Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
JANUARY/FEBRUARY 2013

Summer Post Op inside!

ROWAN NICKS
A lasting legacy with the Foundation for Surgery, p16

ASC 2013
Get ready for Auckland, p12

The College of Surgeons of Australia and New Zealand

Expanding the *options*

Working on flexible training for all

2013 Workshops & Activities

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

Supervisors and Trainers for SET (SAT SET)

26 February, Adelaide; 16 April, Melbourne

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues.
This workshop is also available as an eLearning activity by logging into the RACS website.

Keeping Trainees on Track (KToT)

5 March, Brisbane; 19 March, Melbourne; 9 April, Sydney

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

Communication Skills for Cancer Clinicians

9 March, Melbourne

In four hours you will learn evidence-based, step-by-step communication skills that break down the challenge of delivering negative diagnoses to patients and relatives. A trained-actor steps in mid-way through the morning to run a role play exercise where you practise newly-learned communication skills in a safe environment resembling a real-life scenario. Theoretical linking, plus a video and discussion, form other parts of the program offered in partnership with the Cancer Council Victoria.

Non-Technical Skills for Surgeons (NOTSS)

15 March, Adelaide; 19 April, Melbourne

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

Polishing Presentation Skills

22 March, Melbourne

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.

Surgical Teachers Course

11-13 April, Melbourne

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

Process Communication Model

18-20 April, Melbourne

PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. This workshop can also help to detect stress in yourself and others, as well as providing you with a means to reconnect with individuals you may be struggling to understand and reach. The PCM theory proposes that each person has motivational needs that must be met if that person is to be successful.

NSW

9 April, Sydney
Keeping Trainees on Track (KToT)

QLD

5 March, Brisbane
Keeping Trainees on Track (KToT)

SA

26 February, Adelaide
Supervisors and Trainers for SET (SAT SET)

15 March, Adelaide
Non-Technical Skills for Surgeons (NOTSS)

VIC

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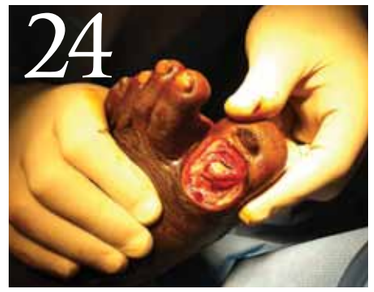
Process Communication Model

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

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

contents

REGULAR PAGES



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ON THE COVER: Expanding the Options. Working on flexible training for all

President's Perspective

Parallels in the air

In keeping with the Festive season, rather than reflect on a political issue I felt I would like to add a more personal tone to this perspective and write a book review of what I have read over the past three or four weeks. Needless to say there are a few surgical messages.

I am sure most of you will remember the story of QF32, the Qantas jet where shortly after take-off from Singapore Airport, engine number 2 exploded and through the skill of the flying crew the crippled aircraft was successfully landed. Subsequently, the pilot, Richard de Crespigny has written an account of the event entitled *'QF32'*.

The book begins with an account of de Crespigny's early life, his fascination with engines and aircraft, and later with computers, and early indications that he was "a problem solver". He talks of a respect for machinery and a "bottom up" approach.

In many ways there is an analogy to a surgeon who is engrained with, and indeed loves, basic sciences such as anatomy and pathology. This core understanding was to stand de Crespigny in good stead when he faced the QF32 crisis, in that he possessed core knowledge and understanding which enabled him to resolve the enormous challenges posed to him and his crew.

De Crespigny then discusses his training in the Air Force. It is a very broad brush approach with the opportunity to obtain differing skills and face differing challenges; for example flying fixed wing aircraft including Caribous and Macchi jets and flying Iroquois helicopters.

To me there were again parallels with a varied surgical training. The skills learned in urology, thoracic surgery, orthopaedics and neurosurgery have served me well as a general and trauma surgeon. Equally they would be extremely valuable to a rural surgeon.

I often wonder whether, as we become increasingly specialised as surgeons, by limiting our exposure to other surgical crafts we become less able to deal with the challenges we sometimes face unexpectedly. Similarly, by placing more emphasis on investigations and less on clinical skills are we less able to reconstruct a difficult case from "the bottom up."

As the book starts to focus on the A380, we are reminded of two critical aspects of air safety: simulation and preparation. Events such as those described in de Crespigny's book have parallels in our craft, especially emergency surgery. The author also describes preparing his team, what type of relationship he expects with team members.

De Crespigny telephoned his flight crew the evening before the flight, met them in the lobby of the hotel and travelled to the airport with them. On arrival at Changi Airport they distributed the briefing documents, addressed potential problems including for example taking on board an extra two tonnes of fuel because of an ash cloud over Java.

I found the concept of a "sterile cockpit" interesting. In effect this means there is complete focus on the task at hand, in this case take-off with no talking unless required. Four minutes into the flight, engine 2 exploded. The next 100 pages describe how the crew handled the emergency.

I appreciated the importance of preparation, a variety of skill sets and a team approach with a good leader. Decision making skills were highlighted. On making his final approach, de Crespigny undertakes a trial landing; not all his cockpit crew agreed with this approach. It is interesting to reflect on his leadership and decision making at this time. Was he rash? What experiences prepared him?

Taking the lead role

In the current politically-correct environment in which we live, there is a tendency to flatten hierarchical structures and diminish the importance of leaders, particularly in the operating theatre and in the trauma team. For pilots, and surgeons, this approach is fraught with risk.

De Crespigny's book re-enforced this. Clear lines of communication, role delineation and task delegation, and a leader prepared to make tough, but informed decisions played a crucial role in allowing the pilot to safely land the aircraft.

Equally the pilot had to trust his team. Comment should also be made about the team in the cabin who again were exceptionally well led and knew their roles and responsibilities. Finally I believe de Crespigny reaches a point of information overload, a point where no further information can be processed by the brain. It is about this time he starts to reconstruct the incident from "the bottom up".

QF32, Richard de Crespigny, 2012, Pan Macmillan Australia Pty Ltd

Safety at the Sharp End, A guide to non-technical skills, Rhona Flin, Paul O'Connor, Margaret Crichton, 2008, MPG Books Group

In their book 'Safety at the Sharp End', Rhona Flin and her colleagues talk about situational awareness. Initially a military term, much of the research in this field has come from aviation and after reading 'QF32' I can understand why! A good pilot, or surgeon, will have a good mental model of the task or situation at hand, including not just the specific task, but the surrounding environment.

The authors of Flin's book talk of a total situation awareness capacity where a point is reached where incoming information exceeds mental capacity. In maintaining good situational awareness these authors recognise the importance of a good briefing, fitness for work, minimising distraction, a "sterile cockpit", regular updating of the situation, monitoring, encouraging staff to speak up where appropriate and time management as being crucial. If you choose to read 'QF32' you will see how each of these facets is critical in ensuring the safe landing of the aircraft.

Along these lines, I would wholeheartedly recommend General Surgeons Australia's MOSES (Management of Surgical Emergencies) Course which uses real clinical scenarios to flesh out these attributes to improve operative performance. The principles of this course could easily be extended to other surgical specialties.

'QF32' is 355 pages of large type and is an easy read. Surgeons will recognise a "surgical personality" in de Crespigny which may enhance the book's readability. It is an excellent aeroplane read!

Mike Hollands
President

How we are faring

The results of the 2011 Census highlight some important issues

As I get older, I have succumbed to the phenomenon that each year passes more quickly than the previous year and holiday periods even more so. They now flash by! I can't believe that once more I am sitting at my desk.

Nevertheless, the College is refreshed by the break and preparing to redouble efforts to engage both with surgeons and for surgeons. It promises to be a busy year with many challenges ahead.

As surgeons, we are busy people. I know this to be true from the 2011 Surgical Workforce Census. The average Australian surgeon spends approximately 16 hours per week engaged in consulting and procedural work in the public sector, and 27 hours per week in the private sector. The average New Zealand surgeon spends almost 19 hours in the public sector and 20 hours per week in the private sector.

These findings are at odds with predictions of a decline in working hours among younger surgeons. In fact, the percentage of Fellows who prefer to work fewer than 40 hours per week steadily increases with age (17 per cent of Fellows aged 30-39 years compared with 30 per cent of surgeons aged 50-59 years).

This suggests that younger Fellows may start off working long hours, but that this is not sustainable or desirable in the longer term, with Fellows ultimately reducing their workload.

Underutilisation of surgeons is another significant finding. Of male surgeons aged 30-39 years working 50 hours or less per week, almost 24 per cent of those surveyed wished to work more hours. This trend is not seen in other age brackets, with 63 per cent satisfaction and 9 per cent underutilisation in 40-49 years, and 63 per cent satisfaction and 6 per cent underutilisation among Fellows aged 50-59 years.

The majority of surgeons believe that there is more work available in their principal public and private sector workplaces. Approximately 70 per cent of Fellows believe there was a need for additional surgical Full Time Equivalent (FTE) positions in the public sector, and 56 per cent believed there was a need for additional FTE positions in the private sector.

The shortage of surgeons in the workplace was most acutely felt by Paediatric Fellows and Plastics Fellows, and felt least acutely by Cardiothoracic Fellows. By region, 35 per cent of Western Australian, 32 per cent of South Australian and 61 per cent of Northern Territory respondents believed there was a need for more than a 1.0 FTE position in their public practice location.

I would like to take this opportunity to thank the vast majority of surgeons who took the time to contribute to the 2011 census. (The 2011 Surgical Workforce Census Summary Report was distributed with the November/December edition of Surgical News.) It is very important data and is used by the College both for internal planning and for external negotiations. Without this data we would be at the mercy of jurisdictional data that can be very inaccurate.

Throughout 2012, the College was heavily involved in negotiations with Health Workforce Australia (HWA) and the census data proved invaluable. In fact HWA's report to Health Ministers very much reflected the College's views. It is noteworthy that surgery was not identified as one of the specialties where significant shortages in the future are expected. I think this finally extinguishes the myth that the College operates a "closed shop".

However, numbers are only one side of the coin – the other is distribution. Workforce maldistribution continues to be an issue in surgical workforce planning. Lifestyle, family ties and the desire to live in a metropolitan location were the biggest influences on a Fellow when deciding the location of their private practice.

Approximately three-quarters of Fellows rated those three factors as 'very important'. Private practice opportunities were considered 'very important' to 27 per cent of Fellows, while remuneration was considered by only 14 per cent of respondents to be 'very important'.

The involvement of surgeons in surgical training is of course crucial, with the very future of surgery in Australia and New Zealand dependent on the generosity and goodwill of those who train and educate. It is therefore pleasing to report that the majority of Fellows reported that they are involved in SET supervision with almost 40 per cent spending more than five hours per week on SET supervision.

Even though my own holiday to me seems to have been very abbreviated, I have at least been able to take time off – I have enough colleagues in close proximity to cover my absence. This is not true for all surgeons, particularly those working in rural or remote areas. Their absence either leaves an unfair burden on their remaining colleagues or possibly even completely deprives their community of appropriate surgical access. The challenge of providing appropriate locum coverage is being explored by the College – it is one of the tasks before us in 2013.

This year, like all previous years, will bring its own peculiar problems that we as surgeons will have to confront. Like all previous years there are dark clouds on the horizon, but for the present I am enjoying the sunshine, refreshed and re-invigorated.

Bring on 2013.

Michael Grigg
Vice President

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

Applications are invited from eligible Post Fellowship Trainees for training in HPB Surgery.

The ANZHPBA's Post Fellowship Training Program is for Hepatic-Pancreatic and Biliary surgeons. The program consists of two years education and training following completion of a general surgery fellowship. A portion of the program will include clinical research. A successful Fellowship in HPB surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, assessment, and final exam. Successful applicants will be assigned to an accredited hospital unit.

To be eligible to apply, applicants should have FRACS or sitting FRACS exam in May 2013. Any exam fails will not be offered an interview.

For further information please contact the Executive Officer at **anzhpba@gmail.com**

Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), to Leanne Rogers, Executive Officer ANZHPBA, P.O. Box 374, Belair S.A. 5052, or email anzhpba@gmail.com.

Applicants will need to be able to attend interviews which will be held early June 2013 in Melbourne.

Applications close 5pm, Friday March 29th.

Can you ear it?

A government group in New Zealand has suggested there can be savings made in reducing ear surgery. By reducing the rate of grommet insertion to that of Britain's, the National Health Committee believes it can save $4.4 million (NZ) a year. But the Chairman of the New Zealand board of the Royal Australasian College of Surgeons Scott Stevenson doesn't believe the savings are there. Mr Stevenson said the College had concerns about some of the National Health Committee's savings discussions. Fellow Colin Brown said: "The UK is not a good reference point … In my opinion, children are substantially under-treated in the UK."

***Otago Daily Times*, January 10.**

Vic surgery in crisis

A number of severe cuts by the Victorian State Government to elective surgery are causing job losses in that state's hospitals.

The cuts are said to protect patient care from the coinciding Commonwealth cuts, slicing $616 million from the past two health budgets. Chair of the Victorian Regional Committee of the College, Robert Stunden said he believed people were being retrenched or moved, and was concerned for the already stretched waiting list. "The cutbacks are biting hard … I have never seen morale in any health service like it is in Victoria today."

***The Age*, January 23.**

Taking it too far

More Canberra residents are taking to ear surgery to reconstruct the stretched lobes of their youth. For just half an hour each week, Fellow Tony Tonks corrects perforated ears. "The excess skin is excised and the bits that are left are reshaped to form an ear lobe."

He said that skin had amazing elasticity and surgery was only needed for holes larger than 10 millimetres.

"It's a bit like a piece of chewing gum. If you pull a piece of chewing gum a little, it will snap back, but if you pull it too much, it loses its elasticity and won't."

***Sunday Canberra Times*, January 13.**

Surgical Snips

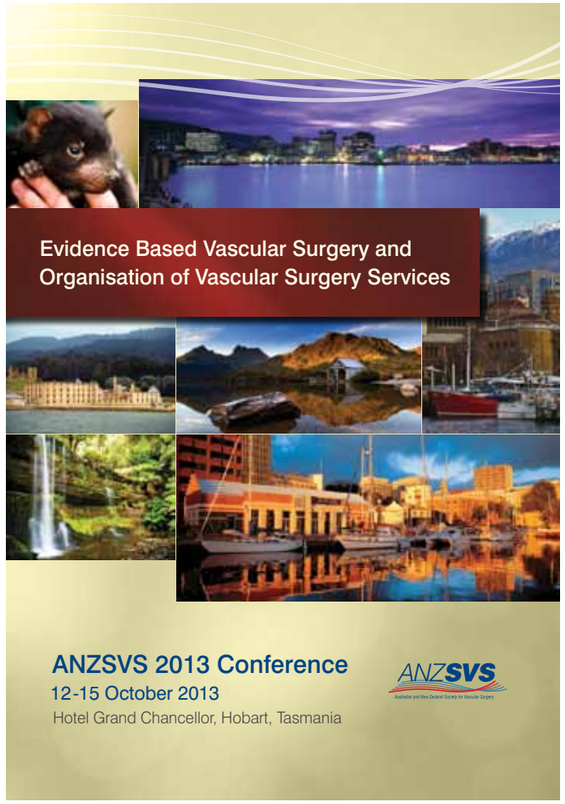
Australian Opposition Shadow Treasurer Joe Hockey is the latest of a string of personalities to go under the shrinking operation of bariatric surgery.

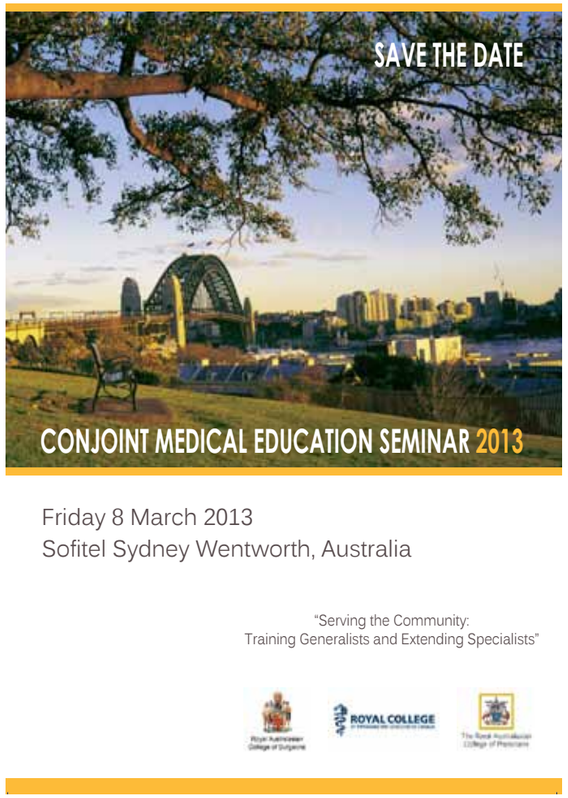
Not shrinking in risk

President of the Obesity Surgery Society of Australia and Fellow, Professor Wendy Brown said the increasingly popular lap-band surgery "sends a signal to the brain that makes an entrée sized portion as satisfying as the main course." Though the message is being reinforced that the surgery should be the absolute last measure in the fight to lose weight.

"The lap-band should be the last solution … people need to go into it realising it is not just a quick fix. Professor Brown said.

***Australian Financial Review*, January 18.**





Is our healthcare sustainable?

Surgical Leaders Forum October 2012

As part of the most recent Surgical Leaders' Forum, College Councillors and Specialty Society office bearers were invited to view the issues around the public health debate from a different perspective – that of health ministers.

Former Western Australian Labor health minister the Hon. Jim McGinty and former Victorian Coalition health minister the Hon. Rob Knowles gave generously of their time to explain the purpose, priorities and pitfalls of your average health minister.

Mr McGinty, now chairman of Health Workforce Australia, identified the five things that keep a health minister awake at night:

- Emergency departments and the associated issues of ramping and waiting times;
- Elective surgery waiting times;
- Uncaring treatment;
- Scandals; and
- The threat of being overridden by the Premier (or Prime Minister).

He said these dangers are always borne in mind when major reforms to a health system are being contemplated. He noted also that media are a potent player in the health debate, but are perhaps too inclined to play up the human interest angle of an individual's story while ignoring the public interest angle of a policy debate.

Mr McGinty offered some useful advice to those institutions, like the College, aiming to influence public health policy. He told us to be on friendly terms with the decision makers, but not to shy away from using oppositions and backbenchers to advance our case. And he told us to loudly condemn those decisions of a nakedly political nature.

He said it was a regrettable fact that teaching and research do not resonate more with health ministers, but that this was because they receive nothing like the media coverage given to the scandals and crises associated with the delivery of care.

Mr Knowles was at the centre of the Kennett Government's reforming efforts in the early 1990s and acknowledged that the funding cuts involved were only made possible by the Victorian public's awareness that the economy was in dire trouble. This enabled the government to require a 10 per cent funding cut across the entire public health system, and the introduction of casemix funding.

He said that, similarly, the community today will only support drastic reform of the public health system if people can be persuaded that the existing arrangements are unsustainable.

He noted that the Kennett government reforms were about more than cuts, with greater efficiencies generating a 28 per cent boost in productivity.

He counselled against giving complete control of the public health system to the Commonwealth as "they don't know about healthcare delivery and, worse, think they do".

Among fundamental problems in Australia's public health system identified by Mr Knowles was the relative disadvantage experienced by Indigenous Australians, the less educated, and those living in rural and remote areas.

Significantly, he noted that while many of the community's health problems lie outside our public hospitals, most government money is still poured into those hospitals.

He suggested that a program to address end of life issues could dramatically reduce the incidence of transfer to public hospital emergency departments. This would honour patients' and their families' wishes, thereby improving the end of life experience, while reducing pressure on EDs.

And he noted that Australia does not have a health system, but rather a series of systems with imperfect or non-existent connectedness.

Mr Knowles also identified a weakness in those systems that has been the subject of College advocacy for several years: there is no dedicated and explicit funding stream for education in our public hospital funding model. He suggested that universities be the holders of dedicated funding for postgraduate medical education and that this would open up all sorts of new sites for specialist education, including private hospitals.

