SURGICAL NEWS

THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS
VOL 15 NO 1
JAN_FEB 2014

Advocating best practice

Championing standards for quality care **p28**

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The College of Surgeons of
Australia and New Zealand

2014

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

WORKSHOPS & ACTIVITIES

Read all about Professional Development's Successful year on **page 40**

Supervisors and Trainers for SET (SAT SET)

25 February, Adelaide; 29 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.

Process Communication (PCM) – Part 1

28 February – 2 March; 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. These needs are different for each of the 6 different personality types; each person represents a combination of these types, but usually one is dominant.

Keeping Trainees on Track (KToT)

4 March, Melbourne; 26 March, Gold Coast; 8 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

29 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 practice 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)

18 March, Adelaide; 15 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.

Finance for Surgeons

31 March, Adelaide

This whole day course establishes a basic understanding of how to assess a company's performance using a range of analytical methods and financial and non-financial indicators. It reviews the three key parts of a financial statement; balance sheet, income (profit and loss) and cash flow. Participants learn how these statements are used to monitor financial performance.

Polishing Presentation Skills

9 April, Brisbane

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

3 - 5 April, Gold Coast

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

Writing Medicolegal Reports

24 July, Brisbane

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

Strategy and Risk Management for Surgeons

7 August, Brisbane

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

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

AMA Impairment Guidelines 5th Edition: Difficult Cases

13 August, Sydney

The American Medical Association (AMA) Impairment Guidelines inform medico-legal practitioners as to the level of impairment suffered by patients and assist with their decision as to the suitability of a patient's return to work. While the guidelines are extensive, they sometimes do not account for unusual or difficult cases that arise from time to time.
This 3 hour evening seminar compliments the accredited AMA Guideline training courses. The program uses presentations, case studies and panel discussions to provide surgeons involved in the management of medico-legal cases with a forum to reflect upon their difficult cases, the problems they encountered, and the steps they applied to satisfactorily resolve the issues faced. Please note: Fellows will still need to attend AMA training to be accredited to use AMA guidelines.

WORKSHOPS
March-April 2014

NSW

17 March, Sydney
National Simulation Health Educator Training (NHET Sim)

8 April, Sydney
Keeping Trainees on Track (KTOT)

QLD

26 March, Gold Coast
Keeping Trainees on Track (KTOT)

3-5 April, Gold Coast
Surgical Teachers Course

9 April, Brisbane
Polishing Presentation Skills

SA

25 February, Adelaide
Supervisors & Trainers for SET (SAT SET)

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

31 March, Adelaide
Finance for Surgeons

VIC

24 February, Melbourne
National Simulation Health Educator Training (NHET Sim)

28 Feb – 2 March, Melbourne
Process Communication Model Part I

4 March, Melbourne
Keeping Trainees on Track (KTOT)

11 March, Melbourne
Academy Educator Studio Session

14 March, Melbourne
Conjoint Medical Education Seminar

15 March, Melbourne
Academy Educator Studio Session

29 March, Melbourne
Communication Skills for Cancer Clinicians

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

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

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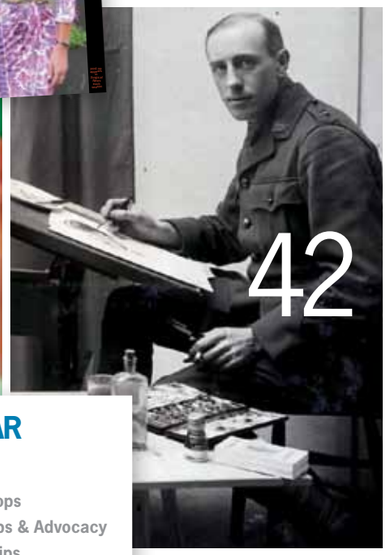

REGULAR PAGES

Correspondence to Surgical News should be sent to: **surgical.news@surgeons.org**
Letters to the Editor should be sent to: letters.**editor@surgeons.org**

T: +61 3 9249 1200 **F:** +61 9249 1219
W: www.surgeons.org

ISSN 1443-9603 (Print) / ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis

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GREETINGS FROM MYANMAR

A nation opening up to the world

MIKE HOLLANDS
PRESIDENT

I am writing this from Myanmar where I am attending the 60th Annual Scientific Meeting of the Myanmar Medical Association.

