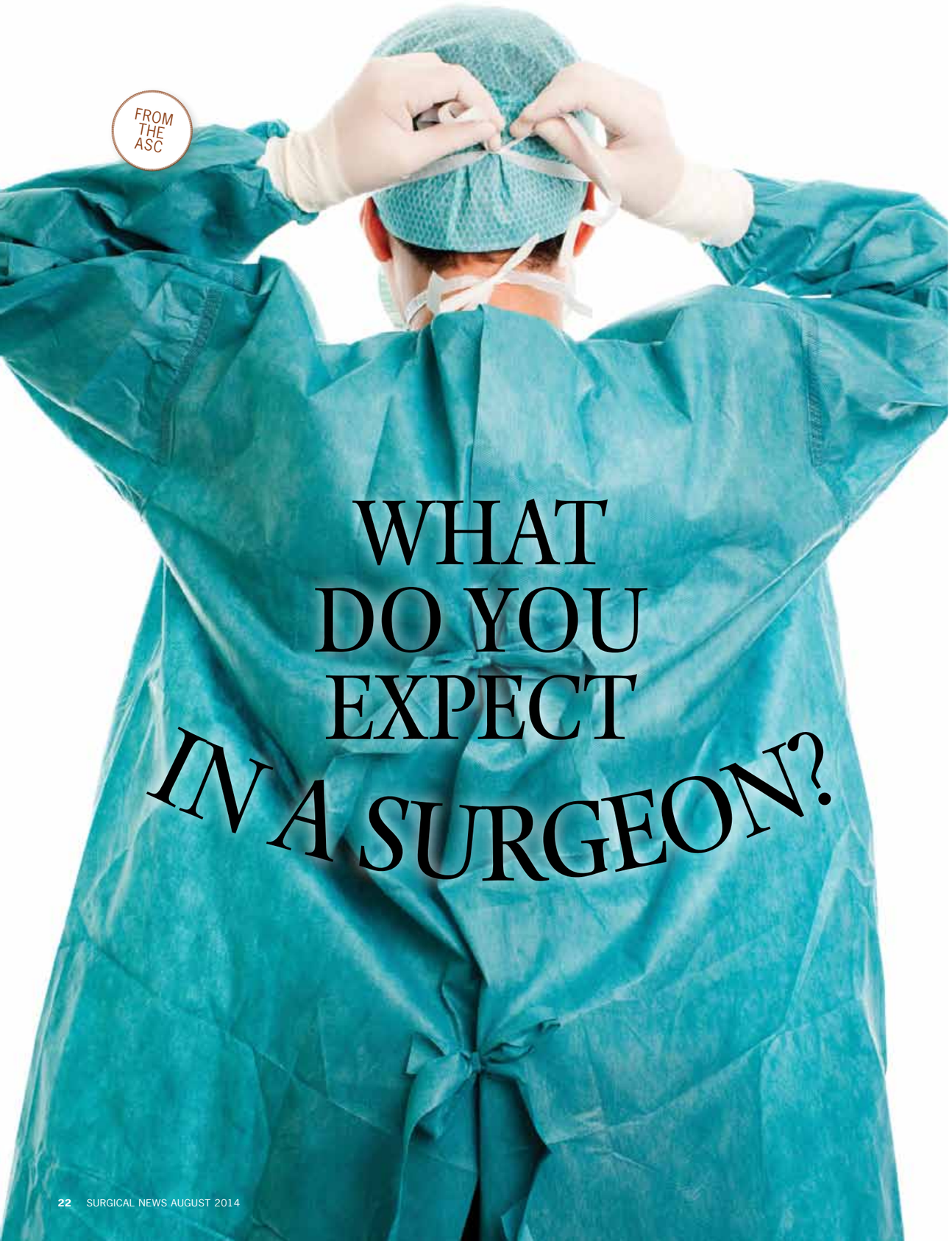
If that sounds like we threw it together at the last minute, yes we did, but that's improvisational theatre. When it works, the result feels like a natural, spontaneous collaboration – a true ensemble performance. When it doesn't, there is an agonising death on stage.

It's a bit like what we do in a real operating theatre. Each of us prepares our special role, then we turn up and play our part. There is no script per se; we improvise around the clinical situation presented to us, the needs of the patient, and through each other. Of course the stakes are much higher in an OR.

Do you still run the company ErroMed and what does it do?
Absolutely. ErroMed's mission from the outset has been to make human factors an integral part of healthcare training everywhere. We run courses for clinical audiences on human factors awareness and on specific topics such as safety-critical communication, teamwork and leadership, situational awareness and perception of risk, personal ergonomics, adverse event analysis and the ethical disclosure of adverse events. We also design and run large-scale train-the-trainer programs, with our own educational videos and **DVDs. We even educate medical executives!**

Do you think it is important for surgeons and anaesthetists to be able to laugh at themselves and with each other given the work can be so intense and pressured?
Humour is therapeutic in many ways.

With Karen Murphy



College Fellow Carol-Anne Moulton's interest in psychology drove her research into surgeons' personality traits

HPB oncology surgeon Carol-Anne Moulton completed the majority of her surgical training in Australia before returning to Canada, her country of birth, to complete a surgical oncology clinical fellowship at Toronto General Hospital. Now an Assistant Professor at the University of Toronto, Professor Moulton combines her oncology practice with an interest in surgical education, having completed a PhD focussed on surgical judgment, surgical decision-making and surgeon error.

The author of a number of papers describing the psycho-sociological foundations of surgery, Professor Moulton now travels extensively to explain to colleagues the need to 'slow down' when necessary. The recipient of a College research scholarship early in her career, Dr Moulton was delighted to be asked to present her research at the recent ASC in Singapore.

She speaks to *Surgical News* about how the traditional persona of the surgeon as heroic, decisive and certain can not only compromise patient safety, but isolate surgeons both professionally and psychologically.

When and why did you become interested in the psycho-social aspects of surgery?

Psychology runs in my family. My parents are counsellors and clergy and one sister is a psychologist and the other is a social worker. My first career choice after medical school was surgery and the second was psychiatry so I combined them, I guess.

My particular interest was in how we think and I knew during surgical training that things were not always as they appeared. It became clear to me over time that confidence was sometimes being 'put on' while uncertainty was sometimes hidden. I started recognising when colleagues seemed out of their depth, but also resistant to seeking assistance and I wanted to know why and what were the underlying drivers of this behaviour.

This interest led to pursuing a PhD in surgical judgment during which I also developed expertise in qualitative methodology which has enabled me to ask pivotal research questions to help explain natural phenomena such as how we manage our public images or how we react to error.

Is there a stereotypical surgical persona; if so what is it?

I do believe there is a stereotype and it is one of machismo, certainty, bravery and confidence. This is the person who walks with a strut (the surgeon's walk), someone who believes in the adage of sometimes wrong, never in doubt.

I also think this stereotype sets the expectations of how we manage our image even though many surgeons fall short of that in their inner sense of self. So the stereotype likely does not exist in many, but is simply a front that we try to live up to, or pretend to embody.

Do you believe the surgical profession promotes this stereotype by selecting Trainees who fit it?

I think the surgical community feels that there are certain traits that are necessary to be a 'good surgeon' such as decisiveness, quickness of thought and action, the ability to work well under pressure and tirelessness. I don't think the surgical community understands completely that these are traits we train for.

I think that there may be some tendency for Trainees to be selected on this basis but, more importantly, I think we 'morph' them into clones of ourselves through the process of socialisation. Every professional wants to 'fit in' and be a valued member of their group and therefore Trainees learn the 'rules' for how to be, how to behave, how to act very quickly.

What problems or risks to patient safety are posed by promoting such attributes or expectations as certainty, decisiveness and heroic action?

I believe this can foster a culture in which decisions are made too quickly without necessary reflection and thought because of the pressure to be certain. This, in turn, can inhibit Trainees and staff consultants from asking for help in a timely manner or not at all.

Are there benefits in such traits as confidence and decisiveness in that they can lead to effective performance?

I am sure there are. The concept of self-efficacy is an interesting psychological concept that also has similar ideas within the social psychology world with theories of the 'looking glass self'. This refers to studies showing that belief in oneself can improve a person's chances of success. In other words, the more a surgeon believes that he can achieve a good surgical outcome, the more he tries, perseveres and succeeds.

The 'looking glass self' explains how we can view ourselves through the lens of others around us. So, if we are surrounded by a team that believes in us, so too is our self-belief enhanced. As a surgeon, I have experienced both sides of this and have found it interesting to 'play' with these concepts as I have been operating myself.