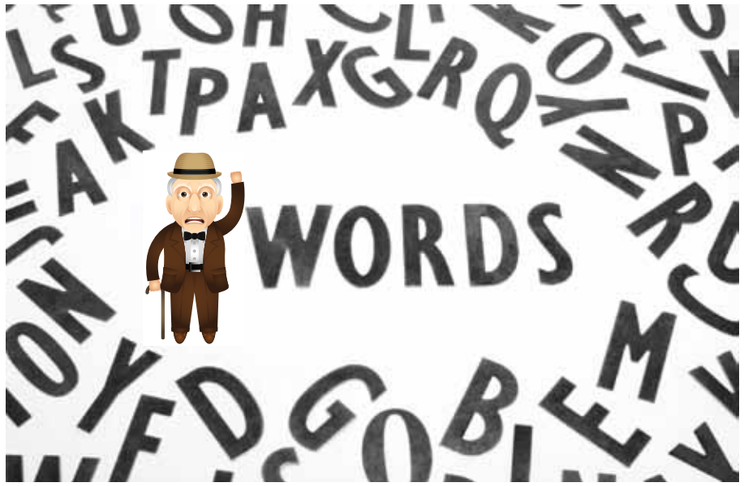
So beleaguered is the health minister's position, Mr Knowles said party affiliation is often a secondary consideration, with health ministers of different political stripes sometimes feeling they have more in common with each other than with their party colleagues.

He urged the College to ensure that its advocacy was in no way self-interested and was focused squarely on system-wide issues and improvements.

Attendees were then addressed by serving and former private hospital CEOs, who were asked to make an imaginary 10 per cent cut to their spending, and then the surgical service directors of three major public hospitals in Australia and New Zealand.

As health spending consumes more and more of government budgets, to the point where it will soon be unsustainable in the smaller jurisdictions, the Surgical Leaders' Forum gave surgeons a fascinating insight into the political and economic dimensions of the problem.

Jim McGinty, Jeremy Sammut and Rob Knowles address the Surgical Leaders Forum audience.



Use it write!

There is one thing that really annoys me and that is the inaccurate use of words

I was driving behind a truck the other day that proudly displayed a sign: "Beware: stopping continuously". Now the truck was moving and so that could not be true. What they really meant was stopping repeatedly or stopping often, but not stopping continuously or it would be stationary.

We curmudgeons can be very prickly about the incorrect usage of words. The word "gay" is an example. Gay means cheerful, happy, carefree. As we all know it has another meaning quite unrelated to its original usage. I was surprised to read that the term assumed its new meaning in the 1920's when the idea of gaiety was extended to mean "carefree and uninhibited". However, what really annoys me is that the word is an adjective and now it is used as a noun. Such corruption of the language!

In regard to noun-verb confusion, I need hardly mention the use of the word Google as a verb. "If you don't know the meaning of the word "curmudgeon", why don't you google it?" In the medical sphere we get a surgeon writing, "I consulted Mr Brown today regarding his hernia". What he really meant is that Mr Brown consulted with me regarding his hernia. "Consult" is an intransitive verb which means it does not have a direct object and needs to have "with" before the person with whom one consults.

The modern spell checkers are also to blame for the carelessness in written expression. If the words are not highlighted then the assumption is that the spelling must be correct. "The witch and a bee would be an unlikely pair" becomes "The which and a be wood bee an unlikely pear" without the batting of an eyelid. Try it yourself and you will find that the only slight hiccough is the word "which" this is sometimes detected as being wrong.

Our language is bedevilled with difficult words that sound the same, but are spelt differently and have different meanings (homophones). So we get see and sea; there, they're and their; to, two and too. What is more, no one notices if they have used the wrong one and if they do notice they don't care. I have a grandson whom I thought was severely dyslexic as his postings on Facebook were riddled with spelling errors. "Any one whant to hang tomoro" is a typical posting. However, when I saw his school book I found that he can write and spell, but on Facebook they don't care.

As for me I am so particular with words and spelling that it is almost a religious wright with me. When I right a word, I always make sure that I rite it write.

The next Annual Scientific Congress will be held in Auckland and the Scientific and Social program is now settled. It is shaping up to be an excellent meeting. By now all Fellows and Trainees should have received the provisional program for the 82nd Annual Scientific Congress in Auckland, New Zealand. If you have not received a program, it can be accessed via the Congress website, asc.surgeons.org

It is not too soon to register for the congress. Go on to the website, asc.surgeons.org click the link and follow the instructions.

The congress officially starts with the Convocation and Syme oration at 4.30pm on May 6 with the President's Welcome Reception at 5.45pm. Fellows who have received their Fellowship in the past five years and have not previously convocated may apply to convocate. They will receive complimentary registration for the meeting. All eligible Fellows have been contacted by e-mail.

On Monday, May 6, before the Convocation Ceremony, there are a number of important activities. The 'GSA Trainees Day' and the 'Developing a Career in Academic Surgery' course are high profile events that attract big attendances. In addition to these programs there will be eight other workshop sessions.

The scientific program will run over four days from Tuesday, May 7 to Friday, May 10. In all, 25 section programs are being convened. Our international and national faculty members will participate in the Scientific program and the Masterclass program which this year has 28 separate sessions. There is sure to be one that relates to your area of practice.

Highlights of the congress

Plenary program

The theme of the congress is 'Sustainable Surgery' and this has met with an enthusiastic response. The four plenary sessions will be a highlight of the congress with outstanding national and international speakers addressing pressing and topical issues that have relevance for Trainees and Fellows of the College.

The four sessions are:

1. 'Sustainable training and workforce development'
2. 'Sustainable Research and Development'
3. 'A Sustainable role for the College'
4. 'Sustainable Quality and Healthcare services delivery'

The line-up of speakers to deliver the Named Lectures will generate great interest.

President's Lecture
Sir Ray Avery

John Mitchell Crouch Lecture
Professor Russell Gruen

BJS Lecture
Professor Murray Brennan

ANZJS Lecture
Professor Charles McGhee

Herbert Moran Lecture
Mr Graeme Woodfield - nominated

James Pryor Memorial Lecture
Professor Ron Patterson

Tom Reeve Lecture
Dr Monica Bertagnolli

Mike Wertheimer Lecture
Mr Ian Civil

American College of Surgeons
Dr Nancy Baxter

Colorectal Surgery program

The three-day colorectal surgery program is highlighted by the visiting speakers from Australia and overseas. Professor Sandy Herriot from the Peter MacCallum Clinic in Melbourne, Associate Professor Torbjorn Holm from Stockholm and Professor Thomas Read from the Lahey Clinic will lead discussions on a wide range of colorectal topics from rectal cancer treatment to enhanced recovery programs in colorectal surgery. The Mark Killingback prize for the best research paper by a Trainee or recent Fellow is always fiercely contested and the program will be enhanced by the colorectal masterclass program which includes tips on how to get your papers published. The section dinner will be held at the Auckland Art Gallery on Wednesday, May 8.

Surgical Oncology program

The Surgical Oncology program will profile College visitor Professor Monica Bertagnolli from the Harvard University Medical School who has a special interest in gastrointestinal cancers and soft tissue sarcomas. We look forward to her involvement in the oncology program and to hear the latest developments in the genetic understanding of the development of gastrointestinal cancers. Professor Bertagnolli will also take part in the masterclass program to discuss the very apt topic of "Work life balance for the surgeon".

Trainees Association program

Dr Deborah Wright has convened a wide ranging and relevant program to issues facing Trainees. There is a session on surviving and thriving through surgical training and other relevant topics related to publishing journal articles and applying and securing an overseas Fellowship. The ever popular Trainees dinner will be held at Hopetoun Alpha and promises to be just as successful as ever. The John Corboy Medal will be presented at this dinner.

The Executive and Scientific Convener look forward to welcoming you to Auckland for an outstanding Congress. For further information on the 2013 Annual Scientific Congress in Auckland, go to asc.surgeons.org

Professor John Windsor
– Congress Convener
Professor Andrew Hill
– Scientific Convener

In Memoriam

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

Harold Thomas, NSW
Urologist

Peter Heery, NSW
Cardiothoracic Surgeon

Terence Horne, Tas
General Surgeon

Leo Walker, NZ
General Surgeon

Bruce Leckie, NSW
Cardiothoracic Surgeon

Richard Gye, NSW
General Surgeon

William Sealy Wood, NZ
General Surgeon

Ernest England, WA
Urologist

Philip W van Gelderen,
NSW General Surgeon

Richard Lloyd Cahill, NSW
Opthalmologist

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

Informing the College

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

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

CASE STUDY

Revision left total knee replacement

Laparotomy/ bowel resection/femoral herniorrhaphy

This is the first case study for 2013 in a series of case note reviews taken from the Australian and New Zealand Audit of Surgical Mortality (ANZASM).

This study provides important lessons for all surgeons that, if learnt, can lead to better outcomes for our patients. The cases come from both the private and public systems across Australia. ANZASM is proud of the expansion of the audit into the private hospital system and is pleased that the forward-looking hospitals see this as a useful tool in their quality control systems. Many cases come from the public hospital system as this is where many of the elderly patients with acute surgical problems are treated. A theme that is common to many of these cases is the need to have in place systems that provide adequate handover of care, as well as prompt notification of problems or change in the condition of the patient.

The Commonwealth Qualified Privilege legislation ensures the data in these cases can only be used for the purposes of the audit so contributions from treating surgeons and from assessors are absolutely confidential and privileged. Information is obtained under this quality assurance activity. Details that may identify individuals have been changed, although the clinical scenarios remain intact.

I trust you find this case study an educational opportunity and welcome any constructive feedback through the new web blog discussion forum found at http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/?date=201301. The 3rd National Case Note Review Booklet can also be obtained as a hard copy or in an electronic format, by contacting your local ASM office.

Case summary

An elderly patient with mild comorbidity (hypertension and gastro-oesophageal reflux) was admitted for a total knee replacement. The patient was transferred to the rehabilitation unit after an uneventful surgery. The intern notes indicate no abdominal examination was performed and no cause was suggested.

Over the next week the nausea and vomiting persisted. Occasional watery diarrhoea was noted and an infective cause was suggested. A fluid balance chart does not seem to have been kept over this time. A case note entry stated that suprapubic tenderness was present.

Treatment centred around antiemetics, oral and IV fluids. Gastroenteritis, side effects of opiate analgesia or postoperative ileus were listed as possible causes for persisting symptoms. An abdominal x-ray done after a further period demonstrated distended bowel loops and this prompted a surgical referral. When a general surgical registrar reviewed the patient several days later and diagnosed an obstructed left femoral hernia, the patient was tachycardic and hypotensive.

At laparotomy, a strangulated left femoral hernia with perforated small bowel and extensive peritoneal soiling was found. In addition to repair of the femoral canal, a small bowel resection with end-to-end anastomosis and extensive abdominal lavage was performed. Postoperative care was provided in intensive care.

The day after the laparotomy, spreading abdominal cellulitis led to the wound being opened with discharge of haemoserous fluid with odour. The surgical team was informed and felt that further surgical intervention would be of no benefit. Over the next few days the patient become more acidotic with increasing inotrope requirements and required haemofiltration. Death subsequently occurred.

Assessor's comment

The care provided by the medical rehabilitation unit appears to have been inadequate, firstly in respect of fluid and electrolyte management, and secondly by failure to establish a cause for the ongoing vomiting, abdominal distension and constipation.

The failure to involve a more senior surgeon in the assessment of the patient is worth noting. This led to a delay in the investigation for a possible surgical cause. The outcome in this patient could have potentially been avoided if an appropriate and timely surgical referral had been made.

The patient was in a rehabilitation unit for one week with anorexia, nausea, persistent vomiting, minimal bowel action and abdominal distension, without establishing a diagnosis. Postoperative ileus is an unusual complication of knee replacement and other surgically-related causes should have been considered.

The case notes are deficient, with no documentation of medical history and physical examination on the day of admission. The initial assessments appear to have been done by very junior staff.

Appropriate investigations (e.g. CT scan) towards a diagnosis were not ordered. Fluid balance was not recorded in a patient described as having daily vomiting and poor intake.

Subsequent management in terms of surgical intervention and postoperative resuscitation in the ICU were appropriate, but there is a real likelihood that the outcome would have been different had the diagnosis been made earlier.

Guy Maddern
Chair, ANZASM

Poison'd Chalice

"All too short…"

One of the pleasures, or maybe it is a curse, of growing more experienced (or is that just older), is the increased capacity for reflection based on reminiscence. Being increasingly drawn into oneself at the expense of the outside world is surely the first step to full blown dementia.

Alas, I recall taking these steps some time ago! Well at least I can still recall that! One thing that I have learnt is never to utter those fateful words that can be guaranteed to confirm any listener's suspicions that they are dealing with a deteriorating mental capacity. The fateful words, of course, being "in my day …"

It is the new year – another year. I am sitting on the raised dais of the auditorium, waiting to be introduced and begin my address to the new interns as they prepare to embark on the first day of their professional lives.

I am planning to speak to them about the journey they are beginning and the importance of that journey as having value in and of itself. But I also want them to reflect for a moment on their final destination, even at this early stage. What would they like to have achieved?

Some years ago I stood on this very same dais alone. And many years before that I sat in the auditorium as part of the audience. Now, as a sign of the changing world, I am but a member of a panel. I am the only clinician. My fellow panel members include a rather attractive young woman from Human Resources (wherever did that title come from!), a lawyer from the Corporate Counsel section, a representative from the medical indemnity industry and a representative from the finance department.

The chair of the meeting is the Head of our Intern Education Department. Why do we have an Intern Education Department? What are our medical schools doing? Indeed, is each of my fellow panel members a personification of my failure and that of my generation to preserve an inhabitable professional world? In my day, (there I have lapsed) as I began my journey, autonomy was valued and now we are servants to accountability.

My address is received with polite attentiveness. The faces of my audience are young – very young. Was I really so young when I commenced my intern year? I remember feeling daunted, but not young. I have clear recollections of 'first times' – inserting an IV, a futile CPR attempt, the "pop" of relocating a dislocated shoulder, or … cutting the knots too short for the Professor of Surgery. Shakespeare's description of a summer day in Sonnet 18 comes to mind – "all too short".

Those were the days

And I remember the disasters. I remember the large example of Australian womanhood waddling into the Emergency department one hot summer's night where I was the intern on duty. She had an urticarial rash over her entire body. A history of allergy to sulphonamides and a recent prescription of Bactrim by her local GP made the diagnosis clear.

I remember feeling pride in my new found skill as I successful placed an IV line in a pudgy forearm. As I administered hydrocortisone, I asked, by way of conversation, whether she was allergic to anything else. "Why yes" she replied "hydrocortisone!" No she couldn't be – yes, she was.

As the full blown anaphylactic reaction overwhelmed her, I called for the crash cart. A word came into my brain "ADRENALINE". I drew it up and injected it when another word came into my brain "SLOWLY". Too late, it was in. Well she survived, albeit after a stint in ICU. But her rash was cured.

I look once more at the young, eager faces in front of me. I am sure they are looking at me and seeing someone much older, somewhat removed, much as I did when I sat in their place. And I suppose I am old, being closer to the end of my career than the beginning. And yet I feel an affinity for them.

It doesn't seem that long ago that I was sitting where they are sitting. I cannot believe it is that many years ago. And I still experience something of the same trepidations with each new clinical challenge. If given the chance, would I want to go back and be in their shoes again? Probably not, and yet the thrill of the challenge, of the journey is a powerful lure.

The day will come when I know it will be the last time that I will be addressing a new crop of interns. And I know on that day, Shakespeare's words of Sonnet 18 will be screaming in my brain: "All too short!"

Professor U.R. Kidding

Continuing his work

College benefactor Rowan Nicks left a very important legacy

In his lifetime Rowan Nicks gave generously as a surgeon and a friend to many around the world. He believed fervently in his mantra of 'teaching the teacher to teach others' and established the Rowan Nicks Scholarships and Fellowships to support young, promising surgeons from underprivileged backgrounds to become the surgical leaders of the future in their home countries.

Made as a bequest to the College in 1991, the Rowan Nicks Scholarships and Fellowships are designed not only to enhance the surgical skills of young surgeons, but also to provide leadership skills such as teaching, research and administration.

The suite of scholarships reflects Rowan's desire to improve the surgical care offered to the people of developing nations and to create strong professional links between the Australasian and the UK and Irish surgical communities. The Program has provided training opportunities for more than 50 young surgeons from 21 countries.

The success of the Rowan Nicks Scholarship Program is due as much in part to Rowan's financial contribution as it is to his vision that even a small investment in education through international exchange can reap significant benefits.

And just as Rowan had hoped, many of the scholars who have spent time in Australia, New Zealand and selected overseas training centres under the dedicated mentoring of local senior surgeons, have now become leaders in surgical care in their home nations – a testament not only to Rowan's generosity, but his great vision and care for others.

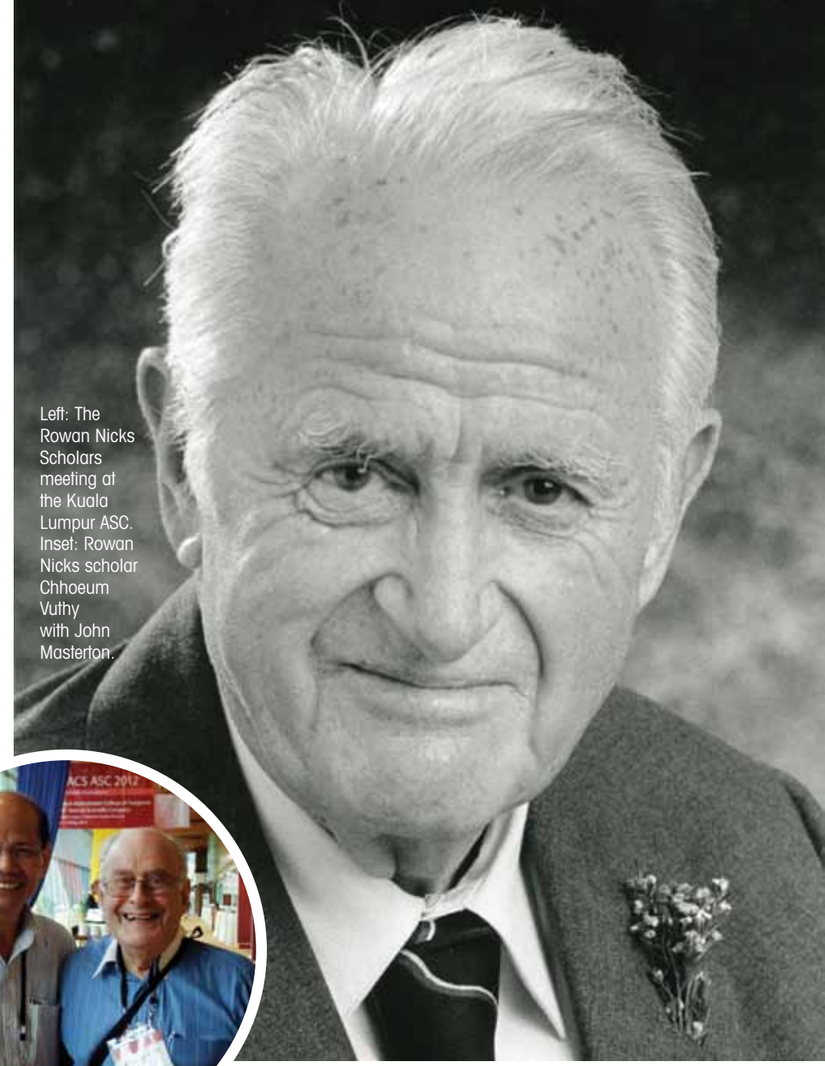
The current Chair of the Rowan Nicks Committee, Mr John Masterton described Rowan as an "enormously generous and engaging man".

"The general plan when Rowan first approached the College was that surgeons from Africa and India be assisted to come to Australasia not just to increase their surgical skills, but to help them to learn how to run a department as a potential leader in their own country," Mr Masterton said.

"These were lofty aims yet while he was one of the most charming people I have ever met, he was also a most determined and single minded person and while he was still physically able, he travelled repeatedly, and sometimes with his great friend Weary Dunlop, to maintain links with some of these scholars.

Over the past 20 years, Rowan's legacy has continued to grow, long after the earliest scholarship recipients have returned home. Each Scholar is encouraged to share their skills and knowledge with their colleagues upon return to their home countries. Some of the first recipients of the award from Bangladesh and Zimbabwe have gone on to become professors in teaching positions and leaders of surgery in their regions, publishing widely.