Myanmar is a country approximately the size of New South Wales and Victoria combined, with a population of 60 million people and 189 ethnic groups. Naypyidaw is the capital, although Yangon remains the largest city and commercial capital.

Over the past two years or so Myanmar has undergone substantial political change with a democratically elected government, albeit with some caveats to true democracy. As a whole, people I meet are delighted with the changes. As the nation opens up politically it opens to the world. I visited two years ago and cannot get over the changes in what is a very short time frame.

Healthcare systems in Myanmar are more sophisticated than we might imagine. The links between university and hospital remain strong and the principles of post-graduate education are respected. There is, for example a three year Masters program for orthopaedic Trainees. The leaders of the medical community are often the orthopaedic surgeons, something I have noticed in other developing countries.

The spectrum of pathology encountered is quite different to Australia and New Zealand. Tuberculosis remains a major public health issue; snake bite and tetanus remain the second and third most common indications for admission to ICU. Investigations are used sparingly although there is a functioning MR machine in Yangon general.

When patients and their families have to pay, it is amazing how much more cautiously investigations are ordered. I attended a clinicopathological correlation meeting at Yangon General. We discussed a case of a caecal cancer presenting in a 16-year-old girl as a per anal intussusception, a case of Caroli's disease in a 4-year-old, a cholangiocarcinoma, two interesting ureteric anomalies, and a complex parotid mass among others.

While not the healthcare system we would expect in Australia or New Zealand, Myanmar is doing okay. Perhaps we should ask whether our College should contribute to on-going capacity building. I think the brief outline above has identified the need for improvement. Our College has always had the defining principle of capacity building when conducting overseas aid and this is certainly the case. We should be proud of our achievements thus far.

Our first project, partly funded by the Foundation for Surgery, is the Primary Trauma Care Course. Initially conducted in Yangon with close supervision it is now run in Mandalay and Naypidaw as well as Yangon and the course is now self-sustaining and needs very little outside oversight. This was followed by a request to train Emergency Physicians. With the assistance of the Australian College of Emergency Medicine, our College has played a major role training 18 Emergency Medicine doctors. I must emphasise the course was taught and assessed by the Emergency Physicians. When I last visited there was no such thing as an Emergency Medicine Physician. On arrival in Casualty a patient was registered and then referred to a hospital team for workup. There was no real understanding of urgency or triage.

Seventeen of the 18 candidates passed. Myanmar has requested we train another 16 doctors and this course will commence in February, 2014. We have also conducted two ATLS Courses with wonderful assistance from surgeons in Singapore, Malaysia, Thailand and Hong Kong, many of whom funded themselves.

Richard Perry and his team have also conducted Surgical Skills Courses which have been very well received. While not a College activity there is an active cardiac surgical presence with Australian teams visiting Yangon General Hospital.

Where to next? James Kong, who has played an enormous role facilitating this work and without whom we would have achieved much less, is keen to conduct further courses including ATLS, Surgical Skills and hopefully, some non-technical skills such as TIPS or NOTSS and MOSES. James has also raised funds for a training centre in Yangon and hopes that our College will play an advisory role.

I believe we can be proud of the accomplishments of our College and Fellows in Myanmar. To my mind the work we have done thus far demonstrates clearly that we are making a meaningful contribution.

The HOT issues:

HOURS, OUTLETS AND TAXES

The College has instigated a campaign to bring about change in the area of alcohol-related violence

MICHAEL GRIGG
VICE PRESIDENT

As the great majority of us brush the remnants of the beach from our feet and return to work, I welcome you all to 2014 on a more sombre note than usual.

The College expects this will be a break-out year with regard to community-wide recognition of an issue that has been front-of-mind for many of us.

The misuse of alcohol in the community and the associated trauma and harm such misuse generates is the quintessential 'elephant in the room' for communities on both sides of the Tasman.