Has the increase in the number of women in surgery changed the stereotype and if not why not?

I am not sure. People talk about the feminisation of surgery, but I think it is falsely leading us to believe that if we increase the numbers of women in surgery, we decrease the male stereotype. ▶

FROM THE ASC

That might happen to a degree, but I wonder whether we are just seeing women 'acting like men' to again fit in to the culture of surgery. The question of changing a culture is more complicated than simply increasing the number of women. We have to understand gender as opposed to sex.

The masculine traits (which are only so labelled by society) comprise the dominant accepted persona of a surgeon so we tend to display these qualities to each other. The feminine traits (that I am convinced are also felt by men) tend to be hidden. I think we need to find a way to be able to freely display both when necessary, but for this to happen, the profession would have to change its value system. It may also require changes in public expectations of surgeons as I believe this is also a driver behind the stereotype.

Why is it important for surgeons to understand the culture and implicit expectations placed upon them?

This is important because it allows surgeons greater freedom to put on certain fronts when required such as when dealing with patients who need us to act confidently to engender trust. It also then allows us to know that it is a front and that if we are not certain, it is perfectly acceptable to ask colleagues for advice and input behind the closed doors of the clinic or surgeons' rooms.

Should efforts be made to change the culture and therefore the stereotype or do the benefits associated with confidence and certainty outweigh the risks?

That is a million dollar question. I suspect most surgeons would be more competent, safer and happier if we were to begin to understand these socio-cultural influences on our decision making. I think we'd be happier when we begin to see that 'faking' something we do not feel can eat away at us and prevent us from seeking help when we need to, such as debriefing after a complication, for example. If we understand the pressures on us, we are then in a better position to make deliberate choices of how to act professionally and respond emotionally.

Were you pleased to be asked to present at the ASC in Singapore?

Of course. I always feel pleased to have the opportunity to share what I believe to be very valuable information with fellow surgeons and colleagues, particularly at a RACS meeting given the support I received through the College to complete a Masters Degree in Surgical Education.

With Karen Murphy

NEUROTRAUMA SUCCESS OF ACUTE

The successful delivery of this course for the past seven years continues to improve rural skills

MARIANNE VONAU
TREASURER

Due to Australian geography and distribution of neurological services, rural surgeons may be called upon to perform emergency neurosurgery to save a patient's life or reduce neurological morbidity.

From 2007 to 2013 inclusive, the Royal Australasian College of Surgeons delivered 12 Acute Neurotrauma workshops to over 200 participants. Three of these workshops were offered in Adelaide, three in Melbourne, two in Brisbane and one each in Perth, Townsville, Geelong and Sydney.

The aim of the course is to dispel the fear of opening the skull. The participants received training in how to perform burr-holes, do a craniectomy or a craniotomy for head trauma emergencies using relatively inexpensive and simple equipment, such as the Hudson Brace and the Gigli saw.

This equipment can easily be available in smaller hospitals. Participants were taught to correctly evaluate the patient, determine whether on the spot treatment was needed and how to proceed following contact with a neurosurgeon. Time was spent operating on cadavers until the participants were comfortable with performing the procedures.

All the workshops have received excellent feedback from the participants and there have been waiting lists for workshop attendance. Some of the major concerns that motivated participants to attend were: unavailability of staff to perform or assist in rural hospitals, no confidence in performing the procedures, and communication issues with some neurosurgical units, in the emergency situation.

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

I am very grateful for the support I have received from my colleagues in facilitating these workshops and take this opportunity to thank Teresa Withers, Eric Guazzo, Laurence Marshman, Glenn McCulloch, Marguerite Harding, Stephen Santoreneos, Amal Abou-Hamden and Ellison Stephenson for their great contribution.

They have also commented on how they have enjoyed imparting skills to their rural colleagues. I'm also very thankful to Professor Peter Reilly, who took the lead in developing a series of online modules now available on the College's website as a complementary resource.

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

The workshops are primarily for rural surgeons, but are also open to other health care professionals, such as retrieval emergency physicians. This year, Acute Neurotrauma training is being offered to a maximum of 40 participants the day before the WA, SA and NT Annual Scientific Meeting (7 August) in Perth and the day after the Provincial Surgeons of Australia Annual Scientific Conference (24 August) in Darwin. I am thankful to Teresa Withers and Paul Poulgrain who will act as co-facilitators on one workshop each.

Are you interested in attending Acute Neurotrauma? Express your interest to the Professional Development Department via PDactivities@surgeons.org or call +61 3 9249 1106.

The Editor
Surgical News

Dear Sir,
I wonder if anyone has measured the volume of water used during an orthodox 'scrub-up'?

I note on page 36 of the May issue of *Surgical News*, that during the pictured scrub-up of three people, two taps are shown running water unused.

I remember once when scrubbing, a registrar beside me had his foot continually on the pedal-operated scrub water source. I suggested that WA was a thirsty state and needed our help to conserve water.

Do we need to emphasise the need for conservation of all materials, as well as water, in the training program?

Yours Faithfully,
Bernard Catchpole
WA Fellow
Emeritus Professor of surgery
University of Western Australia

EDUCATION AND TRAINING

COVER STORY

THE MYTHS OF SURGICAL EDUCATION & TRAINING

In the process of new agreements some old rumours surfaced; here they are made clear

SIMON WILLIAMS
CENSOR-IN-CHIEF

Over the past two years the Fellowship and College and society staff have spent a great amount of time and energy in negotiating new agreements for the support of the Surgical Education and Training program. The last of 13 agreements was signed in March, bringing the process to an end.
Unfortunately, during the negotiation process a number of myths about training have bubbled to the surface, particularly about the new fee structure. Here are some of the common myths, as well as the facts that dispel the myth.

MYTH: Trainees have nothing to do with the College during training, as it is all delivered by the specialty society.

FACT: Trainees interact with the College every day. The College is more than the bricks and mortar of the Spring Street building, Elliott House in Wellington, ASERNIPS in Adelaide or any of the regional offices. The College is its members; the Fellows that are the surgical supervisors and trainers in the unit, that are members of the specialty training board that governs training, are examiners that test Trainee knowledge and leaders in determining the minimum standards of a competent surgeon participating in continuing professional development.
Most, if not all, specialty societies require members to first hold a FRACS. It is the recognised standard in Australia

PERIOPERATIVE MORTALITY

These reviews in New Zealand will assist to a bi-national approach to audits

NIGEL WILLIS
CHAIR, NEW ZEALAND NATIONAL BOARD

New Zealand's Perioperative Mortality Review Committee (POMRC) was established to review and report on perioperative deaths with the intention of reducing mortality and morbidity and thus improving the quality of our health services. Committee members are appointed by the Minister of Health and include a number of surgeons from this College (Cathy Ferguson – who is Deputy Chair of POMRC, Jonathan Koea and Jean-Claude Theis). As POMRC reviews deaths while under the care of any proceduralist and anaesthetists, other Committee members are anaesthetists (including Leona Wilson, the Chair of POMRC), nurses, an obstetrician and gynaecologist, intensive care specialist and public health epidemiologist.

To date POMRC has taken an epidemiological approach. Data is gathered from our National Minimum Dataset (which contains information on all discharges from all public hospitals and from some private hospitals) and National Mortality Collection (which includes information from coroners' reports; from Births, Deaths & Marriages Registry; from police and from the courts). Having access to information from both within and outside of the health system improves the quality of the data and enables tracking of perioperative deaths after discharge.

POMRC defines a perioperative death as one that occurs within 30 days following an operative procedure or after 30 days, but before the patient is discharged to home or a rehabilitative facility procedure. These also include deaths in hospital while under the care of a surgeon, even when an operation has not been undertaken.