Foundation for Surgery
Passion. Skill. Legacy.



Left: The Rowan Nicks Scholars meeting at the Kuala Lumpur ASC. Inset: Rowan Nicks scholar Chhoeum Vuthy with John Masterton.

"More recently we in the committee have turned more to our closer neighbours in the Pacific Islands and South East Asia, bringing scholars from Vietnam, Myanmar, Cambodia, Laos, Nepal, the Philippines and as far afield as Mongolia," Mr Masterton said.

Between 2011 and 2013, the Program has helped train the Solomon Islands' first Urologist and Fiji's first Neurosurgeon, broadening the scope of specialist services available in some of our closest neighbouring countries.

Since his death in 2011, Rowan's estate has continued to support the Rowan Nicks International Scholarships, the Rowan Nicks Pacific Islands Scholarships, the Rowan Nicks Australia and New Zealand Exchange Fellowships and the Rowan Nicks United Kingdom and Republic of Ireland Fellowships.

All the scholarships are administered through the College as part of the College's Foundation for Surgery.

Through generous and thoughtful donations from Fellows and others, the Foundation itself has dispensed millions of dollars to support surgical research and aid work since it was established in 1981.

In addition to the international surgical scholarships administered through the College, Rowan and his close friend the late Russell Drysdale, established the Rowan Nicks Russell Drysdale Fellowship in 2005 to support individuals wanting to make a contribution in the area of Australian Indigenous health and welfare.

With generous bequests from both Rowan and Russell, and later from their estates, the Nicks/Drysdale Fellowship, which is administered by the Faculty of Medicine of Sydney University, has supported 13 Fellows to undertake projects and studies that have tangibly improved Aboriginal and Torres Strait Islander health and welfare.

The Nicks/Drysdale Fellowships have been held mostly by Indigenous men and women, but there have also been a few non-Indigenous recipients. One of the first to hold a Nicks/Drysdale Fellowship was Associate Professor Louise Lawler, a charming and very capable nurse and school teacher, now at the University of Woollongong.

Her work was with Indigenous adolescent youth in Dubbo with the aim, which was successful, to encourage them to complete secondary schooling to Year 12. Louise is now the administrator of the Nicks/Drysdale Fellowship Program.

"All of these achievements stand as an on-going testament to the generosity, care, determination and vision of one extraordinary man – Rowan Nicks," as Mr Masterton attests.

The Chair of the Board of the Foundation for Surgery, Professor Kingsley Faulkner, said the surgically-focused Rowan Nicks Scholarships now formed part of the $24 million invested by the Foundation, with interest generated used to support not only international aid projects, but world-class research.

He said that each year, Fellows contributed approximately $200,000 to the Foundation and he particularly thanked them for their support of the annual 'Pledge A Procedure Week' fund-raising campaign that is held each June.

"Some of this new money has been used to support the development of emergency medicine in Myanmar," Professor Faulkner said.

"It has been wonderful to see the support of Fellows for this and other fundraising campaigns run by the Foundation. I think we should be proud that we have chosen to show both the surgeons and the people of Myanmar that we care about the provision of quality health care in their country." ▶

Professor Faulkner said some of the major achievements created by Foundation funding recently include:

- Support for the Pacific Island Fracture Management course held in Suva which trained approximately 70 health professionals, including surgeons, to deliver high quality orthopaedic care;
- Funding of regular Primary Trauma Care programs in Myanmar that have now trained more than 700 health specialists, including surgeons, to treat severely injured patients quickly and methodically;
- Encouraging Indigenous doctors to become surgeons by funding use of the mobile Surgical Simulation Unit at Australian Indigenous Doctors Association Symposiums;
- Improving ear health in Australia's Indigenous communities by providing surgical equipment to identify and treat Chronic Suppurative Otitis Media at Cherbourg, Queensland's third largest Aboriginal community and at the Tharawal Aboriginal Medical Service in NSW.
- Awarding approximately 40 Foundation for Surgery scholarships and grants annually to support the expansion of world-class research across all surgical specialties and sub-specialties.

"The Foundation for Surgery had a very humble beginning in 1981 and from that beginning we are now working to develop relationships within the corporate sector to help us expand our work. We are also now getting enquiries from other Colleges wanting to know how we have made the Foundation such a success," Professor Faulkner said.

"The College Patron, the Prince of Wales, has also written to us seeking our guidance on how he could better co-ordinate his philanthropic work in Australia.

"I think all Fellows should feel a sense of pride in the achievements of the Foundation for Surgery both because of our aid work and our support for research.

"Everything we do represents a genuine effort by the College to do more for the public than our core business; it badges Australia as a caring nation and it shows that as a profession, we have the expertise and willingness to assist our colleagues from different countries and different medical disciplines to improve patient care.

"Our support of young surgeon/scholars also places scientific research at the core of our profession, which is crucial because no discipline advances without research," Professor Faulkner said.

With Karen Murphy

Donations to the Foundation for Surgery to help support the expansion of health care in developing countries, Indigenous health programs and the provision of research scholarships and grants can be made on the donation form included in this and each issue of *Surgical News*.

Teenagers can be challenging. Surgical parents often struggle to provide the supervision and support needed to keep their beloved children out of harm's way. It can be tempting when one's practice is busy to provide the means for a good education, but not find adequate time for the family to ensure that the children are secure, grounded and live within the intended boundaries.

Last month I discussed low vitamin D levels. On a related matter I consulted recently with a headstrong, physically mature but emotionally insecure, 16-year-old teenager, Ultraviolet.

This visit was the result of a severe bout of blistering sunburn. But not from being at her parents', the Never H'Omes', beach house over the weekend.

She had been to a tanning studio, desperate to look good for the school formal. There is no doubt she is an attractive redhead, but with fair skin she is never likely to acquire much tan. She was struggling to grasp this reality.

The staff had admitted her without asking her age or demanding any sort of written consent or health enquiry, as per the legislation. Like many teenage girls she had been wearing make-up, which had only accentuated the effects of the ultraviolet on Ultraviolet.

Legislation bans under-18s from using sun studios, and staff are also supposed to be trained to refuse fair-skinned phototype I's on the grounds of potential for harm. The staff should advise against wearing make up and take an adequate medication history. They could be up for a hefty fine of up to $146,000 if I report them.

I had a number of matters to discuss with Ultraviolet. First I explained that the heaviest users of sunbeds are young adults, the majority of whom are female. Next that it is young people who are most at risk of DNA damage in their skin, leading to subsequent development of cancer, particularly melanoma, often in early to mid adult life. This is because sunbeds emit ultraviolet light and that it is UV exposure that increases the risk of melanoma, especially in fair skinned individuals. Third, that the tanning studio had acted illegally.

The sunbed's days are numbered

WHO has published a factsheet on the dangers of sunbeds and the States of Victoria (Australia), Ontario (Canada) and California (USA) have passed legislation making it illegal for fair skinned or under-18s to use sunbeds. NSW will do so from the end of 2014.

The three main types of UV are A (400-315nm), B (315-280nm) and C (280-100nm). Damage to biological systems, including DNA, is the result of UV photon's power to alter molecular bonds. UVA as well as UVB causes DNA damage within the layers of the skin and impairs DNA repair.

The *British Medical Journal* just published a meta-analysis of the evidence regarding sunbeds and melanoma. It was based on 27 studies in 15 countries in Europe. "Having ever used a sunbed" increased the risk of cutaneous melanoma 1.25 times (1.09-1.43), and though this was statistically significant, it is hardly dramatic.

However, use before the age of 35 increased the risk to 1.87 (1.41-2.48). The systematic review estimated that of the almost 64,000 cases of cutaneous melanoma in those 15 countries of Europe, a small proportion, some 3,400, were the result of sunbeds.

The popularity of sunbeds is shown by one recent study from Denmark which estimated that tanning beds had been used in the preceding year by 2 per cent of children aged 8-11 years, 13 per cent aged 12-14 years, and 38 per cent of 14-18 year olds. Seventy per cent of users were girls.

I would refute claims that tanning studios are healthy because they can be used to treat Vitamin D deficiency. Yes, Vitamin D3 is made by exposure of the skin to UVB (spectrum 270-300nm, but mostly 295-297nm) which reacts with 7-dehydrocholesterol.

We should expose ourselves to UVB from sunlight, without getting sunburnt, as this the natural way to boost or maintain Vitamin D levels. An alternative is Vitamin D supplements. And for Ultraviolet, hoping not to be a shrinking violet, at that school formal – it would be best to accept being fair, or failing that, risk the stains and smears that go with a spray tan.

Dr BB G-loved

Flexible Surgical Training

Let's expand the opportunities

Cover Story

The year 2012 was a big year for women in Australia – indeed, on December 31 a BBC World journalist declared that 2012 had been the "Year of the Women" in Australia. But how do things stand for women surgeons?

Women remain under-represented in surgery. While women make up approximately 55 per cent of Australian medical students, the 2012 College statistics show that only 27 per cent of surgical Trainees are women.

Among active and retired Australasian surgeons that figure falls to only 8.05 per cent. If we look at "active surgeons", that percentage of women rises to 10.2 per cent. Women are still very much a minority in surgery.

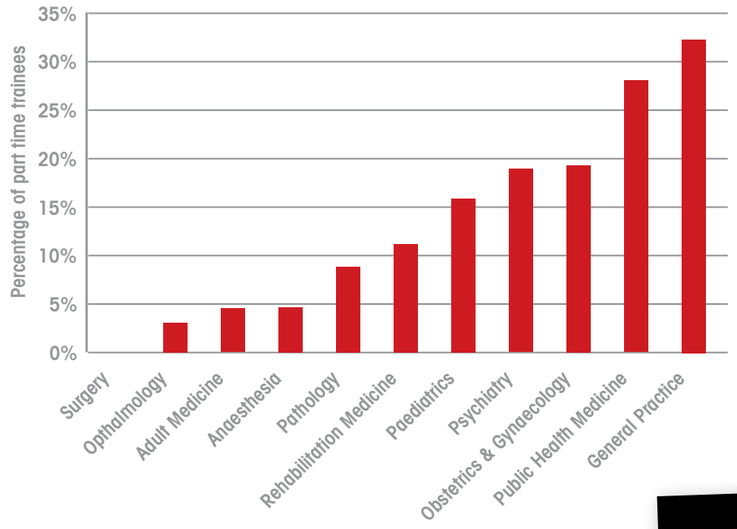
In 2012, the College Women in Surgery Section developed a five year strategic plan with objectives in leadership, flexible training, mentoring, advancement, recruitment and retention as ways to achieve the Section's objectives.

Flexible surgical training is a gender-related, but not gender specific issue. We know that male medical students and male surgical Trainees also wish to have flexible surgical training options. What's good for the goose is also good for the gander.

The WIS Section published a perspective on part time surgical training in the December 2012 issue of the *ANZ Journal of Surgery,* calling for hospitals and surgical supervisors to work together with the College to provide flexible surgical training positions for Trainees.[1]

The full text article is freely available online and is recommended reading for surgeons and Trainees. The same issue of the Journal features an editorial on part time surgical training by Phil Truskett and an article by Susan Neuhaus about the South Australian experience which validates the part time surgical training model in general surgery.

Figure 1: Australian part time advanced trainees in 2009 by specialty



In 2013 you can expect to see more conversations on flexible surgical training and we hope this will translate to more Trainees being able to undertake flexible surgical training. We have a long way to go, as statistics show that surgical training has the lowest level of flexible training of any medical specialty in Australia (Figure 1 above).

A survey of Trainees conducted by the Royal Australasian College of Surgeons Trainee Association in 2010 demonstrated that more than a third of Trainees were interested in less than full time training.[2] While the College has a part time training policy that allows part time training, the practical barriers mean that flexible surgical training is practically non-existent.

The College is establishing a Flexible Training working party that will aim to confirm the need for and logistics of flexible training, and will look at how to advocate for its introduction.

This is a very positive step; ultimately to improve access to flexible surgical training we need hospitals (employers), surgical supervisors and the College to work together to identify and accredit flexible training positions in all states and all specialties.

How to make it work

Ongoing Trainee surveys can quantify demand and facilitate workforce planning. Different specialties and hospitals will face different challenges in providing flexible training posts, which need to be considered and discussed.

Statistics are important in measuring whether we're performing adequately on flexible surgical training and also on gender equality. The College is not an employer, so it won't be subject to the legislative requirements of the Workplace Gender Equality Act 2012, which will require companies that employ over 100 people to provide information on gender equality indicators. Hospital figures are also unlikely to paint the surgical picture – it's only when we examine national data by specialty that we see how poorly surgical Trainees fare in comparison to their peers.

One way that we can improve our data is to introduce a full range of gender equality indicators to the College annual reports, with details of flexible work practice arrangements and gender-based reporting of intakes, deferrals and withdrawals.

We know that women are much less likely to enter surgical training than men. We don't know whether more female Trainees have deferred, withdrawn or been dismissed from surgical training in the past five or 10 years when compared with male Trainees.

Unfortunately without a gender-based breakdown of this data we are working blind – and whether you're a surgeon or a layperson, it's clear that is not an ideal position to operate from.

Introducing flexible training into a historically rigid system won't be easy. I've heard surgeons express concerns that flexible surgical training will adversely affect training quality. I understand this cultural perspective, but the data suggests otherwise.

Those who suggest that flexible surgical training means that Generation Y Trainees want to take the easy way out don't understand flexible training models. Flexible training offers Trainees an additional option in the difficult juggle to balance work, personal and training demands. It allows Trainees to continue working when their only other options are temporary or permanent cessation of training.

This year may not be the year that we achieve access to flexible surgical training for all Trainees who desire it, but if it's the "Year of Flexible Surgical Training Conversations", that will be a great start.

Jill Tomlinson
Deputy Chair, Women In Surgery Section

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Matthias Wichmann

Fair Dinkum – No Bull!

The Provincial Surgeons' Meeting in Mount Gambier

The 48th Annual Scientific Conference of the Provincial Surgeons of Australia (PSA) took rural surgeons from Australia and New Zealand to Mount Gambier in the South-East corner of South Australia. Almost 120 surgeons and their partners met early in November in The Lake City under the traditional PSA motto of 'Fair Dinkum – No Bull'.

The Pre-Conference Workshop focused on Laparoscopic Hernia Repair – with two experts from Adelaide (Nick Rieger and Darren Tonkin) as tutors. This workshop was followed by a welcome reception celebrating the region's (Coonawarra) wineries. The local products were thoroughly researched.

The conference then started with a number of lectures on "Treatment of Inflammatory Bowel Disease in Rural Australia"

Contributions came from Glenn Guest (Colorectal Surgeon in Geelong), Peter Bampton (Gastroenterologist in Adelaide) and Frank Voyvodic (Radiologist in Adelaide and Mount Gambier).

Current standards of surgical and medical care as well as diagnosis were well covered by these distinguished guest speakers. A surgical debate investigated the question whether or not laparoscopic surgery is the standard approach for patients suffering from Inflammatory Bowel Disease (IBD) and a panel discussion with a rural patient suffering from IBD further focused on the problem of care delivery in rural Australia. The conference also delivered new and valuable information about the latest research results regarding the aetiology as well as medical treatment options for IBD.

The conference theme was extensively discussed and a number of new ideas and treatment approaches for better patient care became evident during this meeting. In addition to news on 'Inflammatory Bowel Disease', Tim Price (Oncologist in Adelaide) provided an update on oncology in colorectal and gastric cancer.

The papers presented during our meeting were of high quality and it was not easy for the judges to identify the best papers of each category. Once again – the presentations were guided by the PSA motto – fair dinkum, no bull...

The social program was full of music and dance as well as good food and wine – no-one regretted having come to visit The Mount. PSA danced this year!

Artistic reminder

During the Conference a local limestone sculptor produced a piece of art that will be on display in the renovated Mount Gambier Hospital and will remind everyone involved with the meeting of the wonderful time we had here in Mount Gambier with our colleagues and friends from the PSA. The Hand made by Ivo Tadic was chosen due to the multiple links with our work as surgeons: we greet, help, protect and sometimes even heal our patients using our hands!

I would like to thank Emma Thompson and my wife Juliane for their great help and enthusiasm with the preparation and running of the meeting and look forward to many more great meetings of this exciting group called 'Provincial Surgeons of Australia'.

Matthias Wichmann
PSA 2012 Scientific Program Convenor

summer *Lifestyle*

post op

16 page lifestyle section

African Specialist

Canberra surgeon leads luxury safaris

post op appears in *Surgical News* each season

Walk on …

ACT plastic and reconstructive surgeon Mr Chandra Patel has lived an extraordinarily well travelled life

Born in India, Mr Patel moved to Kenya as a young boy, and then lived in England and Scotland while completing his medical and surgical training. He later spent time in the US expanding his surgical skills before arriving in Australia in 1981 to undertake a craniofacial Fellowship in Adelaide.

Originally intending to return to Kenya, Mr Patel chose to remain here with his Australian wife Lindy after political upheaval there made his return problematic. Yet, never has he lost his love for the land of his boyhood.

After making numerous family trips to East Africa with his young family, Mr Patel now leads luxury safaris for friends and acquaintances to the glorious wildlife reserves spread across Kenya, Tanzania, Botswana and Uganda. He talks to Surgical News about the primal pulling power of Africa.

How many safaris have you now led?

In the current format, that is luxury safaris rather than family holidays, I would say about 18.

What originally spurred you to organise such journeys?

My wife and I have always liked going back to visit the game parks and wild life reserves in East Africa and people we knew were quite envious of these trips, but too scared to do it themselves. So we decided to make use of our knowledge and take up to 12 to 18 people with us. Usually they are people we know, or people who know friends of ours, but we are quite selective. They can't be selfish or inflexible because as with most journeys, particularly on safari, things can go pear shaped and you have to be able to deal with that.

What do the trips usually involve?

We try to make it about three weeks and usually we stop somewhere along the way, maybe in South Africa, the Middle East or Mauritius depending on the route we take. Then we organise two weeks on safari with a few days at the end at a lovely coastal resort to rest and recover.

I organise the itinerary and where we go often depends on the season which is obviously the driver of animal behaviour such as migrations, while at other times of the year it can be too wet to get to where you want to go.

Most of the travelling is done by four-wheel drive and I use a family friend in Kenya who runs a boutique tour business to provide our guide and driver. That makes a huge difference because he knows what we like, the style of accommodation we want and we have a strong trust relationship.

What is the standard of accommodation like across East Africa?

Most of the people we have taken have been absolutely astonished at the high level of accommodation and hospitality available. Eco-design is very important in East Africa which means there are no eyesores. We tend to stay in lodges, villas or luxury tented accommodation which are usually permanent, but offer a night under canvas with an ensuite bathroom.

The hospitality industry was established by the Swiss decades ago and the standards have remained at that level. Some of the people we have taken are amazed that they can eat a six-course five-star dinner, then return to their luxury tent and have animals wandering past during the night.

Have you ever experienced any danger on safari?

There is always a risk when you are around wild animals particularly if the guides are untrained. Our guides are very knowledgeable and can read an animal's behaviour and likely reaction from its body language. Mostly on safari, you can have leopards, lions or elephants wander past, but in the game parks and reserves they are not interested in humans unless they feel threatened; they are just going about their business.

The only dangers to visitors arise when people ignore the clear signs and warnings of where to walk and when to walk there. In terms of politics or violence, I tend to stay away from Kenya during election time which seems to be the only time that passions get high and avoid going anywhere near the Somali border areas.

What do you love about being on safari in East Africa?

The land itself is incredibly beautiful – and I would say unmatched – with wide and glorious vistas, valleys, bush, lakes, volcanos, high plateaus and mountain terrain. One of our favourite activities when there is to take a morning flight ▶

Clockwise: Ngorongoro Crater, Wildebeast River Crossing, Cheetah spotting, Naivasha Lodge, Chandra Patel with one of his tour groups.

on a hot air balloon over the Masai Mara, an incredible game reserve in Kenya which is linked to the Serengeti National Park in Tanzania. You float above and see the animals starting their day and then have a champagne breakfast.