The recent festive season provided many examples of the end-result of excessive alcohol and an ever-lengthening list of victims; innocent and otherwise.

Most reasonable people across Australasia recognise our attitude to drinking is an issue, and in polite conversations condemn it, but then with a shrug condone it and say, "But what can we do – that is just the way it is".

The alcohol-fuelled 'king-hit' and the fate of the seemingly innocent victims dominated headlines in recent weeks. I heard an interview with the mother of an alleged perpetrator who said, essentially, she felt sorry for the victim, but drunken violence is to be expected because "boys will be boys".

Perhaps even worse is the presumption that nothing can be done because the alcohol industry is "too powerful".

Everyone can see there is a problem and we are reminded of the issue's existence with almost every evening news bulletin. Our media drips with stories and images of violence and harm and echoes with the 'tsk tsk' of those who want things to change, but are bereft of a plan.

What has been missing is a constructive recommendation on how to address the problem. Increasing the penalties for reckless antisocial behaviour may be appropriate, but is not the answer.

As we did with the issue of compulsory wearing of seat-belts in cars and bicycle helmets, the College has identified the key aspects of the alcohol-related harm issue that need to be thrashed out and has instigated a campaign to bring about change.

The College's campaign to reduce alcohol related harm in our community has been encapsulated in the mnemonic 'HOT' and that stands for Hours, Outlets and Taxes; the three key areas where we believe change must occur.

The campaign has already attracted early media and public attention.

In the week before Christmas, a 'Letter to the Editor' titled *Surgeons' 'HOT' advice to battle alcohol-fuelled violence* was sent to major newspapers under my signature. I am pleased to report that the letter was published prominently in many leading newspapers throughout the country within 24 hours.

The Letter to the Editor read:

"Surgeons are on the 'frontline', along with police, ambulance officers, nurses, Emergency Department staff and others, when confronted with the adverse consequences of alcohol excess in the community.

Sadly, the ability to inflict alcohol-fuelled violence is sometimes beyond the medical profession's ability to heal it.

The Royal Australasian College of Surgeons has applauded and supported the police campaign 'Operation Unite' since its inception and we are convinced that, as a community, we must rethink our attitudes to alcohol.

Alcohol-fuelled violence has become a blight on our society. Being drunk should not be acceptable. Being drunk and violent must be condemned.

As a nation we have to recognise that there is a problem and, as a nation, we have to take action. The College is calling on community leaders and the public to champion the 'HOT' issues.

These are: Hours – Outlets – Taxes (HOT). We need to reduce the number of 'Hours' alcohol is available, particularly after 2am. We need to reduce the number of 'Outlets' where alcohol can be bought in our community. We need to tax alcohol appropriately to instigate change.

If nothing changes then nothing changes – and that means we as a nation will have admitted that drunkenness and the idiotic and bloody violence it inspires in our streets, in our homes and on our roads is just the way we are.

"Surely that is an admission we cannot make.

The College supports both Government and broader community action to acknowledge the problem of alcohol misuse, to introduce legislation and regulation to protect the community, encourage appropriate alcohol use and embrace and model ways of responsible drinking.

This is not about wowserism; it is about addressing the issues of violence, trauma and tragedy that result from excessive consumption and misuse of alcohol.

A fundamental role for the College is to ensure that those responsible for setting and implementing policies that impact on the health of the Australian and New Zealand communities are well-acquainted with the views of surgeons.

The College has an impressive record of achievement and leadership in this regard, but we are under no illusion as to how long and hard this battle will be. Personally I am looking forward to it.

Oh, and by the way – Happy New Year.

ANZGOSA
Australia & New Zealand Gastric & Oesophageal Surgery Association

Post Fellowship Training in Upper GI Surgery

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

ANZGOSA's Post Fellowship Training Program is for Upper GI 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 Upper GI surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, and assessment. Successful applicants will be assigned to an accredited hospital unit.

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

To be eligible to apply, applicants should have FRACS or sitting FRACS exam in May 2014. Any exam fails will not be offered an interview.