POMRC has recently released its third Annual Report. This details the epidemiology of perioperative mortality for the years 2007–2011 in five clinical areas it considered important (cholecystectomy; colorectal resection; general anaesthesia; elective admissions for low-risk patients – ie. those classified as ASA 1 or 2; and pulmonary embolism). It compares previously published perioperative mortality rates and examines the World Health Organisation's standardised public health metrics for surgical care. As with many data sets, there are some limitations and POMRC is careful to identify these in its report. Notwithstanding those reservations, the data from those five clinical areas showed the following:

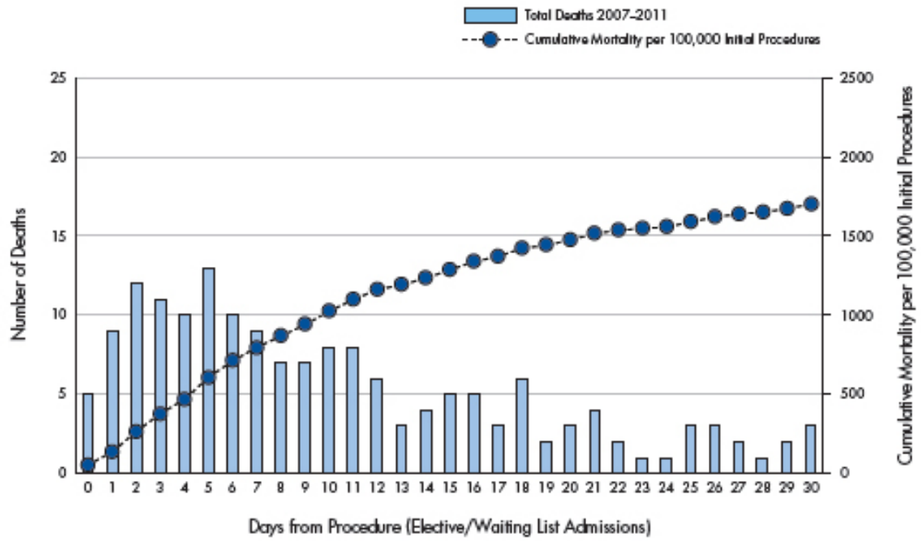
- **cholecystectomy –** a death rate within 30 days of surgery of 0.98 per cent for emergency admissions and 0.15 per cent for elective admissions;
- **colorectal resection –** a death rate within 30 days of surgery of 8.46 per cent for emergency admissions and 1.7 per cent for elective admissions (both these figures are for patients aged 45 or above);
- **general anaesthesia –** a death rate of 0.13 per cent within one day of surgery;
- **elective admissions for low-risk patients –** a death rate within 30 days of surgery of 0.06 per cent; and
- **pulmonary embolism –** a death rate for patients who had surgery/anaesthesia and developed pulmonary embolism of 0.06 per cent for emergency admissions and 0.009 per cent for elective admissions.

Table 10: Mortality Following Cholecystectomy by Main Procedure Type, New Zealand 2007–2011

MAIN UNDERLYING CAUSE OF DEATH	Total Deaths 2007–2011	Number of Procedures	Annual Average	Deaths in Category (%)
Cholecystectomy				
Laparoscopic	20	26,930	4	16.9
Laparoscopic Proceeding to Open	16	1433	3.2	13.6
Open	82	1860	16.4	69.5
Total	**118**	**30,157**	**23.6**	**100.0**

Data source: NMC: Deaths occurring within 30 days of a cholecystectomy, as recorded in the NMDS.

Figure 2: Mortality Following Elective/Waiting List Admission for Colorectal Resection by Day from Procedure in Adults 45+ Years, New Zealand 2007–2011



Heart disease was the most common underlying reason for death following general anaesthesia, with the risk of death significantly increased for patients who were aged over 65, in poor health, and admitted as emergency patients.

The day of surgery mortality rate for 2007 to 2011 as a percentage of all admissions (and within one day of general anaesthesia) was 80.2 per 100,000 (0.08 per cent for all surgical patients).

The inpatient mortality rate for the same time period was 383.3 per 100,000 (0.38 per cent) for all surgical patients and 370.5 per 100,000 (0.37 per cent) for all deaths related to patients who had undergone a general anaesthetic. These two were selected by POMRC as the best indicators of mortality related to all procedures for the New Zealand health data.

The data suggests a trend towards lower mortality for colorectal resection and cholecystectomy during those five years; and it is apparent that higher mortality rates are associated with:-

- increasing age;
- poorer health (higher ASA status); and
- acute admission.

Although drawing comparisons between perioperative mortality rates across differing health care systems can be problematic, New Zealand's rates would seem to be broadly consistent with those reported in other jurisdictions.

However, of particular importance for New Zealand, the data shows both Māori and Pacific Island patients appear to have a higher incidence of acute surgery and lower incidence of elective surgery. This is consistent with other information that there is still variation in their level of access to health and surgical services. Despite similar ASA status, Māori and Pacific Island patients showed a trend towards higher mortality following both acute and elective general anaesthesia, possibly suggesting slightly poorer health in general.

POMRC's future plans are to continue collation and review of epidemiological data and it is exploring the possibility of producing 'composite case studies' to complement that data.

The Australian and New Zealand Audits of Surgical Mortality (ANZASM) focus on reviewing individual cases. The New Zealand National Board has supported POMRCs epidemiological work and at the same time has encouraged it to consider extending into individual case reviews.

POMRC agrees that such reviews can lead to improvements in patient care and is now developing an integrated form to collect multidisciplinary data on individual perioperative deaths. That form has undergone internal piloting and is due for externally piloting within the next 12 months. The surgeons' data is similar to that collected in Australia for the ANZASM/CHASM programs. This will enable New Zealand data to be compared to, and potentially collated with, Australian data. When that is in place, the 'NZ' in ANZASM will become a reality.

CONTINUING IMPROVEMENT

The VASM Annual Report notes continuing improvements in surgical care

The Victorian Audit of Surgical Mortality (VASM) has released its sixth annual report as part of a quality assurance program aimed at the ongoing improvement of surgical care in Victoria. According to the report, trends relating to clinical risk management show overall improvements in patient surgical care.

Funded by the Victorian Department of Health and managed by the Royal Australasian College of Surgeons (RACS), VASM involves the clinical review of all cases where patients have died while under the care of a surgeon.

Cases notified to VASM are reviewed by assessing surgeons who are practicing in the same specialty, but from a different hospital. The reviewers are not given any details about the treating surgeon, the hospital or the identity of the patient so that forthright assessment of each case can be conducted.

In this report VASM presents the outcome of reviews conducted into 3,948 deaths over six years from 1 July 2007 to 31 June 2013. During the audit period, a total of 3,306,147 patients underwent surgical procedures in Victoria. Any criticism of patient management raised in the report has been formally directed to the treating surgeon.

VASM has an independent data source, the Victorian Admitted Episodes Dataset (VAED), with which to compare surgical mortality rate and completeness of reported deaths. Both datasets show that surgical mortality is low (0.3 per cent) and has fallen with each successive year, despite increasing numbers of operations being performed in Victoria.

The VASM peer review process is a retrospective examination of the clinical management of patients who died while under the care of a surgeon. Assessments consider whether the death was a direct result of the disease process or if aspects of the management of the patient may have contributed to the outcome.

The VASM educational program aims to address deficiencies in clinical management and it is encouraging to note the decrease of these as progressive reports are published.

> *“Surgical mortality is low (0.3 per cent) and has fallen with each successive year”*

VASM encourages participating stakeholders to further improve their leadership approaches to patient care especially around better documentation of clinical events, better communication between health professionals and improved clinical patient care management.

Most surgical deaths in Victoria are elderly patients admitted as emergencies and with other severe health problems. As we grow older we have more complex diseases and often more complex surgical procedures that could lead to complications.

Providing feedback in these cases is essential to the audit’s overarching purpose, which is the ongoing education of surgeons and the improvement of surgical care for all patients.

The VASM Annual Report is available on the College’s website: www.surgeons.org/VASM

TEACHING SURGERY IN THE BUSH

How well is it done?

ANDREW EVANS, SCOTT KITCHENER, RENEE DAY AND SIMON BROADLEY

The Academy of Surgical Educators would like to congratulate Dr Andrew Evans for taking out this year's Surgical Education Research Prize at the RACS Annual Scientific Congress. The following article is based on his presentation.

Introduction

Rural health is hurting. The reasons why are of course many and varied, but one reason is a lack of doctors. The current strategy to address rural doctor shortages revolves around 'rural pipelines' whereby students from rural backgrounds are selected into medicine and then trained in rural locations to the largest extent possible.

The belief is that positive extended rural clinical experiences for students can pique and maintain their interest in future rural practice and the evidence to support this is becoming more and more robust as the various programs mature.

However, there is a more fundamental question at play. Do these settings provide good learning experiences? Or will we instead train poor quality doctors and thus have a cure that is worse than the disease? This research project set out to determine how well surgery was being taught to medical students at rural sites.

Methods

To try to answer this the 2012 and 2013 cohorts of the Queensland Rural Medical Longlook Program were studied. This program takes Griffith University students in their clinical phase of training and places them in rural sites for six to 12 month stints. Sites were classified as being 'rural' if they were staffed by full-time procedural GPs, with specialists acting in a VMO capacity. Such sites could be contrasted from 'regional' sites, which are usually staffed by full-time specialists.