But I'd say more than anything I love the drama of it because you never know what you are going to see. You could come across a lion making a kill or spend time watching baboons mucking around, thinking how much they resemble a human family, or see elephants socialising. I would also urge people to put the Ngorongoro Crater in Tanzania on their Bucket List. It is a volcanic caldera and is absolutely stunning.

What is the most wonderful thing you have seen on safari?

I'd have to say it is the migration of the wildebeest when more than two million animals migrate from the Serengeti National Park to the Masai Mara. Most people would have seen images of it on the TV, but to actually see it makes your hair stand on end. One of the great dramas within the drama is that they have a number of rivers to cross and up to 10,000 wildebeest can merge at a river bank, but be too nervous to cross.

There is a great deal of to-ing and fro-ing, with one animal going down to sniff the waters and backing away and then another one doing the same thing. Then, all of a sudden one jumps in and then they all stampede forward – some jumping in from great heights – forcing even the hippos to get out of the way. But then the crocodiles come into their own. They take some while others drown and you see their bodies drifting downstream. It is absolutely incredible to witness.

What is the greatest change you have seen in the parts of Africa you have visited since you began leading such safaris?

That would be urbanisation and the human use of land. When I grew up, animals roamed everywhere and it was not unusual to see lions on the outskirts of Nairobi. That land-use pressure is affecting, in particular, animal migration routes which is a worry, but Kenya is doing a good job given that almost 10 per cent of the country is designated as a game park or reserve.

Poaching had a very big effect, particularly on elephants in the 1970s and 1980s, but that was tackled; yet now we are seeing a new wave of poaching driven by the increasing price offered for ivory which represents a new challenge.

What is the benefit to other people of going on one or your safaris and as you approach semi-retirement, do you think you will do more?

I design the whole itinerary, I speak Swahili and I know the customs of the region, have local knowledge and contacts and the ability to sort out any problems that might arise. Also, it's my holiday with my wife so I make sure it's top notch. Perhaps in semi-retirement we might go twice a year, we'll see.

Does taking time out of your working life to do such travelling improve your working life?

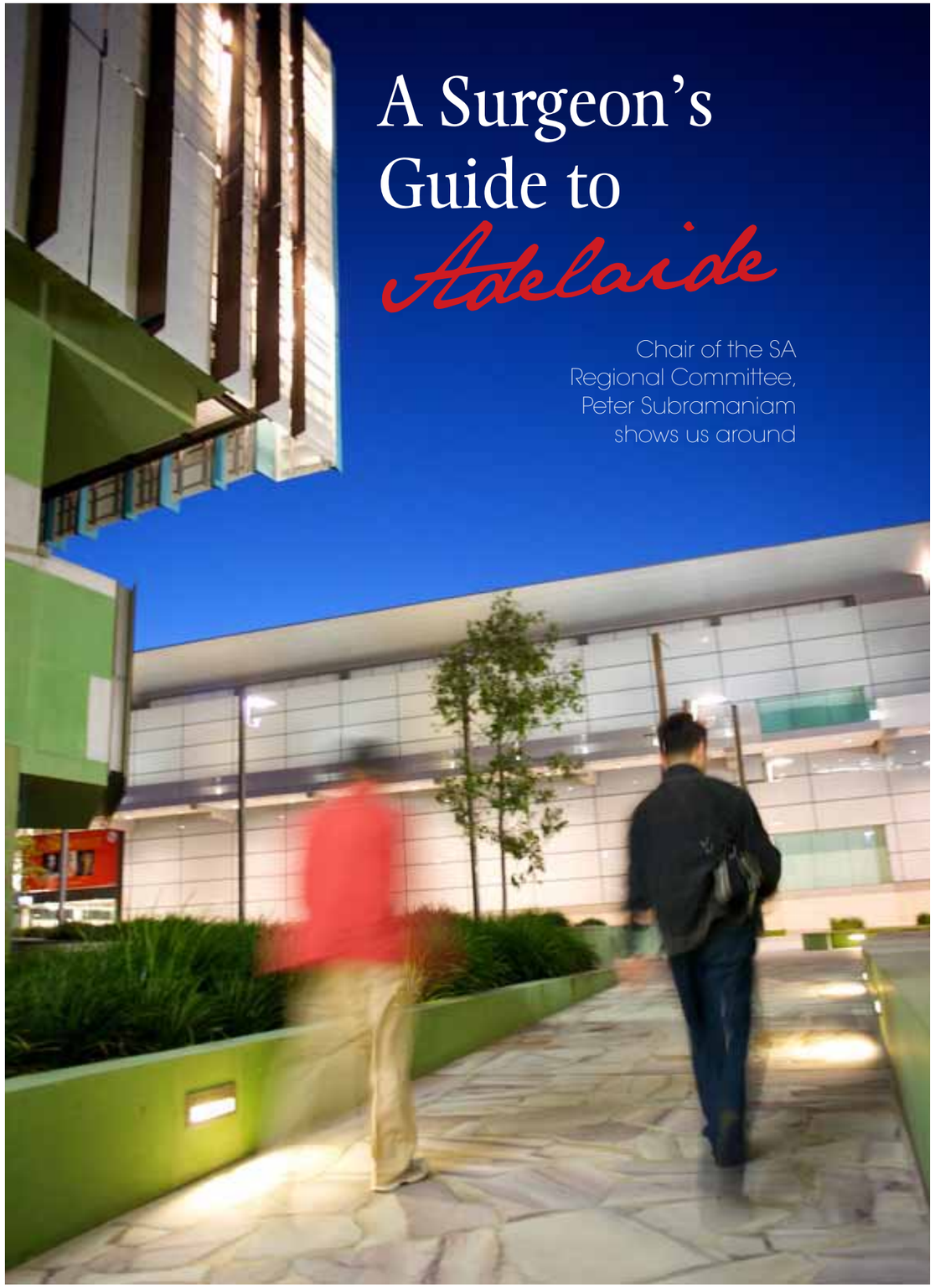
I was given good advice at the start of my career that if I wanted balance and longevity, to take 10 weeks off per year which I do and which has made a huge difference, particularly in terms of spending time with my family. I think as a profession, we don't take enough time away from work, but I am a firm believer that any time not used wisely will not be refunded.

Why is it important to you to share the beauty of Africa with others?

I have a theory, now that science is pretty-well agreed that humanity emerged from East Africa, that it has a deep resonance within the human spirit. I have seen so many people react with absolute awe and wonder and joy to the environment, even people who regularly travel at a very luxurious level all around the globe.

To see how humans lived there from earliest times seems to have a profound effect on people and we love it and are happy to take people with us. I also want people to see how much work is being done to protect the wildlife of East Africa and maybe they will choose to support those efforts.

With Karen Murphy



A Surgeon's Guide to *Adelaide*

Chair of the SA Regional Committee, Peter Subramaniam shows us around

The development of the new Royal Adelaide Hospital – expected to become Australia's most advanced hospital at a cost of almost $3 billion – could inadvertently reduce public access to specialist care, according to the chair of the SA Regional Committee, vascular surgeon Peter Subramaniam.

Mr Subramaniam said the construction of the hospital, expected to be completed by 2016, represented an enormous investment by the South Australian Government giving rise to concerns that funding for specialist services and programs could be cut to help pay for it.

He said since he had taken up the position in July, he had continued the SA College advocacy work ensuring equitable access and the maintenance of high quality surgical services for SA citizens across metropolitan and country areas with appropriate surgical services being centralised at the newly created facility.

"This new hospital represents the single biggest infrastructure project undertaken in South Australia and although it is being built as a public and private partnership it will also represent a massive debt to the state in the future," Mr Subramaniam said.

"We are concerned that the push to centralise specialist services at the new facility could have an impact on public access and patient care if surgical services are rationalised in other centres to meet the required cost cutting to afford this new facility without the capacity to meet the added anticipated activity in the new facility.

"In the past, governments have said that specialist services should be located where the people are located but that's not easily achieved with the particular geography and demographics of an aging population in South Australia.

"The College SA committee, directly with government and through our role in the various representative forums of which we are members, will continue to advocate against reduction of essential specialist surgical services to meet the budgetary restraint necessitated by the cost of the new hospital."

The new Royal Adelaide Hospital will be located in Adelaide's west end alongside the new health and research facilities at the SA Health and Medical Research Institute (SAHMRI).

When completed, the hospital will have the capacity to admit approximately 80,000 patients per annum and will have 40 operating theatres, 800 beds, wireless technology, state-of-the-art IT systems to improve patient safety and a commercial precinct including a crèche, mini-mart, restaurant, cafes and gymnasium.

Mr Subramaniam said the project represented a great advance in health care for the people of Adelaide as well as for researchers, scientists, surgeons and other medical professionals but that care must be taken to ensure the new facility did not inadvertently lead to disadvantage elsewhere.

"As a committee we see our role as making sure the new hospital works and works well for all South Australians," he said.

Mr Subramaniam is a senior visiting vascular surgeon at the Queen Elizabeth Hospital with an established private practice based at Adelaide's major private hospitals.

Mr Subramaniam undertook his medical and surgical training in Melbourne, after arriving as an overseas student from Malaysia. Having completed a General Surgical Fellowship at the Royal Melbourne Hospital, he completed his Vascular Fellowship Training at the Austin and the Alfred hospitals in Melbourne with a final year at the Royal Brisbane Hospital.

He is married to Catherine, who is now a GP in the Adelaide Hills, after the two met in the Emergency Department at Launceston General Hospital when Peter was on rotation there.

"I had to marry her because she could pronounce my name," he laughed.

"We were married in Tasmania where Catherine is from and despite Catherine being in the RAAF, she managed to organise to move with me as I went through my training rotations. So when she was offered a promotion to Officer in Charge of the Health Flight at RAAF Base Edinburgh in SA at the end of my vascular training in 2000, I thought it only appropriate that I followed her.

"Adelaide is an absolutely brilliant city in which to raise and school our three beautiful children.

"It's an elegant, picturesque green-belted city with the Adelaide Hills as a backdrop and the Torrens winding through it but it's also small and well-organised.

"It has a well established equestrian scene, which is important to Catherine who is dressage-fixated, and runs the Annual Adelaide International Horse Trials smack in the middle of the City's parklands.

"As a vascular surgeon with both a public commitment and private practice, I spend quite a lot of time on the move but I can do my rounds, see my patients and still get to spend time with the family at the end of the day which is important to me.

"I am a cricket tragic and I absolutely love being able to walk the five minutes from my rooms in North Adelaide to the Oval when the Test is being played here which brings a sparkling, festival feeling to Adelaide. We love our cricket here in Adelaide.

"We also have a vibrant food and hospitality scene and some great arts events in world-class facilities with such easy access you can leave home, park the car and take your seat at the Opera/ASO/Ballet all within half an hour of the curtain rising."

The following are Peter's top tips to enjoying the stylish City of Churches.

With Karen Murphy

THE MORTLOCK CHAMBER

Described by Peter as one of his favourite places in Adelaide, the Mortlock Chamber is part of the State Library of South Australia and is one of the city's most unique heritage venues. Located on North Terrace, the chamber is a glorious example of late Victorian architecture. With a rich and ornate interior over two levels, the Mortlock Chamber has an historic book-lined first-floor gallery overlooking the main chamber. In an effort to keep such a treasure part of public life, the room is used for exhibitions showcasing the history of South Australia and can be hired for formal dinners, functions and even cocktail parties for high-brow hosts hoping to impress their friends.

FINE AND FUNKY DINING

A small but sophisticated city, Adelaide boasts not only fine cuisine to go with its wines, but a variety of surroundings to enjoy it in. Peter said hidden culinary gems were scattered through the villages dotting the Adelaide Hills and said the Stirling Hotel and Aldgate Pump Hotel were personal favourites while he also enjoyed a summer lunch at The Lane Winery.

"Auge on Grote in the City or Assagio on King William Street in Hyde Park gives you haute cuisine a'la Italia," Peter said. "The central market food court offers a trip to Asian culinary centres and the hide-away Malaysian eateries like Wok's Happening on Hutt Street or the smart student haunts like The Penang Hawker Corner and Nanyang in the Renaissance Arcade on the Rundle Mall are worth visiting and if you like Asian chic try Concubine on Gouger. "One of our favourites is a tiny little European style wine bar tucked away in one of Adelaide's seedier streets. It's called the Apothecary and as you'd expect is located in what used to be an old pharmacy. 188 Hindley Street, Adelaide.

MCLAREN VALE WINE REGION

Described as having a Mediterranean climate and only a 40 minute drive from Adelaide, McLaren Vale has developed over the years into one of Australia's premium wine regions and now boasts more than 60 vineyards offering their world-class wines at cellar door.

A leisurely tasting tour could include sipping and soaking in the ambiance of a nineteenth century homestead (D'Arenberg), a cosy historic cottage or picnic by the lake (Fox Creek Wines), the rustic charm of a working farm (Penny's Hill), an old ironstone barn (Coriole Vineyard) or enjoying panoramic views over the Onkaparinga Valley (Chapel Hill).

"Most people who come to Adelaide immediately think of visiting the Barossa, but McLaren Vale is not only more beautiful, in my opinion, the convenient short drive there from Adelaide is a delight," Peter said.

THE PORT RIVER

The Port River is the western branch of the largest tidal estuary on the eastern side of Gulf St Vincent and extends inland through the historic Inner Harbour of Port Adelaide to the salt-water West Lakes. While the banks along much of the river are largely industrialised, it also forms part of the renowned Adelaide Dolphin Sanctuary thanks to the river's chief attraction the resident dolphins, the only wild dolphins in the world to take up life in the city. Sightseeing boats and kayaks cruise the waters. "Paddling up the river in a kayak with the kids and interacting with the dolphins is a wonderful experience," Peter said.

THE ADELAIDE OVAL

As a self-described cricket "tragic", it should come as no surprise that Peter lists The Oval as one of Adelaide's great treasures. Dating back to 1871, the hallowed ground is situated in the parklands between the city centre and North Adelaide and until redevelopment work began recently, was considered by many cricket followers to be one of the most picturesque cricket venues in the world. History, heroism and legend swirl in the atmosphere of the Oval. Tours of the Adelaide Oval are provided by experts in cricketing history most days of the year when the ground is not in use. Peter said: "When you do a tour when the ground is quiet you can almost hear the whispering of the ghosts. You can almost see the men in their hats and the women in their finery applauding Bradman, or gasping in shock at Harold Larwood's bowling, or in later years cheering on the Chappell brothers."

Past meets the present

With a serendipitous meeting came healing

Breast surgeon Mr Peter Gregory was barely out of Medical School and undertaking one of his first rotations at the Royal Melbourne Hospital's neurosurgical unit when an otherwise healthy middle-aged man was brought in suffering a subarachnoid haemorrhage.

The man, Ross Shelmerdine, was suffering severe head pain and light sensitivity but was lucid and both physicians and surgeons believed his chances of responding to surgery were good.

Sadly, however, after what Mr Gregory describes as a "torrid five days" and two operations, Mr Shelmerdine died, leaving behind a wife and four young children.

While Mr Gregory had spent time with the patient and found him to be an interesting and courteous man, as a junior doctor he was not required to interact with the grieving family who were cared for by the unit's senior specialists.

With no sense of shared loss, this sudden and sorrowful death haunted Mr Gregory for years.

"We all go to work every day with the best of intentions and we all have to find a way to cope with those times when our best efforts are not enough, particularly in the case of sudden and unexpected death," he said.

"The aspect of Ross' death that was particularly upsetting was that he had a berry aneurism of an artery in the brain which usually leads to a massive stroke and virtually instantaneous death.

"However, there is a great deal of evidence to suggest that if such patients get to hospital in time they can be surgically treated and they can survive and there was every reason to believe that Mr Shelmerdine would be such a patient.

"As a junior doctor I didn't have much experience with death and it felt profoundly unfair to me; he was relatively young, he was very fit, and therefore he should have lived.

"Fortunately, in the rest of my career as a breast cancer surgeon, all the patients I have treated who have died, have died at the right time and for the right reasons while we can both share and celebrate the small wins we have achieved along the way.

"As surgeons we don't talk about those deaths that we find particularly upsetting but I'm sure we have all experienced it at one time or another and though with time comes wisdom this death never really left me."

Recently, however, a combination of Mr Gregory's twin, though disparate, interests – sculpting and cycling – led to a serendipitous opportunity to both bring personal private closure while honouring Mr Shelmerdine and his family.

Many years ago, Mr Gregory took up cycling and now belongs to a club that takes vigorous regular rides and races along Melbourne's bay-side boulevards or up into the Dandenong ranges.

Four years ago, in search of another outside interest and desirous of exploring the world of art, he also took up sculpting, learning from the highly-regarded sculpture Barbara McLean, the woman behind the busts of the legends on display at Melbourne's tennis precinct.

Two years ago, Mr Gregory met a new woman cyclist who had just joined the group and over a coffee realised she was one of the daughters of Ross Shelmerdine.

Later, he would learn that Lindy had been with her father on their farm outside Melbourne when he collapsed and that he had died when she was only 16.

"When I realised the connection I immediately felt very sad for her because we weren't, as a profession, very good at communicating with grieving families in those days and sometimes surgeons didn't even see them," Mr Gregory said.

"At the same time, when we first began talking about her father I was worried that it would bring back upsetting memories for her but she was grateful to be able to talk to me about it and learn the physiological processes involved.

"Later, as we got to know each other we realised that we also shared an interest in sculpture.

"Her family are major collectors – and also major benefactors to the Royal Melbourne Hospital – and when I told Lindy that I had loved the sculptures scattered through the grounds of the family estate in Red Hill during an Open Day she gave me a book about them.

"I then wanted to repay the gesture and so began working on a sculpture of Ross for the family."

Mr Gregory, who creates his pieces using clay, then a wax mould and either plaster-of-paris or bronze, began the work early last year, basing it on photographs provided by the family.

The now completed piece is a profile bust of Ross Shelmerdine, mounted on granite.

He presented it to the family in October.

"I did this for two reasons," he said.

"I wanted to give him back to the family who had obviously grieved him deeply and I thought it might be healing for us all.

"On the day I gave it to them, we all sat around, his wife and sons and daughters, and after I explained my connection they all began to reminisce, remembering where they were when they heard the news and laughing and crying.

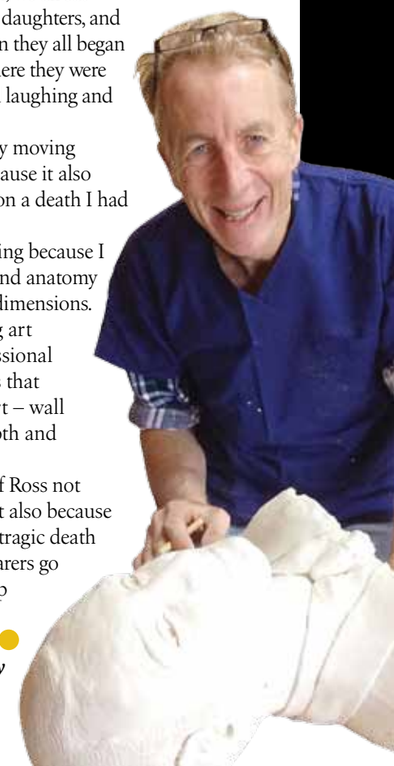
"They seemed to find it very moving which was pleasing to me because it also allowed me to close the loop on a death I had grieved for for many years.

"I originally took up sculpting because I know form, shape, variation and anatomy and wanted to work in three dimensions.