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 ANZGOSA, P.O. Box 374, Belair S.A. 5052, or email anzgosa@gmail.com.

Applicants will need to be able to attend interviews which will be held late May 2014 in Melbourne.

Applications close 5pm, Friday March 28th 2014.

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 2014. 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 late May 2014 in Melbourne.

Applications close 5pm, Friday March 28th 2014.

WHAT'S MAKING NEWS

New plaque for College founder

A reunion of sorts brought together the descendants of College founding member Sir Louis Barnett as a new plaque was unveiled in Hampden in New Zealand's South Island last November.

The plague recognises the home of the surgery great, also best known as the pioneer in the research of Hytatids. Grandson Dick Barnett assisted in unveiling the plaque, recalling his visits to Hampden House.

"We were always greeted with a smile," he said.

***Otago Daily Times*, November 23, 2013**

NZ New Years Honours

Officer of the NZ Order of Merit (ONZM)

Dr Tearikivao Maoate, of Christchurch. For services to Pacific health.

Professor Stephen Richard Munn, of Auckland. For services to health.

Member of the NZ Order of Merit (MNZM)

Dr Allan Leslie Panting, of Nelson. For services to orthopaedics.

Emergency gift

Fellow Douglas Stupart granted a Christmas gift to a family from Geelong, Victoria, when he performed emergency neurosurgery on December 25.

Eleven month-old Taral Nash was seemingly okay after a fall from his change table, but was transported to hospital as a safety precaution. A lump on Taral's head appeared soon afterwards, forcing Mr Stupart into lifesaving surgery to remove the blood clot and relieve bleeding.

"It was a nice example of how different members of the team come together; it was a pretty difficult situation, but was made as easy as it could have been," Mr Stupart said.

***Geelong Advertiser*, January 10**

New bones

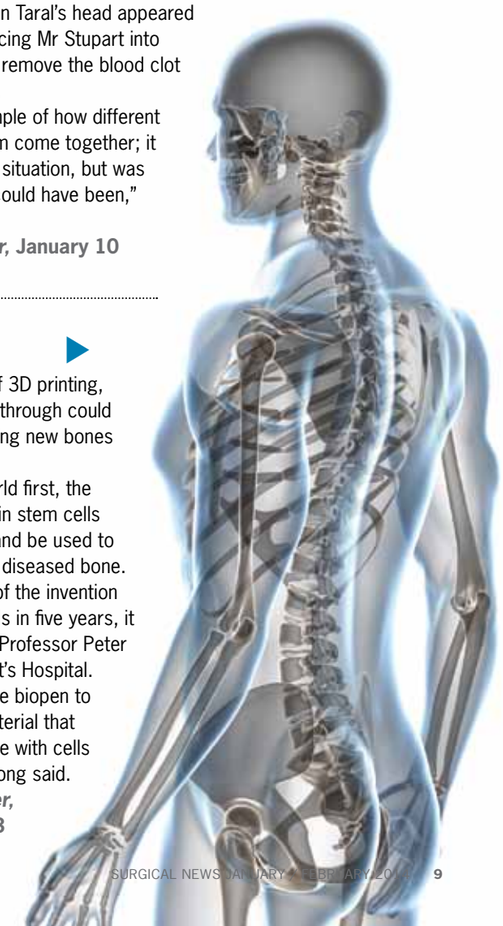
Following the birth of 3D printing, a new medical breakthrough could have surgeons drawing new bones with a 'biopen'.

In an Australian world first, the 'biopen' would contain stem cells and growth factors and be used to repair damaged and diseased bone.

With the prospect of the invention ready for human trials in five years, it has been handed to Professor Peter Choong at St Vincent's Hospital.

"We hope to use the biopen to actually print out material that helps create the bone with cells in it," Professor Choong said.