Learning needs met?	% Agreed
Clinical	47%
Procedural	51%
Theoretical	48%

Examination results
Favours Longlook
2.94 (CI 95% 0.40, 5.47)
p value 0.02

Figure 1

Participation in the study involved three components. A survey to assess their clinical, procedural and theoretical exposure, an interview which was semi-structured and based around their survey responses and finally a comparison of their examination results with those of their metropolitan counterparts.

Results

The Longlook students (n=25) were of similar age and gender ratio to their metropolitan peers. The majority were not from a rural background; however, the 'rurality' ratio of students on the Program was higher than that of the University at large.

On average, over the two years, about half of the students felt they received sufficient clinical, procedural and theoretical surgical exposure to meet their learning needs. There was a notable drop in students reporting sufficient procedural exposure between the two years (20 per cent).

Clinically, there were no examinations in which a clear majority of students felt confident to perform unsupervised. Procedurally, a clear majority of students felt confident in performing basic surgical procedures unsupervised.

During the interviews almost all students reported an abundance of opportunities to work-up undifferentiated surgical cases as they presented to the Emergency Department. On the other hand they felt their postoperative experience was lacking due to generally short postoperative stays and the fact that complications were uncommon.

When combining the surgical examination results across the two years the Longlook students did statistically significantly better than their metropolitan counterparts (2.94 [CI 95 per cent 0.40, 5.47], p value 0.02) Refer to Figure 1. These exams comprised both written and Objective Structured Clinical Examination (OSCE) components.

Discussion

Broadly speaking there was a discordance that ran throughout this study's findings. Subjectively, the students reported an experience that was, learning needs and confidence considered, no better than average and yet objectively their examination results were better than average.

Was there an important aspect of training that the students identified that was not picked up in the examinations process? Was it a case of students always wanting more? Or did they simply know that their experience was different and assumed that different was worse?

Their experience certainly was different; however, it is possible that the extra, less structured access to more patients may have led to improved student learning and comfort in their approach which in turn provided a platform for better results.

Given the students could clearly demonstrate a core knowledge base and group of competencies on their exams, it could be argued that having a different experience does not matter.

The drop in student satisfaction with their procedural exposure correlates with an increase in the number of junior medical staff at those sites. Smaller sites highlight most acutely a risk that applies to all training sites: the risk of too many Trainees.

The training ecosystems of metropolitan and rural hospitals are clearly very different but, again, the question is one of inferiority. Is it better or worse to learn surgery for one day a week over 40 weeks than five days a week over eight weeks? Can procedural GPs reasonably be expected to teach surgical concepts succinctly to a medical student level? The results from this study suggest answers to these questions although further work needs to be done to answer them conclusively.

Two weaknesses of this study should be noted. One tends to bedevil all rural research and that is small numbers. This means that some of the conclusions are, at this stage, suggestive, particularly those where 'no difference was found'. Secondly, a comparison between rural and metropolitan students with respect to the subjective component of the study would be of use and this is in the pipeline.

Conclusion

Despite the challenges involved in delivering a surgical curriculum to medical students at rural sites, they appear to offer a good alternative to metropolitan and regionally based teaching of surgery.

HISTORICAL FINDINGS FROM RESEARCH

Award winning research generated from College scholarship

A General Surgery Trainee working under the supervision of senior colorectal surgeons has become the first ever researcher to confirm the existence and electrophysiological characteristics of extrinsic afferent nerves of the human rectum.

The award-winning research, conducted at the Concord Hospital and the University of Sydney, advances understanding of the physiology of bowel function and dysfunction and overturns previous theories relating to which neuronal pathways affect the conscious desire to defecate.

Dr Kheng-Seong Ng said his research represented the first time that the existence of rectal nerves and pathways had been confirmed and their chemo and mechano-sensitivity described in humans.

Working under the supervision of Professor Marc Gladman, Dr Ng procured sections of normal rectum and colon tissue from surgeons at Concord Hospital who were conducting anterior resections and right hemicolectomy procedures.

Keeping the tissue alive through perfusion and chemical treatments, Dr Ng then dissected 28 separate rectal nerve trunks and studied the nerve activity of neuronal responses to chemical and mechanical stimuli.

Of these, spontaneous multi-unit afferent activity was recorded in 24 nerves. Peak discharge rates increased significantly following exposure to capsaicin and an inflammatory solution while mechanosensitive 'hot-spots' were identified in 16 nerves following mechanical Von Frey probing.

In comparison, spontaneous activity was recorded in only three of 30 nerves studied from 10 colon tissue samples and only one hot-spot identified.

Dr Ng's work, part of a PhD, won the major prize at the Surgical Research Society held in Adelaide last year which provides funds and an invitation to present his work to the Academic Surgical Congress to be held in the US in 2015.

It also received the support of the College with the College granting Dr Ng a Foundation for Surgery Scholarship for 2013.

Dr Ng said that his research not only advanced understanding of the biology of the hindgut, but opened avenues for further research.

"Until now, our understanding of the physiology involved in the gut-neuronal supply has been quite rudimentary with most of our information stemming from animal models which may or may not apply to humans," he said.

"A number of different theories relating to the physiology behind the desire to defecate have been proposed in recent decades including that it derives solely from feeling from the muscles of the pelvic floor, but that is not the case.

"Our research has clearly shown that both nerves and receptors located in the rectum carry information both into it and back to the central nervous system and that they have different electrophysiological properties to colonic afferents."

More to be done

Dr Ng said that while much remained to be understood about the workings of the nerves and their neural pathways, he believed they warrant further investigation to determine if they play a role in bowel disorders.

"Now that we have developed the protocols and overcome the problems we faced to carry out this original research, I think there would be great value in dissecting and measuring the nerve impulses from patients suffering from Inflammatory Bowel Disease (IBD) or with functional bowel disorders such as Irritable Bowel Syndrome (IBS)," he said.

"Patients with IBD suffer abdominal pain, diarrhoea and frequency while those with IBS can be very hard to diagnose because of a lack of organic pathology.

"The problem, however, is that such tissue samples might be very difficult to access because IBS and constipation are not treated with surgery first-line.

"However, on the basis of my work so far I believe that the symptoms such as pain, from conditions such as IBD and IBS, may be caused by an interruption to the nerve signals in the colon or rectum which causes them to over-fire or under-fire and if that is the case the efficacies of pharmacological remedies can be objectively tested using my model."

Dr Ng said his research, which clearly showed a difference between colonic afferent nerve activity and that of rectal ▶

2014 Surgical Workforce Census is under way

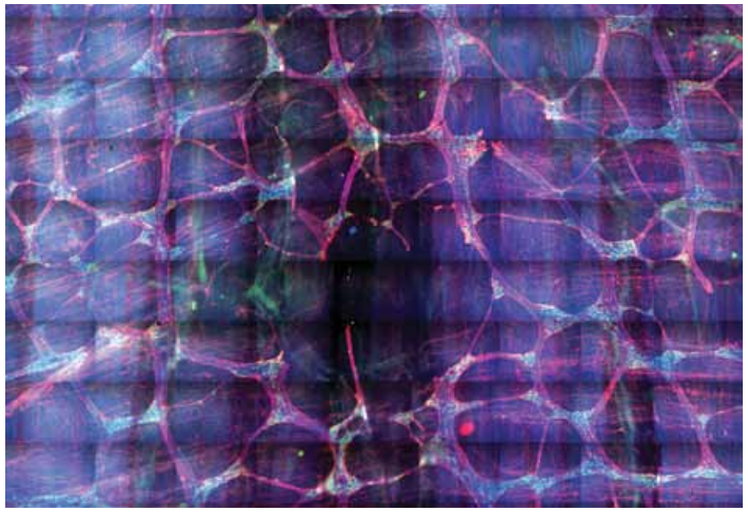
The College thanks Fellows who have completed the 2014 Surgical Workforce Census, and will be following up with Fellows who have yet to participate to maximise the response rate.

The aim of the Census is to better understand issues of importance to surgeons in their day-to-day work and to identify the work patterns of senior Fellows as they transition into retirement. The Fellow's assistance in completing the Census will ensure representative data that could significantly assist the College in its workforce planning advocacy.

Fellows without registered email addresses who have received the survey in the mail are encouraged to use the attached reply paid envelope for convenient return of the completed survey at the earliest convenience.

Please contact Saree Lawler at workforce@surgeons.org or call +61 3 9249 1108 for any queries or alternatives for completing the Census.

The College looks forward to distributing the full report of findings to the Fellowship in a future issue of Surgical News.