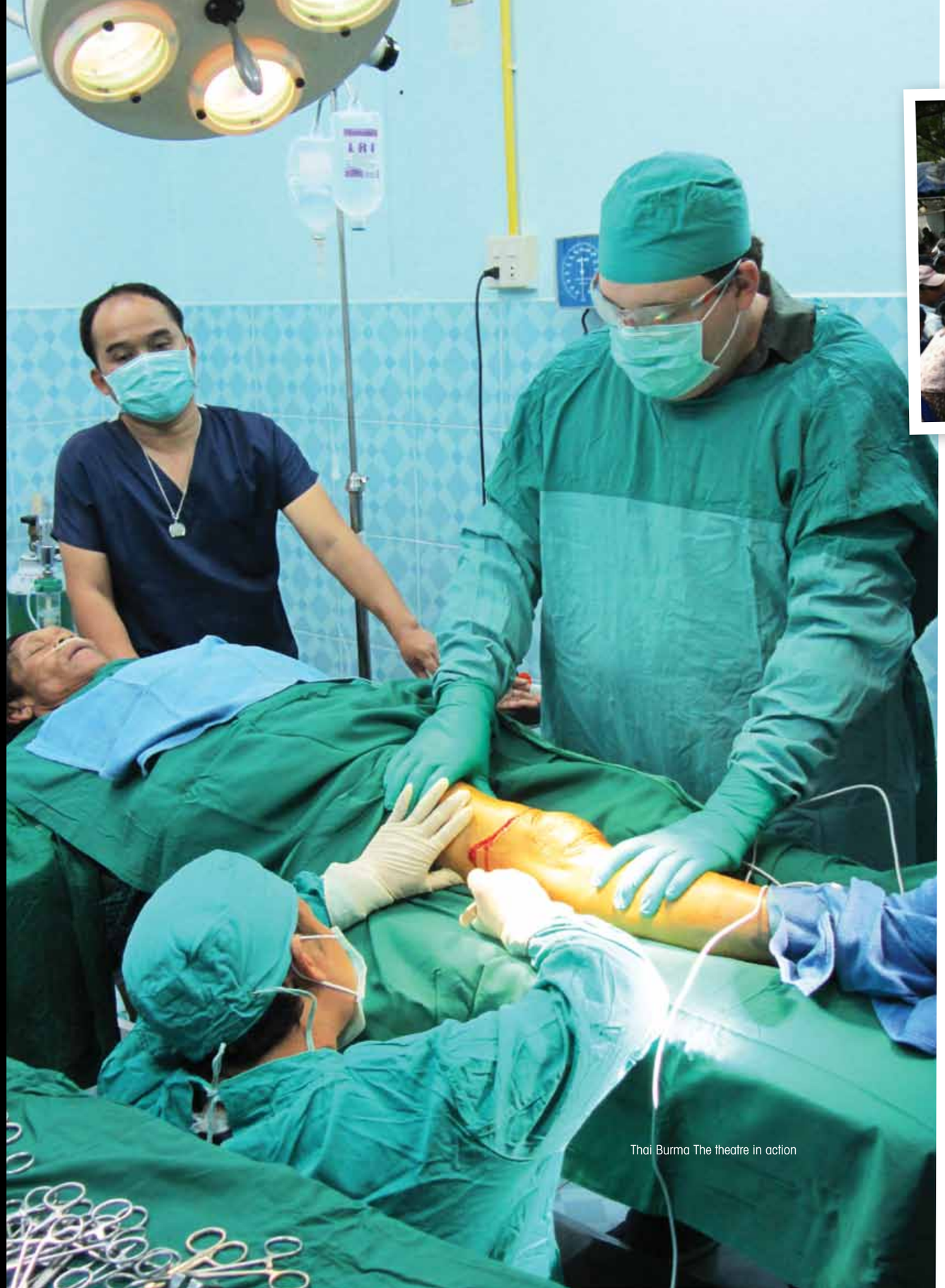
"Yet whether you are doing art for personal interest or professional employment the fact remains that there are only two types of art – wall candy or works that have depth and meaning.

"I wanted to create a bust of Ross not only as a gift to the family but also because this work speaks of a sudden tragic death as well as what doctors and carers go through in their efforts to help others and the pain they feel when they are unsuccessful."

With Karen Murphy

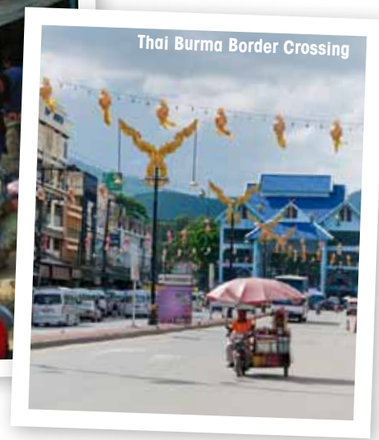


summer lifestyle



Thai Burma The theatre in action

Thai Burma People waiting to be seen in clinic



Thai Burma Border Crossing

A Hospital on the Edge

A Trainee's experience at the intersection of two countries

Mae Sot, a thriving border town on the Thai side of the border with Myanmar (and the setting for the last Rambo movie) is home to the Mae Tao Clinic (MTC), a non-government organisation (NGO) hospital that provides free healthcare to Burmese refugees and migrants.

Having decided to interrupt my SET training I accepted a one-year assignment with MTC, through Australian Volunteers International, as part of the Australian Volunteers for International Development (AVID) program, an AusAID initiative.

Although not a tourist destination Mae Sot is bustling with 'farang' (the Thai word for foreigner). This is thanks to the 100 plus NGO situated in and around the town. Mae Sot is a melting pot of Westerners who have all flocked to deal with the humanitarian crisis on the Thai-Burma border; doctors, engineers, even architects and accountants.

It is also a melting pot of Burmese ethnic minorities who have left the upheaval of their homeland for the safety and prosperity of Thailand. Mixed in with this are the ever friendly Thai shop owners, business people and the army rangers who guard the border down near the local market (who can often be seen enjoying a cool ice-cream while an M16 is strapped to their back).

Across the river in Myanmar is Karen State, home to the world's longest running civil war (some 60 years long), however negotiations earlier last year have brought some respite to the war weary population. Despite this, the hospital's workload continues to increase.

Mae Tao Clinic is situated down a muddy puddle ridden driveway (replace with dusty pot hole ridden driveway if visiting in the dry season) off the main road that runs through the centre of Mae Sot. Easy to miss from this main road, the MTC hospital campus sprawls out behind roadside Burmese teashops and song-tau and motorbike taxi stations.

A collection of dilapidated buildings house the various wards and departments as well as the dedicated local and international staff who achieve so much with the hospital's scarce resources. Thankfully being in Thailand we enjoy constant running water and electricity.

From humble beginnings as a one-roomed roadside clinic, established by Dr Cynthia Maung in 1988, the place has grown into a small regional hospital with medical, paediatric, obstetric and surgical wards and outpatient departments, as well as a psychological counselling centre, prosthetic workshop and small pathology laboratory.

It has even evolved into a teaching hospital, training its own local Burmese workforce of highly skilled medics, and well as community healthcare workers and backpack medics who venture into the villages in Burma and the hospital's satellite clinics.

MTC has extended even further from its roots as a clinic to be an NGO that also runs several large migrant schools and boarding houses and even co-ordinates child protection, women's and other social projects.

My AVID volunteer role in the hospital centres mostly in the MTC trauma and surgical department, which treats around 8,000 patients a year (one of the quieter departments). The workload encompasses mostly minor trauma, wounds and ulcers, fractures (although we have ▸

summer Sojourn

no x-ray machine, but these can be obtained at a cost from the Thai government hospital), as well as common surgical conditions such as herniae, hydroceles and 'Karen Viagra' (the local lads believe that injecting palm oil into the skin of their penis will enlarge it, however they mostly end up with nasty complications).

With no capacity for general anaesthetic, I have learnt that much can be achieved with well-placed local anaesthetic and basic surgical instruments. Our only dressing option is gauze pads, which the staff make by cutting up and sterilising large rolls of gauze dressing.

MTC has developed a reputation in Burma as the place to go for a hernia operation and not a day passes without at least one inguinal hernia repair on the theatre list. With no opiate analgesia patients stoically assist each other to get around the ward and endure their pain with a quiet dignity.

The ward is crammed with post-op patients, either our own or those from other hospitals who could no longer afford the care, as well as patient's with deep seated wounds or ulcers that require intensive dressing changes and those with terminal cancer and other illnesses who leave our department wrapped in a bamboo mat.

The ward has a background stench of gangrene mixed with the smell of the wet season mould, but despite all this the mood in the ward is often jovial and there is a great sense of community amongst the patients and their carers.

A stray cat has made its home in the ward, sleeping on empty beds or unoccupied chairs. He has come to endear himself to the local staff, apart from when he decides to battle other cats in the roof of the theatre room, threatening to bring the whole thing crashing down on our operations.

The operating theatre is a small windowless room tacked onto the edge of the ward. The humid wet season means that our operating gowns rarely fully dry between uses, but the theatre enjoys one of the few air conditioning units at MTC, essential for operating in the hotter months.

Recent encouraging political changes in Burma celebrated by the world's media but approached with a more cautious optimism by locals have had a paradoxical effect on MTC.

With a still steadily increasing demand for its services MTC has seen its funding cut as international donors turn their attention away from border projects and re-focus on projects within Myanmar.

This has left the clinic with an uncertain future. In particular the surgical and trauma department will run out of funding in December. This is certainly an interesting time to be working in this region of the world. With the world's media focused on Burma hopefully problems along the border are not forgotten and MTC can continue to perform its vital work.

For more information on MTC or to donate please go to www.maetaoclinic.org.

For more information on the AVID program go to www.ausaid.gov.au/volunteers or www.australianvolunteers.com

AusAID is working in partnership with Australian Volunteers International to deliver the AVID program.

The views contained in this article are those of the author and do not represent the views of AusAID or the Australian Government.

Anthony Cardin
SET Trainee in General Surgery (Victoria)

Image 1

Image 2

Image 3

Image 1: image of eclipse between 10 and 6 o'clock

Image 2: eclipse between 9 and 5 o'clock

Image 3: The full image of the sun and the solar flare. It is almost the same as the eclipse illustration in Wikipedia of Eddington's 1919 image from Africa which was claimed to confirm Einstein's theory of General Relativity. As Stephen Hawking tells us, gravity is the mainspring of the universe in the equation of space and time. It can bend light waves and it was concluded that this bending of light waves apparently confirmed the theory. I just happened to be a century behind these master minds with my own observational findings.

Surgical Silhouettes

The Eclipse - An alternative focus on excisional defects

On the morning of the recent solar eclipse (14 November 2012) – I had an interesting experience in Parkville, without having to fly to Cairns to see this celestial event.

It should not be forgotten that on any workday morning, there are many personalities whom I meet, walking up and down Royal Parade from the various departments of the University of Melbourne, the Walter & Eliza Hall Institute and even the Monash University School of Pharmacy.

This contingent of academia (who can offer an opinion about anything or everything) – are the people I meet regularly. Yes, we exchange pleasantries. They are part of the passing parade of this magnificent boulevard.

Why was it called Royal Parade? The name was given in the 1870s in anticipation of the future location of Government House in the area now occupied by Melbourne Zoo at Royal Park. Developers scented potential profit and bought up land in the vicinity. As a result the government changed its mind and the location, placing the site in the vicinity of the Botanical Gardens along St Kilda Road.

I learnt this interesting detail years ago from the then chairman of ICI in London, who had relations in Australia. He used to visit them regularly, as well as my wife and myself. Needless to say, he had been an oncological patient of mine (and Ian Wilson's) at the Marsden in the 1970s and he was grateful for his surgical outcome.

Another frequent passerby is my colleague, Peter Doherty, whom I see regularly. On this occasion he had just returned from his umpteenth trip to the halls of academia, lecturing all over the world. As with

Borodin's work 'On the Steppes of Central Asia' – the English title for this symphonic poem of the 1880s – Peter conveys the impression of someone constantly on the move, mentally and physically, from the Asia Pacific and beyond.

He gave me a copy of his latest book called 'Sentinel Chickens – what birds tell us about our health and the world'. It recounts the importance of our avian friends, tracing them from Patten's original 1920s textbook on embryology of the chick, through to MacFarlene-Burnett's egg inoculation technique, to the importance of sentinel chickens left in the countryside to monitor the likes of arboviruses and mosquito inoculations and the Avian flu (H2N2 virus).

It is a bedtime storybook, full of pearls of wisdom and scientific facts from the helix on – pre and post – reflecting the wonderful world of experience of someone who bestrides the scientific world stage like a colossus, yet never losing the 'common touch', reflecting, I think, his unpretentious personality which has produced his success.

At 7.30 on that November morning, Laura Dean, a lecturer in the Department of Pharmacy Studies saw me fumbling with an X-ray film to create a filter for the damaging solar rays (which can cause blindness), in order to visualise the eclipse. Barbera Howlett from the Department of Botany (University of Melbourne) suggested I might make a career change.

The image was unsatisfactory as one could see the skeletal details on the single X-ray film. She suggested I use double X-rays to filter the light, and this proved to be the solution to the problem (one should always accept the advice of a lady). This resulted in a photographic series in a time-dated sequence of the eclipse.

Image 1 shows the shadow of the moon creating an elliptical defect between the clock-face positions of 11 and 7 o'clock. Image 2 is 15 minutes later showing this ellipse had moved through to the 10-6 o'clock position and then another quarter of an hour later between 9-5 o'clock. On the hour (Image 3), I took the final shot when the eclipse had finished. This pin-head disc of white intensity on the X-ray plate was the point of photographic focus and I did not realise its significance.

On viewing it through the viewfinder and magnifying the image with the camera by a factor of 12, I was amazed by what I saw. Mark Hinds, a research biophysicist from the Walter & Eliza just happened to come along and I shared this observational finding with him. His scientific response was quite simple – "I think you may have photographed the craters and solar flares from the sun's surface." – from a distance of 150,000km.

Yet, I was not using a heavy-duty Bronica, Hasselblad, Canon or Nikon camera (the Rolls-Royces of the international photographic brigade). I was using my 12 MP Casio Exilim camera, the size of a cigarette packet. I have it in my pocket constantly whenever I use it for clinical or social shots. It produces image quality suitable for textbook publication or lecture presentations. I regard it as my "Colt 45", ready to hand.

I have to make a declaration (not in the style of Oscar Wilde, who when asked by New York customs in the 1890s: "had he anything to declare?" replied, "Nothing but my genius").

My declaration here is that I paid for this camera and as I had to say before my recent presentations overseas (in Paris in October and London in December 2012), all my Powerpoint presentations were done with the aid of this Casio. There is no conflict of interest.

However, I must mention a little historical pearl about the digital camera story – Kodak of America developed this technology in 1977. The Chairman of the board at the time made the comment at that meeting that "nothing would replace film". How wrong he was. Kodak now is holding onto financial survival by its fingernails, trying to avoid bankruptcy – and yet it was one of the original stocks on the Dow 100 in the 1900's. Mark said it shows what happens when the board and scientists fail to communicate. Do not forget all NASA photographs are digital.

Worth a good story

Let me finish off with a piece of science from Aldous Huxley, who said that in any scientific environment, the fact we do not know its presence does not preclude its existence.

Most of my astronomical contacts said that the eclipse could not possibly be visible so far south. I am not even an amateur astronomer – I was just lucky. Osler's statement about observation encompasses it all, that all scientific advancement originates from incidental findings.

This principle was reinforced recently again when I read in *The Age* the obituary of Nobel Laureate Mme Levi-Montalcini (aged 103). She showed that when tumour cells from mice were transplanted to a chicken embryo, this induced rapid tumour growth; a simple observational finding for which she received the Nobel prize for the Nerve Growth Factor in 1986 in conjunction with Professor Cohen and his Epidermal Growth Factor. It's interesting in my own clinical sphere that the Keystone Flaps are all designed within neurodermatomal precincts.

Finally, let me state philosophically that an eclipse is a metaphor for a wipe-out. I sometimes find it hard to be a little self-effacing in these stories, but the ideas spring to mind and they become the genesis of a story. As Hemingway repeatedly said: "Any story based on truth is a good story and worth printing".

Opus XXIV

Felix Behan
Victorian Fellow

Making complaints against Health Practitioners

Are you protected?

Under the National Law dealing with registration of health practitioners, "complaints" can be made against health practitioners by patients, other health practitioners and anybody else with an interest in the complaint. There are also obligations to make a mandatory notification in certain circumstances.

The National Law contains provisions for strong protection against them for those who make a notification under the National Law, whether on a voluntary or mandatory basis.

A recent decision of the NSW Court of Appeal has tested the protections contained in the Medical Practice Act 1992 in New South Wales ("NSW Act"). The provisions of the NSW Act are substantially different to those contained in the National Law. While it was assumed that anyone who made a "complaint" under the NSW Act would be protected, the decision in Lucire v. Parmegiani & Anor [2012] NSWCA 86 has determined that the protection is not as extensive as originally thought. The Court of Appeal has determined that the complainant in this case, who made a "complaint" to the NSW Medical Board, was not protected and now could potentially be liable for defamation. The matter is now to be re-heard, as to whether a claim for defamation will succeed or not. However, the Court of Appeal has determined that the defence of "absolute privilege" does not apply.

The decision of the Court of Appeal has been decided on quite specific provisions in the NSW Act. The NSW Act has been quite strict in determining the particular areas and conduct which will be protected from claim. Based on the facts in this case, the particular "complaint" was determined not to be "in the process of dealing with (the complaint) by assessment, referral or otherwise".

"A recent decision of the NSW Court of Appeal has tested the protections contained in the Medical Practice Act 1992 in NSW"

Absolute protection from claim would only apply to communications made for the purpose of dealing with the complaint once it was made.

The decision is quite technical, and could well be confined to the particular facts and the particular provisions of the NSW Act.

The National Law, now applicable in all Australian jurisdictions, is a more extensive protection. Unlike the NSW Act, the National Law protects a person who, in good faith, makes notification under this Law. The National Law provides that such a person is not liable, civilly, criminally, or under an administrative process for giving the information.

Some commentators have suggested that the decision of the NSW Court of Appeal substantially weakens the protection for those who make a voluntary or mandatory notification to AHPRA or the Medical Board of Australia. That would be an over-statement. The provisions in the current National Law are substantially different from those which operated under the NSW Act and are formulated on a very different basis. It is, for example, absolutely clear that the protections given in Section 237 of the National Law apply to a person who makes a notification, which is a point of difference to that now interpreted as applying under the NSW Act.

The protection for people who make a complaint under the National Law still requires that the person who makes a notification does so "in good faith". This would not necessarily apply to someone who made a notification for an ulterior motive, such as to smear someone's reputation unduly, or who made a notification not believing the truth or accuracy of the material supplied. It is still open for the protection to be removed where the person making the notification is doing so vexatiously or maliciously.

So, to reassure those who wish to make a complaint under the current National Law, or who must make a mandatory notification under the National Law, it is doubtful that the recent decision in NSW detracts from the protections contained in section 237 of the National Law.

Michael Gorton,
College Solicitor

Thoughts on an ‘active retirement’

Rantings of a ‘retired’ surgeon

After having turned 60 during a period of long service leave from my public hospital roles in the Upper GI Surgery Unit at Monash Medical Centre and as a General Surgeon at the smaller Sandringham District Hospital, I realised that while I believe that I was still a useful member of these units, surprisingly they actually were able to continue to function quite adequately without me! Despite what some surgeons may seem to believe, none of us are indispensible.

Perhaps a new challenge was needed, especially as the younger surgeons, many of whom I had helped mentor through their Fellowships, showed that they were more than capable of managing the large complex cases that I had really enjoyed doing over the previous decades.

But what, I thought, can a surgeon do other than consult and operate just as before? Assisting? Medico-legal? These “semi-retirement options” certainly may appeal to some, but didn’t to me.

It just so happened as I was going through these musings that a younger friend and colleague mentioned that he was about to do a week’s locum in Kalgoorlie, WA.

I asked him more, became interested, contacted a locum agency, and did some short loca at Moruya and at Broken Hill in NSW, and at Mount Isa in outback Queensland and thoroughly enjoyed the change of pace and discovering the challenging breadth of rural and remote area General Surgery.

It also became very obvious that there are many places in Australia – mainly remote, but not only – that are desperately in need of a relieving surgeon to allow the incumbent to have some well earned R&R or to attend meetings and courses in their Professional Development. Professional burnout can be a real concern.

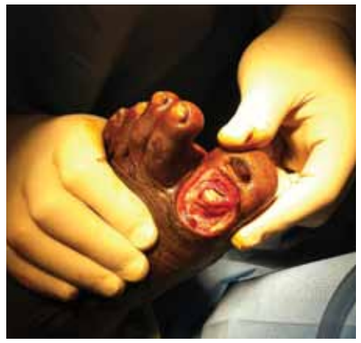
Indeed some places such as the very isolated resources boom city of Karratha in WA, population 16,000 and rising rapidly, have no resident surgeon at all. I now alternate with another surgeon from Perth so that they do have a consultative and operative service almost every second week.