***Adelaide Advertiser*, December 5, 2013**



THE BEST FOR BURNS

Volunteers from the Australian and New Zealand Burn Association held a week-long course on the management of burn cases for 33 doctors, nurses and physiotherapists in Dili

FELLOWS JOHN HARVEY AND IAN LEITCH
WITH KAREN MURPHY

A small team of one doctor and four nurses at the Hospital Nacional Guido Valadares (HNGV) in Dili, Timor-Leste, has been the backbone for providing much needed care for burn victims. The team, led by Dr Joao Ximenes, received training and mentoring through the College's Timor-Leste Program. There will now be greater support and expertise available from the 33 doctors, nurses and physiotherapists who participated in a burns management course organised by the College and delivered at the National Hospital in August 2013.

The course, led by volunteers from the Australian and New Zealand Burn Association (ANZBA), was delivered in response to requests from the Timor-Leste Ministry of Health, HNGV and national doctors to help Timor-Leste improve its management of burns cases. It was provided as part of the College's Australian Timor-Leste Program for Secondary Services (ATLASS II), funded by the Department of Foreign Affairs.

The HNGV receives at least one complex burns patient each week. Doctors and nurses at the national hospital can now provide the specialist care needed. However, there is still a need for better immediate care at the referral hospitals for patients presenting in the districts.

Associate Professor John Harvey from ANZBA who led the course in August 2013 said the doctors in Dili have the expertise to treat severe burns, but within limits.

"Their resources can be stretched at times given that modern burn management is expensive and time consuming; but within basic limits they are capable of dealing with what they confront, including injured children.

"We were keen to enhance the skills of the local surgeons, but also to train the junior doctors who will soon be spreading out across the country and who will often be the first to see the injured patient."

New skills

Dr Joao Ximenes is Timor-Leste's first doctor with plastic surgery skills. He has developed his skills in both cleft and palate surgery and burns management with guidance and mentoring from long-time volunteer Dr Mark Moore. Dr Ximenes spoke of the developing workforce.

"We have a few doctors, including the three surgical Trainees being trained by the ATLASS program, who have good skills for managing burns. We also have four burns nurses who provide good care for burns. They can manage wounds in the ward, but they don't yet have the skills or knowledge about physiotherapy and how to prevent contraction."

Dr Ximenes said that following the training, he had observed the surgical Trainees assisting with burns cases, with two of the Trainees recently demonstrating a good skin graft on a large burn in the female surgical ward.

"Since 2008, burns patients and plastics patients have been my responsibility. This course was very important to improve my own skills and knowledge about burns. The course taught us to use simple materials, which we have here in Timor-Leste. We only have limited materials and they teach us how to use what we have here.

"Every week we receive burns patients from everywhere, all over Timor-Leste."

The Trainees who took part in the course said the most important things they learnt from the course were how to manage burns patients in Emergency, how to manage airways of patients with burns to the face and neck areas, how to do a proper escharotomy, how to accurately identify the percentage of burns and how to correctly administer IV fluids to adults and children.

Members of the visiting team who delivered the course included retired Plastic Surgeon Mr Ian Leitch, Paediatric Burns Surgeon Associate Professor John Harvey, burns nurses Ms Siobhan Connolly and Ms Diane Elfleet and physiotherapist Ms Cheri Templeton.

Fellow John Harvey with Timorese doctors

> *"Their resources can be stretched at times given that modern burn management is expensive and time consuming"*

Mr Leitch said he first heard about the need for more expertise at the Hospital Nacional Guido Valadares from Plastic Surgeon Mr Mark Moore.

"He told me that the two local doctors, Dr Joao Ximenes and Dr Joao Pedro Xavier, were finding that an increase in the number and severity of burns cases was straining their resources, so we got together to see how we could help solve the problem.

"We decided that a modified form of the Emergency Management of Severe Burns (EMSB) course would be the most useful, given language barriers and so instead of a one-day course, this training spanned a working week and was designed to be taught as an integrated course by surgeons, nurses and a physiotherapist to emphasise the team approach which characterises modern burn care."

Mr Leitch, who has had a long association with Timor-Leste since he first went there in 2000 as surgeon to the UN Military Hospital, said that it was this melding of formal instruction and practical real-time teaching in the operating theatres and wards that was found to be most valuable for the participants.