'Immunohistochemistry': a wholemount stain of the human myenteric plexus triple stained for Hu, NOS, and ChAT

Scholarships and Awards

2014:

> Awarded a RACS Foundation of Surgery Research Scholarship ($60,000 over 1 year)
> Awarded a Concord Travel Scholarship to present work at Tripartite Colorectal Meeting, Birmingham, UK ($2,000)

2013:

> Awarded a National Health and Medical Research Council (NHMRC) Medical / Dental Postgraduate Research Scholarship ($66,263 over 2 years).
> Awarded a RACS Peter King Foundation of Surgery Research Scholarship ($60,000 over 1 year).
> Awarded 'Young Investigator Award' for best research at Surgical Research Society Meeting, Adelaide ($4,000)

nerves, could also have significance in relation to understandings of bowel dysfunction following resection including conditions such as anterior resection syndrome.

"We now know that a distended colon and distended rectum give rise to quite different nerve signals," he said.

"However, when we remove the rectum in an anterior resection we bring the colon down to replace it in the belief that it will work the same as the rectum, yet now we know they are not the same likely explaining why a proportion of these patients have some degree of dysfunction.

"Still, we are just at the start of fully understanding human gastrointestinal neurophysiology and there is a long way to go before any of this research could be translated to clinical applicability.

"For the past 20 years, most research and funding has been focused on bowel cancer, which is as it should be given that it is such a common cancer, but now there is a new focus on the emerging field of neurogastroenterology and the impact of surgery and it is exciting to be part of that."

Dr Ng is undertaking his PhD research through the Academic Colorectal Unit based at Concord Hospital which is headed by Professor Gladman, Professor of Colorectal Surgery and Head of the Department of Colorectal Surgery at Concord Hospital.

His PhD co-supervisor is neurophysiologist Dr David Mahns from the University of Western Sydney's School of Medicine.

Dr Ng has now returned to his clinical training at the Concord Hospital and is in the process of writing up his thesis which he hopes to have completed by the end of the year.

He presented his findings at the 2013 Surgical Research Society in Adelaide and travelled in July this year to present at the Tripartite Colorectal Meeting in the UK.

He said that he had greatly enjoyed his time devoted to high-end scientific research and thanked the College for its support in awarding him the Peter King Foundation for Surgery Scholarship for 2013.

"This work has been quite thrilling given that we are the first group to record visceral afferent nerve activity in the nerves of the human hindgut," he said.

"After spending months collecting the tissue samples, then designing the experiments, then dealing with a few false starts and false positives and after David Mahns and I had repeatedly recorded the nerve signals from the rectal tissue, we called Professor Gladman out of a meeting because we were so excited.

"As a body of work, this research has included some really nice, sophisticated science while having bench-to-bedside direct applicability to patient care and surgery.

"It has also given me a range of skills including analytical problem solving, the ability to develop protocols and experiments and the freedom to work autonomously toward a specified goal.

"When such science like this works, it is both thrilling and fulfilling and while it was difficult to step away from clinical training to concentrate on research, it has been greatly rewarding."

Dr Ng said he was honoured by the support provided by the College, particularly because it represented endorsement of his work through a peer-reviewed process.

"It meant a great deal to me that such highly qualified surgeons on the selection committee saw the scientific value and rigour of the research."

The Peter King Foundation for Surgery Scholarship was established to recognise his contribution to the College and is open to Fellows and Trainees wishing to undertake post-graduate research.

With Karen Murphy

IMPROVING THE COLLEGE LIBRARY

Biomedical and pharmacological database Embase offers more resources for Fellows and Trainees

CATHY FERGUSON
CHAIR, FELLOWSHIP SERVICES

To improve access to more journals and further support Fellows, Trainees and IMGs, the Embase database has been added to the list of available library resources. A link to the '1996 to present' section of the database is now available under the 'Search – For a Topic' area of the main library page. Once Embase has been accessed, other sub-sections back until 1974 are also available.

Embase is a biomedical and pharmacological database containing bibliographic records with citations, abstracts and indexing derived from biomedical articles in peer reviewed journals and is very comprehensive in its coverage of drug and pharmaceutical research.

Embase contains over 22 million records, with over 1 million records added annually. Each record contains the full bibliographic citation, indexing terms, and codes; and 80 per cent of all citations in Embase include author-written abstracts. The Embase journal collection is international in scope with over 7,500 active peer-reviewed journals from more than 90 countries

While there is much overlap between the journals indexed in Embase and MEDLINE, there are certainly many journals within Embase that are not found in MEDLINE. Embase includes over 6 million records and over 2,700 journals titles that are not covered by MEDLINE, including more European titles. Embase journals not indexed in MEDLINE include: Surgery, Seminars in Colon and Rectal Surgery, Surgical Neurology International, Surgical Practice, Surgical Techniques Development, Operative Techniques in Thoracic and Cardiovascular Surgery, Archives of Plastic Surgery, Journal of Wrist Surgery, Ophthalmic Surgery Lasers and Imaging and many others.

Embase includes conference abstracts from important biomedical, drug and medical device conferences dating back to 2009. It currently indexes over 1,000 conferences covering 300,000 conference abstracts each year. Some examples include: Biennial Congress of the International Society of Arthroscopy, Knee Surgery, and Orthopaedic Sports Medicine, European Conference on General Thoracic Surgery, Annual Meeting of the American Society of Breast Surgeons and Association of Surgeons in Training, ASiT Conference.

Embase is housed on the same Ovid platform as MEDLINE which will be familiar to users. Features such as easy linking to full-text e-journals licensed by the College and a document delivery order form within the search results area are available in both databases. In addition, with Embase there is an option to eliminate citations held in MEDLINE from results sets. This can save valuable time possibly wasted in re-viewing articles already seen in MEDLINE. Search strategies can also be carried over from one database or subset to another.

The 'Basic Search' tool within Embase is a good starting point for members and allows entry of a search statement or series of terms into the search box. Results are presented in a star ranking system with five stars indicating the best match. More expert searchers tend to use the Advanced Search option and College librarians would start with this in most instances.

Both Embase and MEDLINE are made available for personal searching, but the option of requesting an expert search by experienced librarian searchers is available to all College members. Techniques such as mapping, limiting, combining sets and truncation are all part of a librarian's repertoire in extracting the best possible results from large bibliographic databases.

Online forms to request a search are available on the library area of the website for those members requiring the skills of library staff to obtain necessary information. Results are delivered by email. Options for creating topic alerts are also available if regular updates in areas of interest are a requirement.

Library staff are available to discuss search techniques or provide assistance and tips for those wishing to enhance their own database skills. Ovid also makes available help and self-instructional tools. Go to: http://resourcecenter.ovid.com/site/resources/indexsupport.jsp or their specific Embase presentation at: https://www.brainshark.com/wkovid/vu?pi=zHvz2LYvMz2tkwz0&cmpid=Brainshark:EmbaseOvidSP

Please contact the Library on +61 3 9249 1271 or college.library@surgeons.org to discuss Embase or related matters further.

IN MEMORIAM

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

Noel Langley,
Queensland Fellow

James Sidey,
South Australian Fellow

Graham Dinning,
NSW Fellow

Nicholas Hamilton,
Victorian Fellow

John Heslop,
New Zealand Fellow

Geoffrey Sinclair,
Victorian Fellow

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

Informing the College

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

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

INFORMED financial consent

A look at the current obligations

MICHAEL GORTON
COLLEGE SOLICITOR

Most medical practitioners are aware of the legal requirement for 'informed consent'. That is, the legal requirement to inform patients of all material risks involved in a medical procedure. 'Informed consent' is therefore a clinical and legal requirement.

However, there are suggestions that informed consent also now requires full disclosure of the financial implications of medical treatment to patients. It is suggested that all patients should now be fully aware of the financial implications of medical treatment, including the decision not to proceed, to defer or cancel proposed treatment or to seek alternative treatment. There is clearly a differential between seeking treatment as a private and public patient, depending on whether the consumer can afford private health cover.

At this stage, there would appear to be no legal basis for requiring 'informed financial consent'. However, there are a number of professional and ethical reasons why full financial information should be disclosed to patients.