At other times patients needing even the most ‘basic’ of surgical care such as appendicectomy or abscess drainage, need to be transported at huge expense to Port Hedland 250 km away, or if more complex, 1,500 km to Perth.

So, after some consideration especially of the domestic social and the economic aspects of it all, and I must say with a little trepidation as I saw this as a one way step, I took retirement from the public system, closed my private practice then embarked on what has proven to be my very satisfying new career of locum surgeon.

Certainly all is not a bed of roses: there are the periods of separation from family and friends, some frustrating days of unproductive travel, and of being usually on call 24/7 for a week or two at a time, missing out on my leisure activities with friends such as golf and watching Melbourne AFL (though many would say that I missed nothing in 2011 and 2012), and sometimes just a feeling of remoteness (which also has its positives).

Left: John Leslie enjoying some different travelling; Middle: a common problem in the outback.



I have sadly had to resign from the Board of AMA Victoria, which I had found enjoyable, fulfilling and enlightening, but have found it more and more difficult to attend meetings and so fulfil my obligations.

Fortunately I have been able to retain an Honorary Consultant role at Monash, which enables me to attend MDTs and Unit meetings when in Melbourne, maintaining contacts with colleagues and helping me keep up to date with the latest in surgery.

This has proven to be a small yet genuinely important support role in making my transition, and I would encourage others who may be making similar moves to consider this, and for hospitals to facilitate it.

Some degree of sanity can be maintained by email, internet and especially mobile phones which are a godsend in keeping in touch with all at home, and there is time to read, listen to music and relax, seeing new places that one may be unlikely to see in other circumstances.

Remote places such as Mount Isa, Broome, Karratha, Alice Springs and Broken Hill as well as the less isolated Griffith, Bathurst and Mildura, all have their own attractions.

I don’t mind air travel, build up a lot of Frequent Flyer points and other benefits, and the remuneration is certainly very good, without practice overheads.

When back in Melbourne there are not the regular and sometimes inconvenient phone referrals and calls back to hospital – one can just relax and really enjoy life.

Generally the remote hospitals, many of which lack most if not all subspecialties, have excellent support from the larger regional or capital city hospitals. Also the Royal Flying Doctor Service and other organisations such as Care Flight as well as the various rural ambulance services play an absolutely crucial role in maintaining a reasonable level of medical service to our remote and rural communities.

How it helps

Moving patients is incredibly costly, so having a well trained surgeon in a town can save the health system tens of thousands of dollars by managing just a single patient and avoiding the need for transfer, or sometimes even doing what is needed to enable the patient to be safely transferred semi-electively by the far less costly regular commercial air services.

Advice, especially from colleagues in other specialties, is always just a phone call away particularly when confronted by the unfamiliar and, most times, transport to a higher level of care can be arranged fairly quickly if needed.

The staff at the regional and remote hospitals have all been incredibly welcoming and supportive, and the patients genuinely appreciate the opportunity to receive all, or at least part of their treatment, without having to travel hundreds (or thousands) of kilometres with the resultant family upheaval, costs and loss of family support.

Locum surgeons are mainly either senior experienced people wanting a lifestyle change, or young ones who have just completed their Fellowships and are either “testing the water” or waiting for definitive appointments to become available.

At either end of the scale, locum surgical work provides a fantastic and satisfying opportunity to use one’s skills, test one’s limits, make a good living, and provide a really vital service to the Australian rural and remote communities. It may not be for everyone, but I would urge colleagues to at least consider this at some stage in their careers.

Here I have, of course, been speaking from a surgical point of view, but similar opportunities, and needs, are out there for anaesthetists, physicians, paediatricians, obstetricians, ED specialists, and generalists.

John Leslie
Victorian Fellow

International recognition

Developing curriculum to high standards

PHOTO: Royal College of Physicians and Surgeons of Canada

College representatives attending the International Medical Education Leaders Forum (IMELF) at the headquarters of RCPSC in Ottawa, 16 October, 2012.

Members of College educational groups have been working together over the past 18 months to develop a range of training resources that were showcased internationally in October 2012. At a series of meetings and conferences that took place in Ottawa, Canada, College representatives, Graeme Campbell, Chair Professional Standards, Phil Truscott, Chair of BSET, and Wendy Crebbin, Manager of Education Development and Research Department, and myself presented papers and workshops and participated in a range of discussions with leading medical education experts from many countries.

The conferences which we all attended were the:

- International Medical Education Leaders Forum (IMELF) 16 Oct 2012
- International Conference on Surgical Education (ICSE) 17-18 Oct 2012
- International Conference on Residency Education (ICRE) 18-20 Oct 2012

Areas of particular interest were the competency training standards (www.surgeons.org/media/18726523/mnl_2012-02-24_training_standards_final_1.pdf) and the teaching resources designed to enhance the teaching and learning of clinical decision making.

The training standards are unique in medical education. In a number of ways the College standards are quite different in their conceptualisation and design from the numerous 'milestone' projects that are common in a number of countries.

Unlike 'milestones', it was never intended that the College standards would be specific to either a specialty or a training level. The result is that the College standards document is compact in size and simple in language, both of which make it easier to use than many other training and assessment documents.

The abstract, authored by Wendy Crebbin and David Watters, 'Defining Standards for a competency based surgical training program', was selected as one of the top three abstracts of the ICRE conference and subsequently has been published in the December volume of the Journal of Graduate Medical Education (http://www.jgme.org/toc/jgme/4/4).

The teaching of clinical decision making is a challenge to medical specialists world-wide, and the fact that the College has developed the Clinical Decision Making course to address this issue drew a great deal of interest across each of the meetings.

- Graeme Campbell, Wendy and I were invited to conduct one of four workshops at the IMELF. The discussion and critique at this workshop was very productive and potentially could lead to further collaboration.
- At the ICSE Wendy was invited to present a paper outlining the model.
- At the ICRE Wendy presented a further paper.

The initial design of the teaching phases was developed as part of a collaboration with representatives of Royal College of Physicians and Surgeons of Canada (RCPSC) and the Royal Australasian College of Physicians (RACP) and is therefore potentially generic across most areas of medicine.

In the 10 days following those conferences Wendy visited faculty at the Wilson Centre in Toronto; at McGill University in Montreal; and Western University, London, Ontario. At each centre she received a very positive reception and a great deal of interest in our educational developments.

Faculty and researchers at each of those centres were particularly interested to talk with Wendy about the material on teaching clinical decision making and were keen to be involved in future developments in that area. It is intended that further workshop development of the Clinical Decision Making course, across medicine and surgery, will occur in Sydney In March, prior to the Conjoint Medical Education Seminar.

College members intending to attend the ASC in Auckland in May this year will be among the first to have an opportunity to participate in the Clinical Decision Making course which is being launched at the ASC.

Stephen Tobin
Dean of Education

New Library resources for 2013

More benefits for Fellows and Trainees

In 2013, the Library will be commencing a new range of subscriptions. The medical publishing market is changing and this presents some great opportunities for libraries, but also, unfortunately, the loss of a couple of very popular society owned journals.

Electronic book loans

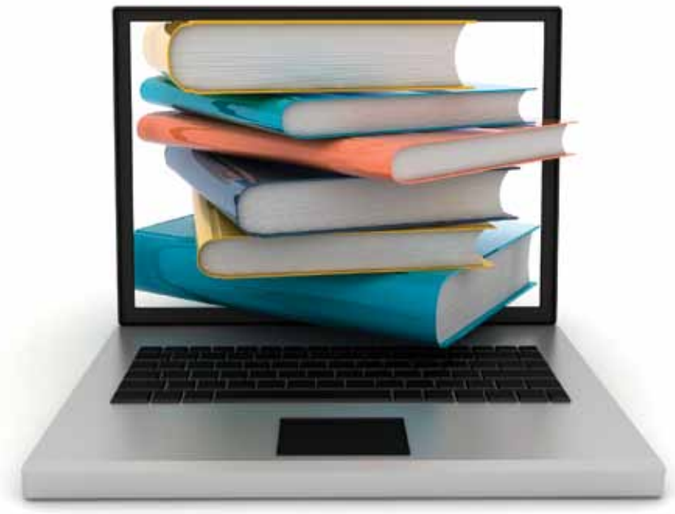
The Library is introducing downloadable books. Fellows and Trainees will have access to a broad medical library of e-books which can be downloaded as PDF files, and borrowed for four weeks (the PDF disintegrates at the end of the loan period). Books can be borrowed, renewed and reserved via the catalogue. The Library will be able to track what is borrowed and purchase these titles permanently. The Electronic Book Loans (EBL) system means that patron usage will drive what is purchased and the Library will be able to build up a strong collection of useful resources.

Society journals no longer available

One of the trends in specialty journal publishing has been an increasing unwillingness to allow the College to provide access to all our members via a single subscription, regardless of pricing.

The College has been advised that several key specialty journals will be unavailable after January 31, 2013. The journals are Plastic & Reconstructive Surgery, Diseases of the Colon and Rectum (DCR) and Journal of Trauma and Acute Care Surgery. These are key journals for the specialties, and convenient access to the latest content will be greatly missed.

The reason that these journals are now unavailable is because the Societies who own the journals will not allow the College to continue the subscription. The Societies who own the journals have made it known that they prefer to pursue an affiliated agreement with other relevant societies. Unfortunately, there has been no negotiation permitted.



The archives of these journals from Vol.1 (1) until January 2103 will continue to be available on the web site as usual but no new content will be added.

From February 2013, specific articles from the Plastic & Reconstructive Surgery, Diseases of the Colon and Rectum (DCR) and Journal of Trauma and Acute Care Surgery can be requested from the Library.

All other journal titles have been renewed for 2013 and will be available via the web site as usual.

New resources

The Library has added several new titles, specifically for the specialties affected by the loss of key society journals. The two new titles are Gastroenterology and Journal of Reconstructive Microsurgery which have often been requested in the past.

The Future?

Development of the Library is greatly assisted by feedback and acquisition requests from Fellows and Trainees. We make every effort to factor these into the Library's long term planning. However, some titles are not available online or with the kind of licence we need to offer access via the College web site. Increasingly we are also finding that we cannot get licences for some international society journals. Most recently, this has also happened at the point of renewal for titles for which the Library has historically had long term subscriptions.

The publishing market is changing. Some publishers have steeply increased their pricing due to pressure from the societies, and in a few cases the journal is not available at any price. Other publishers are making more of their products available online, but they also have very high expectations of what organisations are ready to pay. The College will continue to build Library resources as funding allows.

The College will continue to build Library resources as funding allows. *Email to College.Library@surgeons.org or by phone +61 (3) 9249 1272.*

Cathy Ferguson
Chair, Fellowship Services Committee

Loyalty and the Surgeon/Hospital Relationship

Public hospitals have lost the personal connection

Loyalty involves bilateral respect for the commitment to a cause by each party.

It may exist between citizens and a country, supporters and a football club or between an employee and employer.

This article discusses the unusual relationship that surgeons may have with a hospital, be it a public or a private hospital.

Many of the surgeons in the generation before I entered practice, treated their attachment to a public hospital with the same affection that they felt for their old school. In those days, an appointment to a public hospital was considered a great honour and, of course, their work was honorary.

Times have changed. Does loyalty exist in the modern hospital?

Since completing my FRACS, the hospitals I have worked in for over 30 years have generally assisted me in my practice by providing the where-with-all to do surgery, including the necessary peri-operative care. The public hospital has had collegiate benefits, perhaps the greatest of which is support in managing the difficult case.

The private hospitals have provided, in addition to the routine needs for surgery, new or novel equipment, have introduced case management and have encouraged referrals by arranging educational events to attract referrals to surgeons working in these hospitals.

These have seemed to be ethical and respectable arrangements. These arrangements have encouraged good working relationships. The hospital would respond to my needs and I would participate in hospital committees, accreditation and other administrative processes. This of course was honorary, but was seen by me as a return to the hospital for their assistance to me when needed. I am sure the majority of surgeons across Australia could tell a similar tale.

That earlier generation of surgeons, where true residency in a public hospital was the norm after graduation, where living quarters and meals were supplied and the wages and time off low, also curiously generated loyalty. This loyalty was perhaps, mainly to one's colleagues, but also to the institution.

After graduating to consultant status, surgeons expressed that same loyalty, still while working as honorary surgeons. I observed their willingness to attend Saturday morning ward rounds or meetings, presumably forgoing their children's Saturday morning sport.

Over my lifetime in surgery, the gradual shift to better wages, has come with the removal of assumed privileges, the most obvious being the doctor's dining room and, not surprisingly, free car parking. I am not sure how this was allowed to happen as I am sure any respectable trade union would not have tolerated it for one minute. Did management see it as elitist or as a drain

on finances? What may have been lost is a unique sense of belonging to a worthwhile institution.

In the public environment, I see that the separation of surgeons into their sub-specialty groups has resulted in little opportunity to convene with colleagues other than at occasional, formally called meetings which, from my observations, are poorly attended.

Sadly we now find ourselves in hospital environments where nobody knows anyone outside their special area unless having gone to school or medical school in a past life.

The Community

The doctor's dining room served as the knowledge exchange, the referral house, the social network, all terms little used then, but now part of modern conversation. Casual conversation at the dining table between a junior resident and the head of surgery may have at times given the senior man insight into a resident's view of the hospital functions and a conversation between a psychiatrist and an orthopaedic surgeon may have been enlightening to both.

For reasons I cannot fathom, name badges seem to have disappeared to be replaced by lanyards from which hang the hospital emergency numbers, various security passes, the house keys, a USB device and, oh yes, a small credit card with a name in microprint upon it. This paraphernalia then hangs at the owner's groin where the name tag is hidden or back-to-front. Trying to easily learn or remember a work colleague's name becomes almost impossible.

The change of titles from "Matron" to some incomprehensible title that gives no clue as to the relationship with nursing means that improving the doctor/ nursing communication for the benefit of the patient becomes well nigh impossible.

In my hospital I have been unable to have our names put on the outpatient desk to provide to the patient the simple courtesy of knowing who they are dealing with.

I have also been made aware from surgeons of the past generation that when a crisis in care led to a bad outcome, the then medical superintendent would counsel those involved from the wisdom of his experience.

That role is now occupied, in some hospitals, by non-medical graduates where it is unlikely that there will be any real comprehension of the issues other than protecting the public image of the institution and, dare I say, a manager's own career.

This isolation may leave the average visiting medical officer to see themselves as no more than the hired help to come and do his or her bit and to be given little encouragement to do more. It is the "little more" that enhances an institution and that develops a lasting mutual loyalty which provides benefits to all.

In my hospital our department has overcome some of these inadequacies by having bimonthly meetings in a private room at a restaurant. Registrar performance, research and other administrative matters are discussed. It has only been of recent times that this time has been acknowledged and surprisingly rewarded.

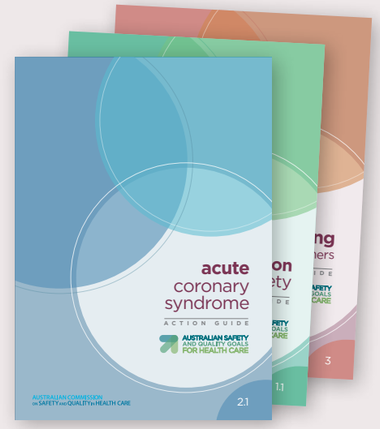
When community private hospitals flourish, often as the result of enthusiastic surgeons nurturing their private practice, but also contributing to the management of the hospital, they may morph into a clone of the large public hospital.

The prior open door opportunities to pass comment about what may seem minor matters is lost as the management moves to the 'executive floor'.

If the manager of a smaller private hospital cannot put aside time once or twice a year to see if a surgeon wishes to express some opinion which may enhance that hospital's efficiency or bottom line, then the opportunity to generate a sense of belonging is lost.

It is the sense of belonging that generates loyalty. In its own right I suppose, loyalty may not count for much, but if at the end of the week we as surgeons feel we have been appreciated and made a meaningful difference to someone's life through our activity, then there may be no greater satisfaction to be gained from our chosen career.

Bruce Love
Victorian Fellow



Australian Commission on Safety and Quality in Health Care

Towards the end of 2012 the Australian Commission on Safety and Quality in Health Care (ACSQHC) in response to a request from the Australian Health Ministers, identified a small set of national safety and quality goals which would improve healthcare over the next five years.

The goals agreed were:

1. Safety of care: healthcare without preventable harm;
2. Appropriateness of care: appropriate and evidence-based healthcare
3. Partnering with consumers: effective partnerships between consumers and healthcare providers and organisations at all levels of healthcare provision planning and evaluation.

As a result, the Commission has developed a set of documents to explain these goals including an overview and a series of action guides.

The Commission hopes that organisations, education institutions and hospitals will consider these capital goals when developing and implementing quality and safety improvement.

Further information is available from: www.safetyandquality.gov.au/our-work/national-perspectives/goals/

New Zealand Medical Assistance Team

Put your hand up

Major disasters when they occur have effects that can be devastating both in terms of morbidity and mortality. To assist with the health problems arising from a disaster a New Zealand Medical Assistance Team (NZMAT) is being established. Refer: ***www.health.govt.nz/nzmat***

A NZMAT will provide medical assistance for disasters domestically and internationally within the South West Pacific area. NZMAT is a civilian-based disaster medical assistance team comprising clinical and allied staff that include doctors, nurses, paramedics, allied health and non-medical members such as logisticians.

Counties Manukau District Health Board and the Pasifika Medical Association have been contracted to support the development of an NZMAT capability.

When will NZMAT be deployed?

The Ministry of Health has the authority to deploy a NZMAT, following a request from District Health Boards (DHBs) for domestic deployments or the Ministry of Foreign Affairs and Trade (MFAT) for deployment in the South West Pacific. NZMAT will provide medical support to the local population by integrating with and engaging with local structures.

During a deployment, Counties Manukau DHB will provide the operational base support for NZMAT in close liaison with the Ministry of Health. The Ministry will coordinate the overall national health response and liaise with DHBs, and the lead New Zealand government agency (such as the Ministry of Civil Defence and Emergency Management or the Ministry of Foreign Affairs and Trade) as required.

During a domestic civil defence event, an NZMAT will not replace the wide ranging support from the health sector to the affected DHB. An NZMAT may be deployed as part of this wider support and this will be coordinated within existing emergency management structures.

Most NZMAT deployments will depart from Auckland where team members will be briefed and issued appropriate uniform and personal equipment.

NZMAT members deployed in a disaster will have numerous skills and will be able and willing to work in a variety of settings in the community or in existing or temporary health facilities.

NZMAT Functions

The NZMAT functions adapted to the applicable emergency scenario may include:

1. Deploying an initial small assessment team consisting of a team leader and public health, clinical, and logistics experts to report back on requirements for health assistance.
2. Deploying a modular health response to support health services in the area overwhelmed by disaster within New Zealand or the South West Pacific, providing there is sufficient supporting infrastructure to accommodate and support the work of the team. Modules may include wound care, primary care, secondary care, public health and/or psychosocial support services as required and requested by the disaster affected area.
3. Providing back-up / surge support for trauma and surgical services in the affected locality when these are overwhelmed by a disaster, providing there is a health and accommodation infrastructure to support delivery of such services.
4. Working closely with other response agencies and authorities to ensure there is joined-up response and that an additional burden for support is not placed on the affected area by the NZMAT deployment.
5. Ensuring NZMAT is led by personnel trained and experienced in health disaster responses.
6. Developing and maintaining a self-sufficient NZMAT capable of deploying into an austere environment to deliver community-based services.

NZMAT members and training

The successful deployment of a NZMAT depends on the team members' ability to work together and be flexible in their roles. Potential NZMAT staff face demanding selection criteria before being accepted. These include fitness, the ability to work within a team, appropriate professional skill sets, the ability to multi-task and willingness to deploy for a minimum of one to two weeks at short notice.

The establishment of a NZMAT is a relatively recent occurrence and a number of new processes are still being implemented such as national databases and various protocols to ensure a coordinated response.

Counties Manukau is leading the development of logistic supply chain arrangements to support a deployed team.

For further more detailed information on NZMAT please link to the NZMAT Operations Manual via ***www.health.govt.nz/nzmat***

Interested in volunteering?

Registrations are invited from clinicians and supporting staff working in pre-hospital, primary, secondary and tertiary care settings within New Zealand.