He also said that demonstrating alternative management strategies in a clinical situation and then subsequently being able to show the result had been a powerful educational tool.

Associate Professor John Harvey, also a member of the visiting team, is Head of the Burns unit at the Children's Hospital at Westmead and has taught the EMSB course in a number of countries including Fiji, Singapore, Bangladesh and Vietnam.

He said the guiding principle behind it and the modified course was to set down burn management principles that could be followed for every burn including initial first aid, resuscitation, assessing the depth of the burn, infection control, graft surgery and the management of scars and contractures.

He said he and Mr Leitch acted only as advisors in theatre to the local doctors during the August visit.

"We were scrubbed and at the table, but all the surgery was done by local doctors," he said.

"We advised on techniques and made suggestions and in theatre and during ward rounds discussed when to conduct graft surgery and how to do it."

"The timing of the visit fortuitously coincided with the presence of a number of patients with acute burns at different stages of resolution and an acute admission of a child with a 20 per cent deep flame burn." ▶

International Forum at the RACS 2014 Annual Scientific Congress

Sands Expo and Convention Center, Marina Bay Sands in Singapore

Monday 5th & Tuesday 6th May

Theme: Working together for our patients
Convenor: Glenn Guest

The 2014 International Forum in jointly convened by the Royal Australasian College of Surgeons, Australia and New Zealand College of Anaesthetists and the Alliance for Surgery and Anaesthesia Presence (ASAP).

PROVISIONAL PROGRAM

Monday 5 May

- The global burden of surgical disease Professor Stephen Bickler, San Diego
- The Emergency and Essential Conditions we must treat to improve global surgical outcomes
- The Lancet Commission for Global Surgery: metrics for global surgery Prof Russell Gruen, Prof David Watters and Dr Rowan Gillies
- Peri-operative Mortality Rates: Making a global impact. How will they help?
- Rowan Nicks Keynote Lecture: Datuk Harjit Singh (Malaysia)
- Surgical and anaesthetic education programs: Improving health outcomes and making an impact; case studies from the region. What can the College contribute?
- Keynote Lecture

Tuesday 6 May

- Presentations by RACS Rowan Nicks Scholars
- Hypothetical: Achieving the Common Good in the Aid Maze. Conflicting priorities: Government vs Organisations vs Individuals, Brain Drain, Role of trainees, Whose standards? Who really benefits from research? Is my best good enough?
- Keynote Lecture: Dr Kelly McQueen, President, ASAP
- Measuring the effectiveness of surgical and anaesthetic interventions: dollars, DALYS and dilemmas
- Keynote Lecture
- Improving health outcomes by targeting specific conditions requiring tertiary expertise: Club foot, Cleft palate, Cataracts, Middle ear infection

Participants at the International Forum must register for the Annual Scientific Congress: http://www.racsanzca2014.com

Associate Professor John Harvey with Timorese doctor Dr Joao Ximenes

Associate Professor Harvey said the majority of burns cases seen in Timor-Leste involved accidents related to cooking including children falling into fires or boiling liquids, women whose skirts have caught alight or through the effects of exploding kerosene stoves.

He said he believed the burns management course had been a great success and that team members were keen to maintain contact with their counterparts in Dili, to provide future support and, where possible, help with resources.

He praised the work of the College undertaken since Timor-Leste gained Independence.

"I think the input of the College has been critical in helping to provide structure around which the East Timorese people can build their own health care system," Associate Professor Harvey said.

"The fact that much of the work done by the College has been based around mentoring is one of the keys to its success in that such relationships help us to remain sensitive to the local culture and aware of both resource limitations and skills required.