The College Code of Conduct for all surgeons requires:

"A surgeon will:

1. when charging a fee for professional services:
   a. ensure that it is reasonable and does not exploit a patient's need
   b. provide information about fees when obtaining consent to treatment
   c. disclose to patients any relevant interest in or of a third party

2. be honest in financial and commercial matters

It is a breach of this Code to:

1. take financial advantage of a patient"

The Medical Board of Australia 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (March 2014) requires:

- Ensuring that your patients are informed about your fees and charges (clause 3.5.3)
- Not exploiting patients' vulnerability or lack of medical knowledge when providing or recommending treatment or services (clause 8.12.1)
- Being transparent in financial and commercial matters relating to your work" (clause 8.12.5)

Accordingly, the Medical Board of Australia regards most health professionals as having a professional duty (if not a legal obligation) to inform patients of financial implications of treatment (including no treatment or alternative treatment).

It is also clear that a misunderstanding or misrepresentation of costs can lead to complaints to relevant health complaints bodies, whether the Health Services Commissioner, Health Complaints Commissioner, Medical Boards etc. For example, complaints to the Health Commissioners/Health Ombudsman in the various states and territories in relation to costs or information regarding costs have averaged 5-8 per cent of all complaints. Complaints about costs and information regarding costs have constituted approximately 30 per cent of complaints to the Private Health Insurance Ombudsman.

Medical professionals have an interest in ensuring that their costs are clear and transparent. There is obviously some reticence on the part of some professionals to discuss costs. However, in this 'modern world', consumers are aware of rights, want to understand all cost implications, and certainly wish to know how much they will be out of pocket.

General experience has also shown that a large reason for consumers and patients seeking to make complaints against health professionals has been a lack of knowledge or information or lack of communication. Information and communication regarding costs is part of this message. Good communication in relation to the costs and expenses likely to be incurred by the patient may avoid expensive and time consuming complaints.

JOHN CORBOY MEDAL

An award for up and coming leaders

Dr John Corboy (1969-2007) was elected chair of the Royal Australasian College of Surgeons Trainees' Association (RACSTA) in 2007. He was a great leader and a selfless representative of Trainees of the Royal Australasian College of Surgeons. He gave generously to his peers his time and wisdom. His energetic service to the profession and his tenacious passion for surgery despite personal adversity was remarkable. This distinguished award for surgical Trainees commemorates Dr John Corboy's achievements and recognises exceptional service by other Trainees.

The John Corboy Medal may be awarded annually to a Trainee who demonstrates the characteristics for which John was admired. As this is a unique award that recognises Trainees of the College, the presentation is made at the Annual Scientific Congress (ASC).

The award is made to a candidate who shows some or all of the following qualities in the performance of his/her duties, in service to the surgical community, in the manner and approach to the fulfilment of their surgical training or by their commitment to and involvement with the community of surgical Trainees:

- Outstanding leadership
- Selfless service
- Tenacity
- Service to Trainees of the College

Nominations for 2014 are now open.
To obtain a nomination form, or for any queries, please contact Ms Fiona Bull, Manager, Surgical Training, at fiona.bull@surgeons.org
Nominations will close 5 pm on Friday, 26 September, 2014.

NO LIFT TO HEAVEN

Why have lifts today become so complex?

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is elevators. Sure they are necessary to get to the 50th floor of a building (or even the 1st floor for an old curmudgeon), but it is the way they are organised. I recent went to the College ASC in Singapore – now there is a city that is organised, but that is a tale for another day.

Mr and Mrs Curmudgeon stayed in a lovely hotel that had 46 stories. The first time we caught the lift to our room on floor 26 we got in the lift and saw that the lift went to 24, but not 26. Did that mean two flights of stairs? What about those who were on 46? We exited the lift and then saw a sign (which would have been behind us as we entered the lift) indicating a second set of lifts to get to floors 25 to 46. Problem solved!

Well, not quite solved. The line of lifts was arranged on a slight curve so the lifts at the end could not be seen properly. Added to the problem was that the arrival of the lift was announced by a soft bling, not unlike one of my tones on my mobile phone – so we missed a few lifts as I looked for my phone in my pockets. At last the lift directly in front of us arrived and we were able to get it to 26.

Well that is also not quite the full story. The number 26 button would not work and we sat unmoved and apparently unmovable. Again a sign that was unreadable to persons with normal vision announced that it was necessary to insert the room key card (incidentally, we curmudgeons do not suffer from presbyopia – it is that the fonts are absurdly small or in the wrong colours). I was sure that Mrs Curmudgeon had the card, but she said it was in my wallet.

For some reason this 'smart' lift was not smart enough to read my Australian Senior's Card and whisk us to the correct floor.

After a few days I thought I had the system licked, but no. I am sure that there is a measuring sensor that determines the distance that you are from the lift and your age and ability to sprint to the lift. That determines when the lift doors close and the lift hurries away without you. To make matters worse the doors and lift surrounds were glass and so the successful entrants can smile a rather superior sneer at the stranded curmudgeon.

REMEMBER YOUR WELL-BEING when discussing difficult news

Communicating difficult news can be an emotionally charged experience

NICOLE HARVEY
MDA NATIONAL EDUCATION SERVICES

Providing care at a demanding time for patients is a privilege which, although rewarding, can be very stressful. While there is no 'one way' of communicating difficult news, keep in mind some important principles which may reduce the emotional impact on you, as a doctor, during these challenging conversations.

'Difficult news' is any information that negatively affects someone's expectations for their present or future, or changes their impression of the past. It is anything thought to be hard to talk about or 'process' by either the recipient or the messenger of the news.

Ways to reduce personal challenges

- Take time to identify your own feelings about illness, death, and when you can no longer cure or substantially clinically help a person.
- Explore how these feelings affect how you talk to patients about these topics. You will then be more genuine in your communication with patients.[2]
- Studies "... have shown that reflecting on one's own feelings is an essential element in overcoming the tendency to react in non-adaptive ways to patients' strong emotional reactions in the face of bad news ... [making] physicians less likely to use such strategies as giving false hope, providing premature reassurance or offering ineffective therapies"[3]
- Acknowledge clinical limitations and remember there is no need for you to 'know it all'.[4]
- Take time to prepare yourself for each difficult news conversation.
- Consider using Meitar et al's (2009) 'preparatory SPIKES' framework.[4]

> *"take time to identify your own feelings about illness, death, and when you can no longer cure or substantially clinically help a person"*

- Try to avoid having difficult conversations when you are tired.
- Have another health professional present (with the patient's consent)[5] – a colleague can provide support and assistance for both you and the patient.
- After a difficult news discussion, take time to work through your feelings and ensure you are calm before seeing the next patient.
- Also use such time to reflect on the strengths and weaknesses of the conversation you just had to help you improve on the next occasion.
- If possible, talk to other staff about the experience.[6]
- Ensure continuity of care amongst the team about the patient's emotional issues as well as the clinical ones.[7]
- Enhance communication skills through ongoing training and mentorship.
- Take good care of yourself – try to have an appropriate workload, pursue interests outside of work, take annual leave, take time for professional development and look after your health.
- Seek assistance if you feel the quality of your work is at risk from the demands of your role (see information provided below).

Responding to a sense of failure or guilt

Separate the message from the messenger – remember that the health issue is to blame. Focus on being the best doctor you can be for that person rather than only on successfully treating the condition. If you see your role as purely medical, try to expand your purpose to providing both medical and psychosocial care.8

Do not delay for fear of causing grief

It is important to have difficult conversations as soon as practicable. If you wait because of a fear of causing distress, you may lose the opportunity to find out useful information and to provide vital support before a situation worsens. So while doctors may avoid giving bad news to minimise distress, this can leave people "confused, depressed and sometimes angry".[6]

Are you worried about being wrong?

Early conclusions can lead to inaccuracy, so it is prudent to avoid specific prognosis estimates. If you are confident in the patient's specific circumstance, use more general terms that are still accurate, e.g. "weeks rather than months" is less likely to cause a future problem than "two weeks".[9]

If you cannot provide an immediate answer to a patient's question, undertake to return to the issue when you next see the patient, or refer them to someone who can answer the question. Where necessary, acknowledge that not all questions can be answered, e.g. "The uncertainty must be hard for you, but I'm afraid we just don't know."[10]

If you find a patient's question difficult to answer, think about the reason behind the question – it may relate to an underlying issue, e.g. ask the patient, "Why do you ask that now?"10 Reflect on your feelings and expectations about your work, role and medical uncertainty.

Communication skills and self-awareness benefit both you and your patients

Communicating difficult news is a demanding aspect of practising medicine, and you need to strengthen the aspects that you have control over. An important part of this is being aware of your own emotions and taking good care of yourself. This will improve the service you provide and enhance your own wellbeing.

For the full list of references visit: defenceupdate.mdanational.com.au/discussing-difficult-news

This article is provided by MDA National. It was first published in MDA National's Autumn 2014 edition of 'Defence Update'. MDA National recommends that you contact your indemnity provider if you have specific questions about your indemnity cover.