Registering now will enable you to be considered for future NZMAT training, including attendance at domestic NZMAT Team Member training or Australian Medical Assistance Team (AUSMAT) training at the National Critical Care Trauma Response Centre in Darwin.

If you are interested in volunteering for NZMAT you must read the NZMAT Operational Manual in advance of registration in order to understand the requirements and obligations of being an NZMAT volunteer, including agreeing to abide by the NZMAT Code of Conduct specified in the Manual.

How to register

Register interest electronically through ***https://volunteerhealth.org.nz.***
All registrants will be expected to provide information including their professional skills and capabilities, previous experience in health disaster relief or work in developing countries, physical fitness, availability for deployment, vaccinations, passport details, driving licence details, contact numbers, postal, and email addresses, referees; and New Zealand practicing certificate numbers when these apply to the professional group concerned.

You need to allow 20 minutes or more to complete the Registration form once you have assembled the data required.

You will receive confirmation by email as soon as your registration is completed. You will be able to update or revise your registration at any time. Every six months you will receive a reminder notice to confirm your continued registration.

Note that registration on the database does not mean that you will automatically be selected for training or an NZMAT deployment. A confirmed registration will, however, mean you are known to the Ministry of Health Emergency Management Team and its agent Counties Manukau DHB (CMDHB) as a member of a pool of appropriately skilled and experienced people available to respond to a range of health needs in New Zealand or the South West Pacific. Some selected registrants may be invited to undertake mission-specific training or education.

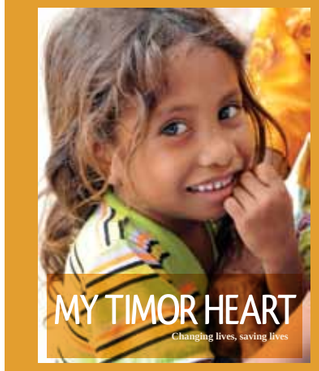
Volunteering in response to a specific event

Pre-registered staff who have been appropriately trained are the most likely to be deployed.

After the 2009 Samoan Tsunami, over 800 health sector staff volunteered to deploy and these all had to be manually managed and sifted for the skill sets required. In future the volunteer database will be used to manage volunteers for a specific event. Registration before an emergency is much preferred and will enable you to be considered for appropriate training and other roles and a more timely response mounted.

Email registrations will not be accepted because of the need to collect consistent data on volunteers' skills, experience, and attributes, to ensure that team composition is matched against needs in the affected area.

For more information please contact Judy.Fairgray@middlemore.co.nz



The College has produced a book, called My Timor Heart, to celebrate our achievements in Timor Leste. My Timor Heart recognises the extraordinary efforts of the medical volunteers in Timor Leste, and the life-changing impact their work has on people living in a country that continues to struggle with the legacy of years of civil war and violence. Using striking photographs and the words of the volunteers, the book tells the story of the many hundreds who have contributed to creating a healthier future for Timor Leste. My Timor Heart is edited by Ellen Whinnett, the Walkley-award winning journalist and Head of news at the Herald Sun. All profits from the sale of the book will go directly to the Timor Leste Program and fund essential surgical services and training opportunities.

Contact Emily Salt at +61 3 9249 1230 or emily.salt@surgeons.org if you would like to purchase the book.

Clockwise: Wyn Beasley presenting, enthusiastic attendees with the Cowlishaw program, Philip Sharp presenting a piece of the Thai/Burma Railway to President Mike Hollands;

PHOTO: John Aloysius Henderson

The Cowlishaw Symposium

The Symposium continues to raise its already high standards

The ninth biennial Cowlishaw Symposium was held at the College in Melbourne on Saturday, October 27. The venue was the Hughes Room and about 30 Fellows and guests were present. At 10am, proceedings were launched by Mr Wyn Beasley, Reader to the Cowlishaw Collection and founder of the Cowlishaw Symposium, which has become an important event on the College calendar.

The eleventh Kenneth Fitzpatrick Russell Memorial Lecture was this year delivered by Mr Gordon Low, whose topic was "Paintings from the Cushing / Whitney Library of Yale University". Mr Low discussed an important group of 19th century Chinese medical illustrations, painted by a Chinese artist for an American missionary doctor in Canton.

The first session wound up with a paper by the College Archivist, Elizabeth Milford, on the 17th century dialogue between body and soul, based on Robert Boyle's "A Free Enquiry into the Vulgarly Receiv'd Notion of Nature".

After morning tea, President Mike Hollands presented an interesting paper on Nicholas Culpeper, of Herbal fame, describing the enigmatic and contradictory aspects of his character. This was followed by a learned paper by Professor David Watters on the enduring influence of the eminent medieval surgeon Gui de Chauliac.

The afternoon session began with a paper by Mr Wyn Beasley entitled "Bach and His". The reaction of most delegates was "Bach and his What?", but "His" turned out to be Wilhelm His, the pioneer physiologist, who found and identified the remains of J.S. Bach in 1894. Modern computer-aided techniques have enabled a very accurate likeness to be made of the great composer, who died of complications following a botched cataract operation. After Mr Beasley, Professor Susan Neuhaus discussed the philosophy of witchcraft, her text being a 19th century English book of that name. The final session of the day was dominated by New Zealand, commencing with Mr Ross Blair discussing the contribution of Antonio Scarpa to the study of aneurysms, and concluding with Professor Alan Thurston on John Hunter and the establishment of the Hunterian Oration.

An important interlude in the proceedings was the presentation of a gift to the College by Mr Philip Sharp. This gift consists of a fragment of a sleeper with a dogspike from the Thai-Burma Railway, and is a memorial to the Fellows of the College who became prisoners of the Japanese during World War II.

Among the special guests were Mary Russell, daughter of Professor Ken Russell, and Virginia West, granddaughter of Dr Leslie Cowlishaw.

The traditional cocktail reception was held after the Symposium in the Council Room, where there was much discussion and analysis of the day's proceedings. The variety of subjects in this Symposium was very broad, and the standard of all the presentations was extremely high. The general consensus was that this year's Symposium was one of the best. Michael Troy even liked the coffee; what more need be said?

Marianne Vonau
Treasurer

Graduate Programs in Surgical Education 2013

The University of Melbourne and the College have joined forces

We are delighted to inform you that the Graduate Programs in Surgical Education offered by the University of Melbourne Medical School through its Department of Surgery and Medical Education Unit in partnership with the Royal Australasian College of Surgeons (RACS) is open for a new intake in 2013, Semester 1 (Feb – June).

This suite of programs addresses the specialised needs of teaching and learning in a modern surgical environment. The programs' content recognises the unique challenges that characterise the clinical settings and the advanced technologies that are increasingly important in surgery and surgical training. Effective teaching skills are essential attributes for educators responsible for training the next generation of surgeons in the complex sets of skills required for safe surgical practice.

The programs allow surgeons to gain formal skills in teaching and educational scholarship. The content reflects critical issues in the broader education community together with specific challenges for surgical education – the role of regulatory bodies, balancing clinical service with training, ethical imperatives for simulation-based education, safer working conditions including safe hours and more.

Applicants will also be considered from individuals in the following specialties – obstetrics and gynaecology, emergency medicine, radiology and ophthalmology. Additionally, applications will be considered from veterinary surgeons, anaesthetists and medical proceduralists.

For more information please visit the Academy of Surgical Educators home page on the College website at http://www.surgeons.org/for-health-professionals/academy-of-surgical-educators/

Royal Australasian College of Surgeons

2014 Rowan Nicks Pacific Islands Scholarship & 2014 Rowan Nicks International Scholarship

The Royal Australasian College of Surgeons invites suitable applicants for the 2014 Rowan Nicks Scholarships. These are the most prestigious of the College's International Awards and are directed at surgeons who are destined to become leaders in their home countries.

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

Applicants for the Rowan Nicks International and Pacific Islands Scholarships must:
- commit to return to their home country on completion of their Scholarship;
- meet the English Language Requirement for medical registration in Australia or New Zealand (equivalent to an IELTS score of 7.0 in every category);
- hold a Master of Medicine in Surgery, or his/her country's post-graduate qualification in surgery. However, consideration will be given to applicants who have completed local general post-graduate surgical training, where appropriate to the needs of their home country.
- be under 45 years of age at the closing date for applications.

Applicants for the International Scholarship must be a citizen of one of the nominated countries listed on the College website from December 2012.

Applicants for the Pacific Islands Scholarship must be a citizen of the Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu or Vanuatu;

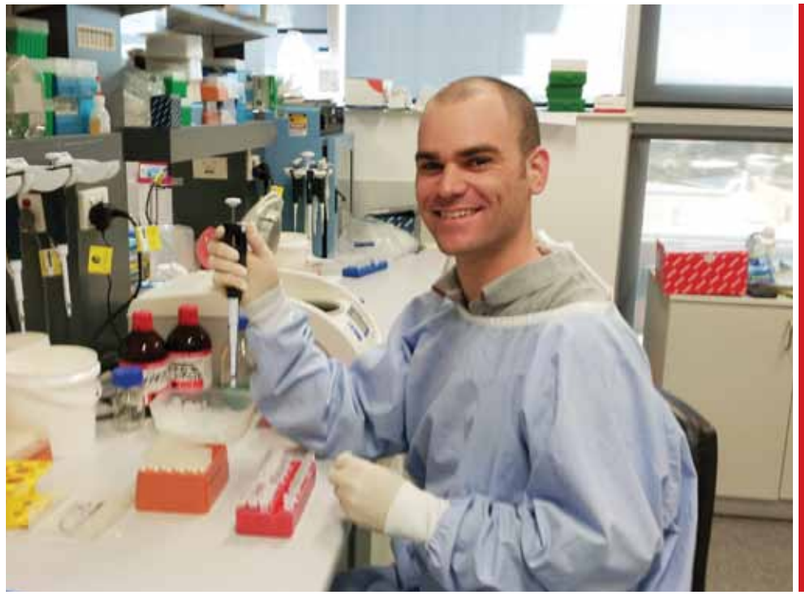
Selection Criteria
- The Committee will consider the potential of the applicant to become a surgical leader in the country of origin, and/or to supply a much-needed service in a particular surgical discipline.
- The Committee must be convinced that the applicant is of high calibre in surgical ability,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

Value: Up to $36,000 pro-rata, plus one return economy airfare from home country

Tenure: 3 - 12 months

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

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



profile

AWARDS
Dr Adam Frankel

2012 Covidien 'General Surgeons Group' Surgical Trainee Research Prize

2012 Raelene Boyle Sporting Chance Scholarship (RACS)

2012 William Burnett Research Fellowship for Surgery (UQ)

2011 Paul Mackay Bolton Cancer Research Scholarship (RACS)

2011 William Burnett Research Fellowship for Surgery (UQ)

2010 Paul Mackay Bolton Cancer Research Scholarship (RACS)

2010 PAH Cancer Collaborative Scholarship

Important markers

The College has helped this Trainee in his important research

Surgical Trainee Dr Adam Frankel has received three College Scholarships to support his research aimed at identifying biomarkers of prognosis in oesophageal adenocarcinoma (OAC), which now has the fastest rising incidence rate of any cancer in Caucasian Western populations.

According to US data from 2010, there were 16,640 new cases of OAC with 14,500 deaths, up six-fold since the 1970s. Similar trends are found in other Western populations including Australia. "Most cancer rates have remained relatively stable in recent decades, but OAC rates have increased dramatically," Dr Frankel said. "In terms of solid cancers, it has an extremely poor prognosis, up there with pancreatic and lung cancers.

"Though the reason for its rapid rise has not entirely been elucidated, there does seem to be a close correlation between OAC and gastro-oesophageal reflux disease (GORD) in Western populations, particularly in men. This in turn may be linked to the rising obesity rate.

"The most commonly agreed understanding we have for this connection is that men store fat in the middle, which increases intra-abdominal pressure, leading to acid being forced up into the oesophagus. After repeated episodes, this chronic cellular insult can contribute to the development of cancer."

Approximately 75 per cent of patients with advanced disease die within five years of diagnosis. The disease particularly affects white middle-aged men. Dr Frankel said two of the central problems facing clinicians in their treatment of OAC were that it often developed without early warning symptoms, and even patients deemed curable and given neo-adjuvant therapy and an oesophagectomy, generally still died within five years.

Using the scholarship funds provided through the College via the Paul Mackay Bolton Scholarship (2010, 2011) and the Raelene Boyle Sporting Chance Scholarship (2012), Dr Frankel has conducted his research using samples obtained from a tumour bank established by Professor David Gotley at the Princess Alexandra Hospital in Brisbane.

Dr Frankel described the tissue bank, a collaborative effort by the upper gastrointestinal surgery unit, as an invaluable, world-class collection.

He said that since it was established in the 1990s, patients with OAC were asked for permission to take samples of their tumour for the purpose of future study.

He said that the upper GI unit did approximately 35 oesophagectomies per annum, meaning there were now hundreds of samples to work with.

He also said the great advantage of such a tumour bank was that by the time the samples were accessed for research, long term survival data and complication rates were available for most patients.

Dr Frankel has undertaken his research as part of a PhD through the University of Queensland, under the supervision of Associate Professor Andrew Barbour, laboratory head of the Surgical Oncology Group attached to the UQ School of Medicine, and Dr Derek Nancarrow from the Queensland Institute of Medical Research.

He said he was now in the process of finalising his findings, which included the identification of some changes in the DNA of OAC that appeared to correlate with patient outcomes.

"In the future, we hope through work like ours, as well as other research being conducted in various parts of the world, to be able to send an endoscopic biopsy of the tumour to the pathology lab, which could then run a simple panel of tests to tell us the likely outcome of various treatment options," he said.

"Aggressive intervention is not appropriate for many patients. Unfortunately, current methods of investigating OAC, including fitness for surgery and pathological and radiological parameters, do not allow doctors to determine which treatment, if any, an individual should be recommended.

"An oesophagectomy is extremely invasive, involves considerable risk of serious complications, and can take a long time to recover from. Yet OAC patients can go through all this and one-third will still die within the first year, and another third in the second year.

"In other words, for at least some patients, our treatment efforts are having a significantly negative impact on the quality of their remaining life, at considerable cost, both in terms of time and money, for little if any benefit.

"If we had biomarkers that could indicate the likely outcomes of various interventions, we could know which patients to treat and spare others the pain, instead advising them to go home and make the most of their remaining time.

"As a surgical Trainee working in the Upper GI Unit, I received first-hand insight into the urgent requirement for improved patient/treatment matching procedures within OAC clinical management systems, and feel extremely fortunate to have received the support needed to conduct this research."

Dr Frankel said he hoped to have a paper outlining his findings published in 'Genes, Chromosomes and Cancer' early in the year, in which he will identify genetic biomarkers of significance which warrant further study.

This year he will be returning to general surgery training and he thanked the College for the support provided.

"I think these scholarships show great vision by the College in that they allow young surgeons to focus on research that is of great interest to us as a profession," he said.

"Medically-trained personnel are ideally positioned to conduct so-called 'translational' research, because we see problems on a daily basis in a clinical setting, and therefore we know the clinically relevant academic questions to ask.

"I hope to continue to have this wonderful mix of research and clinical work throughout my career, not only for the benefit that it may bring to future patients, but also because it is intellectually and professionally stimulating."

With Karen Murphy

2013 Training in Professional Skills (TIPS) courses

The TIPS course is a new program delivered by RACS that offers Trainees and International Medical Graduates (IMGs) the opportunity to:

- understand the importance of professional skills in surgical practice
- recognise what constitutes professional skills
- develop skills relating to professional competencies by practicing in a safe environment.

Seven of the nine defined surgical competencies are related to professional skills. As is the case for technical skills, competence in professional skills requires deliberate and repeated practice for expertise to develop – TIPS provides the setting and structure for that practice.

Learn techniques for working with patients and colleagues that can be applied to clinical practice. Participants have the opportunity to practice communication skills and teamwork in real-life scenarios and receive feedback and guidance from experienced instructors.

The TIPS course is recommended for all SET2+ Trainees and IMGs. Places are available on the following courses in 2013:

22-23 March, Melbourne
15-16 August, Sydney
28-29 May, Brisbane
23-24 September, Melbourne
25-26 July, Adelaide
22-23 November, Auckland

FEES

AUSTRALIA

Trainees: $1,320 (inc GST) **Non-Trainees:** $2,735 (inc GST)

NEW ZEALAND:

Trainees: $1,795 (inc GST) **Non-Trainees:** $3,710 (inc GST)

Registration on the waiting list is free and can be completed either via the online TIPS registration form (www.surgeons.org), emailing tips@surgeons.org or by calling Oana Cochrane on +61 (0)3 9276 7419. Confirmation will then be sent to eligible applicants.

TIPS
Training in Professional Skills

Cross country support

The inaugural program will provide cross-Tasman perspectives on the Indigenous health experience

This year's Annual Scientific Congress in Auckland will host the inaugural forum on Indigenous Health. This realises one of the important aims of the College Indigenous Health Policy: "to promote and support the inclusion of Indigenous people and Indigenous health topics at College conferences".

Fellows from across the specialities working in urban as well as rural and remote areas of Australia and New Zealand are already providing surgical care for Aboriginal, Torres Strait Islander and Maori people.

This forum will give voice to the substantial work being done; it will provide an opportunity to reflect, learn, and consider culturally appropriate and sustainable approaches to the health care we provide.

Importantly, it will send a positive message to Indigenous Australians and New Zealanders, policy makers and the public that the College is working towards fulfilling its commitments in achieving better health outcomes for our Indigenous communities.

The inaugural program will provide cross-Tasman perspectives on the Indigenous health experience. It also aims to highlight what the past may teach us as a College as we move forward in our engagement with Indigenous health.

We are very honoured that keynote addresses will be given by highly respected Indigenous and non-Indigenous academics and medical practitioners, including Dame Ann Salmond, Sir Mason Durie, Dr Jacob Jacob and Professor Helen Milroy.

The opening ceremony for the scientific program will include an official Maori welcome. This is an exciting prospect as this will be the first time that First Nation owners of the land on which the Congress is being convened, are invited to participate

As in past years, the Indigenous Health Committee will hold its face to face meeting at a local Indigenous organisation, to meet staff and to be informed of the work they do. This year the meeting will be hosted by the Hoani Waititi Marae. The marae is the traditional place of gathering for Maori people and is central to Maori culture and community activities.

Hoani Waititi Marae is a recognised leader in Maori medium education and is acknowledged internationally for its development of Indigenous education initiatives. Hoani Waititi enjoys the reputation of having created a number of successful alternate educational, training, health, social and justice initiatives as models for New Zealand.

The Indigenous Health Forum and Official Maori Welcome promise to be inspiring events and we invite all Fellows and Trainees to join us on this landmark occasion.

For further details on the Indigenous Health Forum, please visit the ASC website asc.surgeons.org/ , or contact the Indigenous Health Committee Secretariat at indigenoushealth@surgeons.org

Jonathan Koea
Member IHC and Convener ASC 2013
Mr Pat Alley
Member IHC and Co-Convener ASC 2013
Kelvin Kong
Chair Indigenous Health Committee (IHC)

ASC Indigenous Health Forum

Wednesday 8 May 2013
1.30pm – 3.30pm
Australia

Lessons from the Past

Professor Helen Milroy (Perth)
Helen Milroy is a descendant of the Palyku people of the Pilbara region of Western Australia and is the first Indigenous psychiatrist in Australia. She is currently Director of the Centre for Aboriginal Medical and Dental Health at the University of Western Australia.

New Zealand
The Journey So Far

Dame Anne Salmond
Anne Salmond is the Distinguished Professor of Maori Studies and Anthropology at the University of Auckland. Her collaboration with elders of the Te Whaanau-a-Apanui and Ngati Porou Maori tribes over many years led to three books about Maori life. In 1995 she was made a Dame Commander of the British Empire for Services to New Zealand History.

The View Ahead From Alice Springs

Dr Ollapalli Jacob Jacob (Alice Springs)
Ollapalli Jacob Jacob is a general surgeon at Alice Springs hospital and senior lecturer at Flinders University. His current clinical and research areas of interest are trauma, acute pancreatitis and delivery of surgical services to Indigenous people across barriers of distance and culture. Dr Jacob is the Director of Surgery at Alice Springs Hospital.

New Zealand
The View Ahead

Sir Mason Durie (Palmerston North)
Mason Durie is a member of the Rangitane and Ngati Kauwhata (Maori) tribes. He is a Fellow of the Australian and New Zealand College of Psychiatry and has been actively engaged in mental health research and policy for more than two decades. In 1993 he established a Maori Health Research Centre that has provided national leadership in outcomes research and research into mental health service delivery. Professor Durie recently retired as Professor of Maori Research and Development and Deputy Vice-Chancellor at Massey University.

CONGRATULATIONS on your achievements

Associate Professor Graeme Richardson FRACS FRCSEng
Royal Australasian College of Surgeons medal for service

Graeme Douglas Richardson graduated MB BS with Honours in all subjects from the University of Melbourne in 1968 and was awarded the Ryan Prize in Medicine and Surgery. He undertook surgical training at the Royal Melbourne Hospital and after a number of memorable rotations including to Papua New Guinea he became a Fellow of the Royal Australasian College of Surgeons in 1973. He continued his surgical training in the UK from 1974 to 1976 and was a registrar in vascular, general and urological surgery at the Colchester and District Hospitals for 21 months. Graeme became a Fellow of the Royal College of Surgeons, England in 1974.

In 1976, Professor Richardson returned to Australia and became a Visiting Medical Officer at the Wagga Wagga Base Hospital, the Calvary and the Narrandera District Hospitals in New South Wales. He became only the second rural-based vascular surgeon in Australia and developed a strong vascular service in the Riverina. He has been a pioneer in vascular ultrasound and has gained an international reputation in this field.

Graeme has had a special interest in the clinical and laboratory research into all aspects of venous disease, particularly chronic venous insufficiency and pelvic varicose veins. He has been the supervisor for a PhD thesis in the quantification of chronic venous insufficiency. Graeme has been a frequently invited lecturer and has given numerous presentations. He has published numerous articles in vascular journals and three chapters in textbooks on venous disease.

Graeme Richardson has been very active in College affairs, surgical education and training and in clinical governance. As an educator he has been a driving force behind the Rural Clinical School for the University of New South Wales and has been instrumental in educating countless medical students for 30 years. He has also had a senior role in the Institute of Medical Education and Training in New South Wales.

Graeme has been a highly regarded trainer and mentor for registrars and young clinicians. He has played a central role in the development and implementation of the Early Management of Severe Trauma program in rural areas. Graeme has been a convenor of the Rural Section of the RACS Annual Scientific Congress and has played a prominent role in the Provincial Surgeons of Australia. In 2010, Graeme received the NSW Regional Committee Merit Award for his contribution to surgical affairs in NSW.

In 2000, Graeme was appointed as Senior Lecturer in Surgery for the University of New South Wales at the Wagga Wagga campus and Chairman of the Learning Management Committee. In 2002, he was appointed Associate Professor of Surgery of the University of New South Wales Rural Clinical School in Wagga Wagga.

Graeme Richardson has always had a strong interest in clinical governance and for many years was Head of Department of Surgery at Wagga Wagga. In 2005, Graeme became Staff Specialist Surgeon and Director of Post Graduate Training at the Wagga Wagga Base Hospital.

Graeme Douglas Richardson has made an enormous contribution to surgery and teaching and is a worthy recipient of the RACS Medal.

Citation kindly provided by Mr Joseph Lizzio FRACS

ERRATUM: In the last issue of Surgical News for 2013, the wrong image was produced for the citation of Mr Richard Bennett (pictured here).

Surgical News
always welcomes letters from readers.

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

Medical Ethics and Futility

This is the conclusion of a lecture on 'Medical Ethics and Futility' presented by barrister Michael Nicholls QC at last year's joint WA/SA/NT Annual Scientific Meeting

In this lecture Mr Nicholls addressed a series of difficult ethical questions that might confront the medical practitioner, questions born of the duty to preserve life, but complicated by the need to distinguish between treatment which is medically 'heroic' and that which is 'futile'.

Mr Nicholls, who divides his time and practice between Perth and England, specialises in the areas of family law, international family law and medical ethics. He has kindly allowed the College to reprint his lecture notes in *Surgical News*.

When opinions might be divided between calling proposed treatment futile and calling it an heroic effort, does the law help the doctor? Is there some objective standard that must be observed?

The law tends to look to minimum acceptable standards, not the best. Once duties, the scope of which has been defined, are undertaken, they must be carried out to those minimum acceptable standards. Patients may look for more than that, but the law does not.

A medical practitioner will ordinarily be held to owe a duty of care to a person who is a patient of that practitioner. To fulfil that duty of care, a doctor must exercise reasonable care and skill in the provision of advice and treatment.

In the West Australian case of McCann v Buck[1] in 2000, Macknay DCJ set out the following:[2]

> A medical practitioner will ordinarily be held to owe a duty of care to a person who is a patient of that practitioner:
>
> The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all ways in which a doctor is called upon to exercise his skill and judgment'; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case.
>
> I particularly want to stress the words "single comprehensive duty covering all ways in which a doctor is called upon to exercise his skill and judgment" because it plainly brings decisions which involve considerations of futility within the scope of the "single comprehensive duty".

What is the minimum acceptable standard?

Macknay DCJ went on to adopt the following to describe the standard of skill and care required:

> The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill.
>
> From that I take it that the standard which the medical practitioner must meet to fulfil his duty of care is that of the ordinary doctor, skilled in the specialty in question.
>
> In what is called the "Bolam" test, the position was set out as follows: a doctor who has acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question is not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique.[3]
>
> Mere personal belief in the efficacy of the treatment will not be enough; the belief has to be supported by reasonable grounds.[4] So it is an objective, not subjective, test.[5]

The duty to preserve life

The law has something to say about the duty to preserve life: the doctor's common law duty when assuming the care of a patient is not to do everything possible to preserve life, but to take such steps as other reasonable doctors would have taken to save or prolong life in the same circumstances.[6]

It is however plain that failure to give treatment when it is appropriate to treat may well be unlawful, even if in general terms an omission to act to prevent death does not give rise to criminal charge. The difference is in the duty to act.

At some point, death is not the worst enemy.[7] Defining that point is the problem. Futility in the face of death may be relatively easy, but futility in the face of an unacceptable quality of life quite another.

The duty to incompetent patients

Many patients in respect of whom a question of futility will arise are incompetent, either by reason of age or illness. The doctor's duty in caring for an incompetent patient is clear – he must act in the patient's best interests – that is the core of the doctor's duty, and is the determinant of whether or not to continue treatment.[8]

Summary

A doctor may withdraw or withhold treatment if it is "futile to continue or the patient has no hope of recovery."[9] However, the circumstances in which courts have been involved have usually been rather extreme, for example, the patient has been in a persistent vegetative state – see Garder; BWV[10] in which Morris J accepted that it was lawful to withdraw "futile" treatment – had it been necessary (his determination was based on a statute) he would have applied the "everyday judgment of the fair-minded person".[11]

Who decides if the standard has been met?

It is not a peer review. That was emphasised in the Australian case of F v R[12]:

> The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.

So in Australia, the question of whether a decision to withhold treatment on the basis that it would be "futile" is one which conforms to the standard of reasonable care and skill of the ordinary doctor is one for courts to answer, not doctors.

So for a court to ascertain the precise content of this duty in any particular case it will be necessary to determine, amongst other issues, what, in the circumstances, constitutes reasonable care and what constitutes ordinary skill in the relevant area of medical practice.[13]

That means that the law recognises that when asking whether what a doctor did met the requisite standard, different considerations will apply to different circumstances – there is a lot of difference between an emergency and a case in which there is ample time to reflect.[14]

Doctors treating themselves

It seems that doctors themselves are willing to let go rather earlier than they might be willing to let their patients slip away. Doctors, it seems, do not generally want the treatment they prescribe for others – see "Doctors Die Differently: Why and How."[15] The reason for this seems to be that when doctors are deciding for themselves, they have no one else's expectations to meet and they are better informed.

References

1. [2000] WADC 81.
2. Para. 122, citing Rogers v Whitaker [1992] HCA 58; (1992) 175 CLR 479, 483 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.
3. Taken from the headnote to Bolam v Friern Barnet Hospital Management Committee [1957] 1WLR 582 (McNair J.). "Mr Fox-Andrews put it in this way, that in the case of a medical man, negligence means failure to act in accordance with standards of reasonably competent medical men at the time." That is a perfectly accurate statement, as long as it is remembered that there may be now or more proper standards; and if he conforms to one of those proper standards, then he is not negligent."
4. ibid., p.587.
5. In this context, it is helpful to look at how the definitions in the Health Practitioner Regulation National Law (WA) Act 2010 (No 35 of 2010) measure or set professional standards by using the comparator of the "standard reasonably expected of a health practitioner of an equivalent level of training or experience":
   – unsatisfactory professional performance, of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience:
   – unprofessional conduct, of a registered health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes —
   (d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being:
   professional misconduct, of a registered health practitioner, includes —
   a. unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
   b. more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience.
6. In the Bland case Lord Keith said of the sanctity of life that it does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering.
7. The Declaration of Geneva, 1994, puts the "health of my patient" as a doctor's first consideration. The International Code of Medical Ethics (1983) requires a physician always to bear in mind the obligation of preserving human life. The Declaration of Tokyo (1975) makes it clear that "The doctor's fundamental role is to alleviate the distress of his or her fellow men…" "It is the duty of the physician to promote and safeguard the health of the people. (Helsinki Declaration, 2000).
8. "Four of the Law Lords in Bland regarded the Bolam test as a central factor in determining the doctor's duty, that is, in determining whether to continue treatment is in the patient's "best interests" – Kennedy & Grubb, "Medical Law" 3rd ed Butterworths, London, cited in Skene, "Law and Medical Practice", Lexis Nexis Butterworths, 3rd ed. 2008
9. "The third case in which it is lawful to with draw or to withhold treatment is where the treatment is futile." Skene, "Law and Medical Practice", Lexis Nexis Butterworths, 3rd ed. 2008
10. [2003] VSC 173
11. at [93].
12. (1983) 33 SASR 189 at 194 (King CJ) (approved in Rogers v Whitaker).
13. Gaudron J in Rogers v Whitaker at 492.
14. In Sheppard v Swan [2004] WASCA 215, EM Heenan J referred to the duty of care saying that different considerations will apply to advice and recommended treatment in the different situations of emergency treatment on the one hand, and those cases where there is time and opportunity to consider different treatment strategies on the other hand.
15. Psychiatric Times, Vol. 29, No. 6 (29 June 2012), Arline Kaplan.

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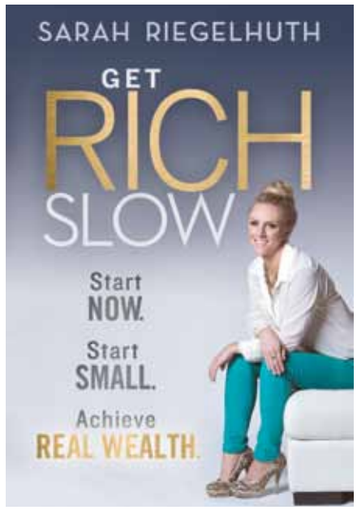

Get Rich Slow: Start Now, Start Small to Achieve Real Wealth

Sarah Riegelhuth
9781118406168 | Pbk | 240 pages
November 2012

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

This book will show you how to take control of your finances and grow your wealth using nothing more than a few key principles and commonsense wisdom. It shows you how to let go of easy excuses, stop waiting around for magically simple solutions, set intelligent financial goals, and design an action plan that you can follow through to completion. Using a storytelling approach, it shares the financial experiences of the author and her clients, guiding readers through the tools and tactics necessary to effect positive financial change in their lives. Although focused on personal finance goals, the lessons here easily translate to life itself.

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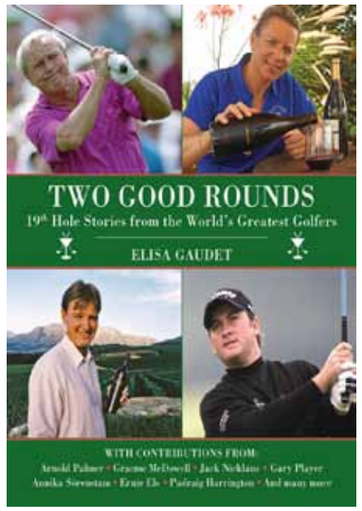

Two Good Rounds: 19th Hole Stories From the World's Greatest Golfers

Elisa Gaudet
9781616086411 | Hbk | 192 pages
December 2011

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It has long been a tradition after a round of golf to gather together and celebrate a win with a second round at 'the 19th hole' or pub as it's better know! In each chapter of this book a high-profile professional golfer discusses their memories of the 19th hole. The results are funny, surprising and heart-warming! A must-read for all golf lovers.

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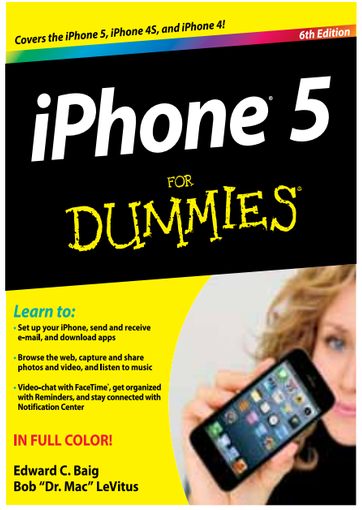

iPhone 5 For Dummies, 6th Edition

Edward C. Baig, Bob LeVitus
9781118352014 | Pbk | 416 pages
November 2012

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

Completely updated and revised to include iOS 6, iCloud, and the latest iPhone 5 features, this full-color book is your guide to all things iPhone. Bestselling veteran authors Edward Baig and Bob "Dr. Mac" LeVitus introduce you to the capabilities of the iPhone for making phone calls, browsing the Internet, sending and receiving e-mails, working with the calendar, watching and recording HD videos, taking and editing great photos, and much more.

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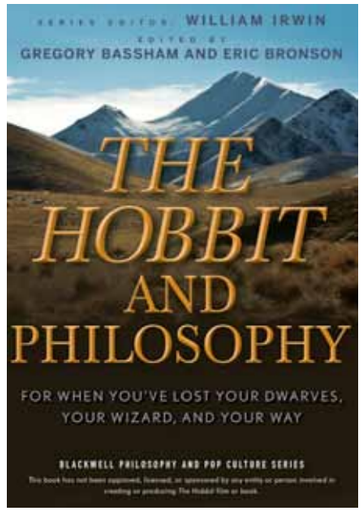

The Hobbit and Philosophy: For When You've Lost Your Dwarves, Your Wizard, and Your Way

Gregory Bassham, Eric Bronson
9780470405147 | Pbk | 272 pages
September 2012

~~AU$22.95~~ | **AU$17.21**
Member Price

J.R.R. Tolkien's The Hobbit is one of the best-loved fantasy books of all time and the enchanting "prequel" to The Lord of the Rings. With the help of some of history's great philosophers, this book ponders a host of deep questions raised in this timeless tale.

- Gives you new insights into The Hobbit's central characters, including Bilbo Baggins, Gandalf, Gollum, and Thorin and their exploits, from the Shire through Mirkwood to the Lonely Mountain
- Explores key questions about The Hobbit's story and themes, including: Was the Arkenstone really Bilbo's to give? How should Smaug's treasure have been distributed? Did Thorin leave his "beautiful golden harp" at Bag-End when he headed out into the Wild? (If so, how much could we get for that on eBay?)

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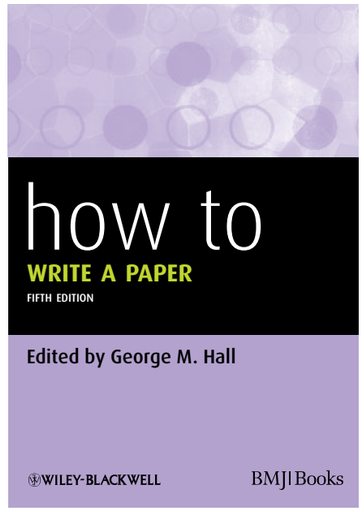

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The Royal Australasian College of Surgeons seeks an **ORTHOPAEDIC SURGEON** to work in Timor Leste (East Timor)

Are you up for the challenge?

If you are:

- A formally qualified and registered Orthopaedic surgeon (a Fellowship in Orthopaedic Surgery or equivalent qualification)
- Keen and experienced to teach junior medical staff
- Passionate about assisting in the development of an orthopaedic surgical service
- Sensitive and adaptable to cultural differences
- Available for deployment in early 2013 for at least 12 months

... then we would love to hear from you!

ACTIVITIES

The Faculty of Medicine and Health Sciences of the National University of Timor Leste has started delivering an 18-month course leading to the Postgraduate Diplomas in Surgery. Orthopaedic surgery forms an important part of this PG Diploma. RACS is an important implementing partner, funded by AusAID, the Australian Government's overseas aid program. An experienced and passionate Orthopaedic Surgeon is required. Your role has two main aims; you will mentor and teach junior doctors enrolled in the Postgraduate Diploma in Surgery together with national and other international faculty and you will also contribute to the development of an appropriate and sustainable orthopaedic service together with the first Timorese orthopaedic surgeon.

Clinical work forms part of the job, but is always directed towards mentoring and training the junior medical staff and medical students. An attractive remuneration package includes accommodation.

LOCATION

You will be based in Dili at the National Referral Hospital, Hospital Nacional Guido Valadares (HNGV).

Interested?

Send your CV & Cover Letter to RACS today!

Contact:

kate.moss@surgeons.org
+61 3 9276 7413

The Timor Leste Program, managed by the RACS and funded by AusAID, currently employs five full-time clinicians at HNGV and co-ordinates around 16 specialist team visits across Timor Leste per year.

Royal Australasian College of Surgeons

2014 Rowan Nicks Australian & New Zealand Exchange Fellowship

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

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

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

Selection Criteria

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

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

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

Tenure: 3 - 12 months

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

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

Developing a Career in Academic Surgery

Monday 6 May 2013, 7.00am – 4.00pm

SKYCITY CONVENTION CENTRE AUCKLAND, NEW ZEALAND

Provisional Program

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

SESSION 1: GENERAL PRINCIPLES
Chairs: Mark Smithers (Brisbane) and Julie Ann Sosa (Durham, USA)

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

9:00am MORNING TEA

9:15am **HOT TOPIC IN ACADEMIC SURGERY - Stem Cells** . . . . . *Julie Ann Sosa (Durham, USA)*

SESSION 2: TOOLS OF THE TRADE
Chairs: Eric Kimchi (Hershey, USA) and Richard Hanney (Sydney)

9:35am Bedside to bench to bedside . . . . . *Lillian Kao (Houston, USA)*
9:55am Basic science . . . . . *Gregory Kennedy (Madison, USA)*
10:15am Randomised clinical trials. . . . . *Andrew Hill (Auckland)*
10:35am Comparative effectiveness research . . . . . *Justin Dimick (Ann Arbor, USA)*
10:55am Surgical education/simulation . . . . . *Jeffrey Hamdorf (Perth)*
11:15am Discussion

11:30am LUNCH

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

SESSION 3: CONCURRENT ACADEMIC WORKSHOPS:

Workshop 1: Interactive Workshop on Issues in Research
Chairs: Mark Smithers (Brisbane) and Julie Howle (Sydney)

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

Workshop 2: Career Development
Chairs: Russell Gruen (Melbourne) and David Watson (Adelaide)

I want to be an academic surgeon. What can I do as a:
1:00pm Medical Student
Deborah Wright (Auckland)
1:15pm Intern
Marc Gladman (Sydney)
1:30pm SET Trainee
Gregory O'Grady (Sydney)
1:45pm Fellow
Win Meyer-Rochow (Hamilton)
2:00pm Consultant
Susan Neuhaus (Adelaide)
2:20pm Discussion

Workshop 3: Presenting Your Work
Chairs: Lillian Kao (Houston, USA) and TBA

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

2:40pm AFTERNOON TEA

SESSION 4: A CAREER IN ACADEMIC SURGERY
Chairs: Andrew Hill (Auckland) and Timothy Pawlik (Baltimore, USA)

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

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

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

AAS Association for Academic Surgery

Royal Australasian College of Surgeons,
Section of Academic Surgery

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Program correct at time of printing, however the Organising Committee reserve the right to change without notice.

The Royal Australasian College of Surgeons

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