How difficult news is conveyed can have long lasting impacts

Communication skills have consequences for both patients and doctors. In terms of medical practitioners, how well a doctor discusses difficult news affects:

- their level of personal and professional satisfaction
- ongoing information exchange with patients
- levels of stress and burnout
- time efficiency[1] – communicating difficult news poorly is likely to result in ongoing problems that continually need to be addressed.

Sources of further assistance

Doctors' Health Advisory Service (DHAS):
ACT 0407 265 414
NT call the NSW DHAS hotline
NSW 02 9437 6552
QLD 07 3833 4352
SA 08 8366 0250
VIC 03 9495 6011
WA 08 9321 3098
Australian Medical Association Peer Support Service: TAS & VIC 1300 853 338
Employee assistance programs (hospital based employees)
MDA National Doctors for Doctors Program: 1800 011 255

CASE NOTE REVIEW

An Endoscopic retrograde cholangiopancreatography (ERCP) case

GUY MADDERN
CHAIR, ANZASM

A frail elderly patient with severe recurrent biliary colic was a 'day of admission' case for a cholecystectomy. The operative risk was very high due to significant co-morbidities including stage II breast cancer, ischaemic heart disease with stable angina, early dementia and hypothyroidism. The preoperative abdominal ultrasound result was not available in the notes, but purportedly demonstrated a large gallbladder calculus, without evidence of biliary obstruction. Liver function tests performed the day before surgery demonstrated significant elevation of all of the hepatocellular enzymes, but a normal bilirubin level.

Laparoscopic cholecystectomy was difficult due to a calculus that obscured the hepatobiliary anatomy. The dissected anatomy was defined by operative cholangiography. This demonstrated high-grade obstruction of the common bile duct due to an impacted calculus of between 5mm and 10mm. Management advice was readily obtained intraoperatively from an available upper-gastoenterological surgeon. The cholecystectomy was completed laparoscopically and an urgent ERCP arranged.

On the first postoperative day, the patient had a sudden syncopal episode and an elevated troponin I level in keeping with a perioperative myocardial infarct. The patient was transferred to the coronary care unit (CCU). Intravenous antibiotics were commenced for treatment of a concomitant urinary tract infection. On the second postoperative day, an elevated lipase level was found in the absence of any significant abdominal tenderness.

ERCP was performed on the third postoperative day and was normal apart from mild biliary dilation. A sphincterotomy was performed. There were no obvious complications following the procedure. The next day the patient suddenly became hypotensive and confused. Multi-organ failure rapidly ensued, and in consultation with the family, active treatment was withdrawn. The patient died several hours later. The cause of death was thought to have been due to pancreatitis, or possibly biliary sepsis.

Comment

It is hard to be critical of the decision to operate at all on this patient given the distressing symptoms and the appropriate consultative process. The only slight reservation about the management of this patient was that little apparent weight was given to the significantly deranged liver function preoperatively. In view of the high operative risk, a preoperative magnetic resonance cholangiopancreatography (MRCP) would have been justified and this would have mandated ERCP preoperatively thus potentially avoiding surgery.

Having stated this, it is likely that the outcome would have been the same in this case since there was evidence of pancreatitis prior to the ERCP. Confronted by biliary obstruction at surgery, the decision to proceed to therapeutic ERCP rather than bile duct exploration was the correct one and the outcome was largely determined by the severe comorbidity of this patient.

Join the conversation: http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2014/anzasmcnraug2014/

FROM THE ASC

A condition suffered by psychiatrists when inspired by surgeons

CARMEL PEISAH
CONJOINT ASSOCIATE PROFESSOR & OLD AGE PSYCHIATRIST
UNSW, UNIVERSITY OF SYDNEY; ADAPTIONS TO AGEING AUSTRALIA; CAPACITY AUSTRALIA
CHAIR, A3G (ADAPTING TO AGEING ADVISORY GROUP)

In May 2014, I was invited as an ASC Visiting Lecturer by the Senior Surgeon's Group to the College Annual Scientific Congress and ANZCA Annual Scientific Meeting, Singapore, building on previous work in the area of doctor welfare, ageing and retirement, culminating in the recent publication in 'ANZ J Surg' 2014; 84:311-315 entitled 'Adaptive Ageing Surgeons' with co-authors: psychiatrist colleague Chanaka Wijeratne, and College Fellows Bruce Waxman and Marianne Vonau.

At the Congress I was privileged to present variously at the Senior Surgeons, Trauma and the Women in Surgery Programs. What struck me in each of these programs was the degree of psychological insight of surgeons within these groups and the shared commitment towards psychological well-being.

A notable highlight of the meeting was the opportunity to participate as a panel member in the 'Senior Surgeons Section: Hypothetical: The ageing proceduralist – challenges for regulators', chaired by Bruce Waxman, with fellow panel members, Lindy Roberts, ANZCA President; Felicity Hawker, 'Retired' Intensivist & Director of Professional Affairs, College of Intensive Care Medicine (CICM); Mike Hollands, General and Upper GI Surgeon, President of the College; Barry Baker, 'retired' anaesthetist; Peter Dohrmann: 'Retired' Neurosurgeon & Deputy Director, Victorian Board of the Medical Board of Australia; Ian Civil: Past President of the College & Vascular Surgeon, Auckland, New Zealand; and Cliff Hughes: 'Retired' Cardio-thoracic Surgeon & CEO, Clinical Excellence Commission.

Both the panel and the audience participation during this hypothetical was active and generated a number of rich insights which I wish to share and document, the hypothetical acting as a precipitant for a giant 'focus group' on ageing and retirement. Some of these insights included:

(i) The initiatives of specialists' groups in dealing with ageing.

Groups such as the Welfare of Anaesthetists Special Interest Group, who, as far back as 1996 promulgated concepts such as the challenges of decreased efficiency with ageing and the need for insight, "mindful practice," change in workplace practices, the option of working without participating in night call roster, "buddy systems", financial planning, keeping in touch after retirement and "retiring into something."

A similar statement was released by the College of Intensive Care Medicine of Australia and New Zealand in 2012 and referred to by Skowronski & Peisah in our article: 'The greying intensivist. Ageing and medical practice – everyone's problem, 'MJA' 2012;196: 505-7.Clearly, many of the panel members 'practiced what they preached' and were active models for such statements, and as such, acted as mentors in ageing.

(ii) Constraints to the enactment of these ideals around ageing

While such initiatives were applauded, both audience and panel members identified real and significant constraints to the enactment of these ideals. These constraints ranged from the need for support from hospital governance systems and resource limitations regarding rostering policies (particularly in small hospitals in rural areas), to the rights of younger doctors participating in adaptive roster arrangements that favour older surgeons and the compliance of such with Fair Work and Industrial Relations legislation on the one hand, and Equal Opportunity legislation and Human Rights frameworks supporting equal and maximal participation of older workers in the workforce, on the other;

(iii) Insight into one's own decline in fluid intelligence , performance and endurance

The need to acknowledge and normalise the concerns of insightful doctors, who even in the transitional stages of the mid to late 50s, (the mean age of surgeons being 52) may notice early signs of decreased efficiency and endurance, particularly following on call-duties, and to recognise the impact of even phone calls and disrupted sleep on the following day's performance, thereby discouraging a superman/superwoman culture.

It is clear from these discussions, that notwithstanding any initiatives from the Colleges of Surgery, Intensive Care Medicine and Anaesthetists, and the very act of awareness raising represented by the hypothetical, these are but one part of the system, and true change relies on a consistent and united position from all parts of the system to support 30-40 per cent of our professional body.

Acknowledgements
Bruce Waxman for his comments on this article and role as ASC Convenor of the Section of Senior Surgeons and the medical practitioner members of A3G, with the aim of advising our colleagues on a healthy approach to ageing. (www.A3G.com.au)

SAVE THE DATE

Learn more about adapting to ageing and making the transition from surgeon to what?

Building Towards Retirement Workshop,

November 15, 2014,

NSW Regional Office RACS, Sydney.

More information in 'Fax Mentis' and 'Surgical News'.

New Zealand "Elliott House" for sale

The College wishes to advise of the sale of "Elliott House" which has been used as the College's national office for New Zealand since 1990

After the large Christchurch earthquake in February 2011, it became increasingly apparent that the seismic rating of Elliott House was not suitable for continued occupation. This fact was brought into sharp relief by the significant Wellington earthquakes of June 2013.

The College has been in rented accommodation at Courtenay Place, Wellington since that time to ensure the safety of staff and visitors to the College.

As College Council's direction is to divest itself of properties and ensure where possible, staff are located in modern, fit for purpose buildings, the decision has been made to sell Elliott House.

The tender process is open until mid-September and any interested buyers should make contact with the designated agents:

Paul Hastings & Co Limited.

Ph: +64 4 472 2066. Website: www.paulhastings.co.nz

For further information, please contact the Director of Resources, Mr Ian Burke at +61 3 9249 1200 or ian.burke@surgeons.org or the NZ Manager, Ms Justine Peterson at +64 4 385 8247 or Justine.peterson@surgeons.org

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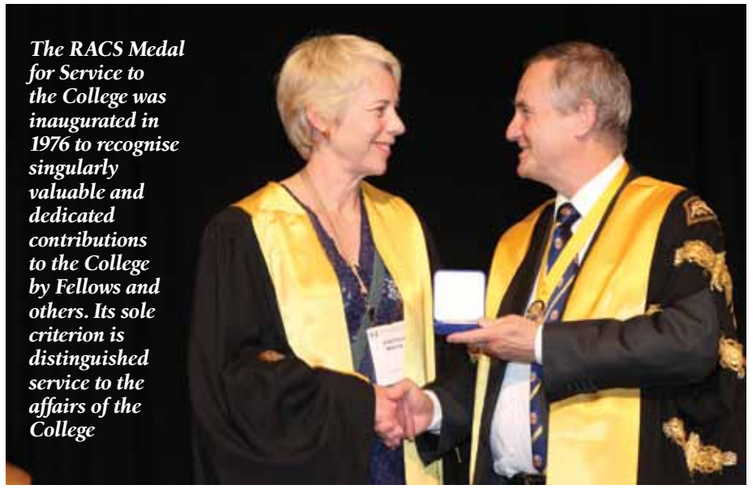


The RACS Medal for Service to the College was inaugurated in 1976 to recognise singularly valuable and dedicated contributions to the College by Fellows and others. Its sole criterion is distinguished service to the affairs of the College

Jenepher Martin FRACS
RACS Medal for Service

Associate Professor Jenepher Martin became a Fellow of the College in 1991 and subsequently achieved Masters and Doctoral qualifications in Education. She served as Coordinator of Surgical Education at the College, a position which subsequently evolved into that of Dean of Education. In that role and subsequently, Associate Professor Martin has been a major contributor to educational development and innovation at the College.

In the late 1990s and early 2000s she was a major contributor to the development of the College Surgeons as Teachers Course, Basic Surgical Training and subsequently Faculty Development for Selection, Interview and Interviewer Training and also the Surgical Teachers Course Manual and Resources.

Associate Professor Martin was also a major contributor to the previous Basic Surgical Training Program. Areas of activity included design of the Learning Portfolio, leadership in the Development of BST online, supporting the implementation of the Basic Surgical Skills Course and ongoing contributions as Chair, Examination Committee and Curriculum Review Committee. She was also heavily involved in processes of assessment and ongoing policy development. Following the introduction of SET, she was involved in the development and implementation of a new Basic Science Examination format and in the implementation of criterion-referenced standard setting in the Basic Science Examination.

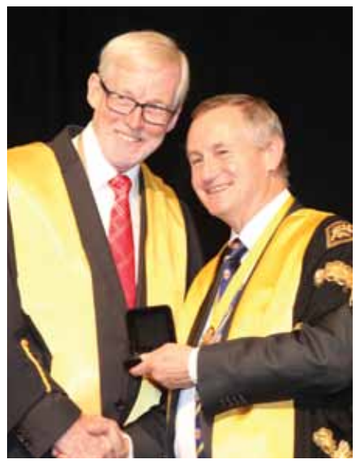
Associate Professor Martin has also brought a greater surgical education focus to the Annual Scientific Congress. She developed and introduced a Surgical Education Program which included plenary sections, visiting speakers and scientific papers. She was convener of the Surgical Education component of the ASC from 1999 to 2004.

Since 1997 Associate Professor Martin has served on multiple College education committees as well as serving as a generally elected Councillor between 2004 and 2010. Most recently she has been Chair of the Surgical Teachers Education Programs Committee (previously the Surgeons as Educators Committee). She continues as a member of the Victorian Skills Centre Oversight Committee and also of the Graduate Programs in Surgical Education Reference Group.

Associate Professor Martin is also an active clinician at Eastern Health in Victoria and is making significant contributions to undergraduate medical and surgical education at Monash University and Deakin University. She continues to promote research in the field of Surgical Education and has created opportunities for Trainees to gain experience in this area.

In summary, Associate Professor Martin has made an outstanding and sustained contribution to the College particularly in the area of surgical education and training. In many ways she laid the foundations for many of our educational processes and courses which are delivered and undertaken today. She is a most worthy recipient of a RACS Medal.

Citation kindly provided by Professor Julian Smith FRACS and Associate Professor Stephen Tobin FRACS



John North FRACS
ESR Hughes medal

Dr John Bevan North obtained his Fellowship in 1974. John has been a visiting orthopaedic surgeon to various teaching hospitals in Brisbane, and in private practice from 1978, and is presently a Senior Specialist at the Princess Alexandra Hospital.

He became a member of the Asia Pacific Orthopaedic Association and of the World Orthopaedic Concern in 1978, and he has been a generous supporter of International Medical Aid activities throughout the Pacific Basin for 20 years.

All who have worked with John are struck by his remarkable enthusiasm for teaching and his respect for patients and colleagues. Throughout his career John has been an exemplar in the standards of professionalism for medical students, new graduates, registrars and orthopaedic surgeons. His mentoring is literally one of 'training by example'.

John has been an Office bearer for the Australian Orthopaedic Association and Royal Australasian College of Surgeons since 1978. His membership of the Court of Examiners culminated in his appointment as Orthopaedic Senior Examiner in 2001. During this time, he was instrumental in the development of innovative computer based fellowship examination strategies in orthopaedic surgery which have become adopted by many other specialties.

John served as Vice President, and subsequently as President, of the AOA for 2008 – 2009 and was awarded the Meritorious Service Award by the AOA in 2009.

He continues to support our College in endeavours such as developing professional development initiatives, promoting tele-health orthopaedic services throughout rural Queensland and as the Clinical Director for the Queensland and the Northern Territory Audits of Surgical Mortality. John is a tireless supporter of college courses which focus upon essential non-technical skills for surgeons in clinical practice.

John's interests include surgical training, education and assessment and ethics and professionalism in clinical practice. Consequently John's wisdom and professional opinions are highly respected and sought after by hospital and Queensland Health Department ethical committees, as well as by various college departments.

John is an outstanding teacher and surgeon whose primary concern is the patients' clinical outcome and overall humane management. Consequently, John has been an example to students, registrars and colleagues with wisdom that only a lifetime of surgical teaching can bring; and he continues to be a generous contributor to local and international orthopaedic services. John works with his team in a unique, respectful manner which has endeared him to all those with whom he has contact – from the most junior of non-medical staff, to the senior colleagues.

John has excelled in, and carefully balanced, his professional career with a model family life.

It is clear that Dr John North is a most deserving recipient of the ESR Hughes Medal.

Citation kindly provided by Dr Lawrence Malisano FRACS.

Inaugurated in 1998, the ESR Hughes Award is designed to recognise distinguished contributions to surgery by Fellows of the College and others. It was created in recognition of the outstanding contributions to surgery by Professor Sir Edward Hughes. The sole criterion for the Award is distinguished contributions to surgery.

Keith Mutimer FRACS
ESR Hughes medall

Keith Mutimer served on Council as the Specialty Councillor for Plastic and Reconstructive Surgery for nine years from 2003 to 2012, including three as treasurer and two as Vice-President. All of us who worked with him can attest to his numeracy as well as his effort, integrity and goodwill on behalf of the College.

Keith is a Plastic Surgeon with a practice in Brighton, Cabrini and the Royal Children's Hospital. He is a graduate of Prince Henry's Clinical School and Monash University (1977), and obtained his FRACS (Plastic) in 1986. He undertook Fellowships and overseas training in Atlanta, Boston, Oxford and Paris. He has led more than a dozen trips with Interplast teams to neighbouring countries including Fiji, Vanuatu, Vietnam and Sri Lanka.

Prior to joining the Council he was a Councillor with the Australian Society of Plastic Surgery from 1996, including a term as President in 2002. He is the team doctor for Melbourne Rebels Rugby Club and is a Paul Harris Fellow of Rotary International (2002).

Citation kindly provided by Professor David Watters FRACS.

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