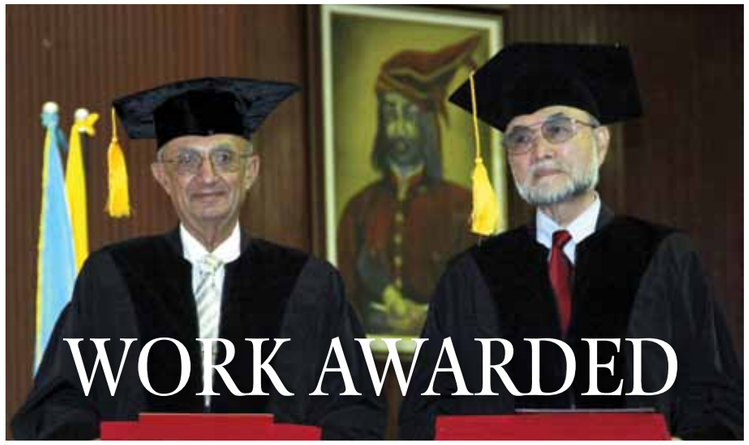
"It means that we get to hear directly what the medical professionals of Timor-Leste need so that we can then work to meet that need, if possible, which is exactly the thinking behind this burns course.

"People still die of preventable burns in Timor-Leste and one of the aspects of this training visit that I particularly enjoyed was working with the young doctors who I hope will go out and spread the message of burns prevention out across the country."

Ms Siobhan Connolly is currently the Chair of the ANZBA Nursing course and was one of two nurses who wrote the new Burns Management course.

She said that spreading the delivery of the material over four days had allowed participants to learn new techniques, engage in discussions and practice new skills.

"In Timor-Leste, even simple things can be an issue for the nursing staff – like the cotton balls that have to be made and sterilised at the end of each day – and experiencing this helps to keep our own working lives in perspective."



WORK AWARDED

Orthopaedic surgeons Professor Bill Cumming and Professor Joe Ghabrial have received the highest award that can be bestowed for services to the nation in recognition of their efforts to help establish an orthopaedic training program across Indonesia

WITH **KAREN MURPHY**

The Sultan Hassanuddin Awards were presented to Professor Ghabrial at a lavish ceremony at the Makassar University in South Sulawesi, Indonesia, in September last year while Professor Cumming will receive his award this year.

In 2010 and 2011, both surgeons were also awarded Honorary Fellowships of the Indonesian Orthopaedic Association, receiving pure gold medals which are traditionally only presented to past Presidents.

Professor Cumming, a recipient of the College's International Medal in 2005 for his lifetime commitment to the Orthopaedic Outreach Program run through the Australian Orthopaedic Association, has been working in Indonesia as a surgical educator, examiner and co-ordinator since the 1970s.

Professor Ghabrial has been providing his skills to the Trainees of Indonesia as a surgical educator and examiner since 2004.

An Emeritus Associate Professor at the University of New South Wales and now retired from operating, Professor Cumming began working in Indonesia at a time when the country had no orthopaedic surgeons.

Now there are hundreds of such specialists with programs now underway to provide sub-specialist training.

For the past 10 years, both Professor Cumming and Professor Ghabrial have been working to help establish a Bali Training Program following a request for assistance by the Indonesian Orthopaedic Association.

"When we began this program, Bali only had two orthopaedic surgeons and now it has 17, two Professors of Orthopaedic Surgery, two PhD's and 40 Trainees.

"With the combined efforts and commitment of health authorities and local orthopaedic surgeons and the Indonesian Orthopaedic Association, an entire new orthopaedic floor has been built at the Sanglah Hospital in Bali," Professor Cumming said.

"All work done within the new orthopaedic facility now comes under the supervision of Professor Siki and Professor Astawa, the Dean of the University of Udayana in Bali.

"It has proved so successful, in fact, that there are now four training centres in Eastern Indonesia in Bali, Surabaya, Malang, and Makassar which is a great credit to the Indonesian Orthopaedic Association and our orthopaedic colleagues across Indonesia."

Professor Cumming, who visits Indonesia around four times each year, said he was deeply honoured to have received the Sultan Hassanuddin Award.

"When I first began working in Indonesia, I would often be working in hospitals that had no bandages, no fluids, not even proper beds with mattresses and linens, so it is a great delight to say that medical care there now is almost unrecognisable," he said.

"Over the years many Indonesian surgeons have stayed at my home and great friendships have been formed too.

"Yet having such a commitment to assist can be somewhat selfish, so I particularly wish to thank my wife Marion who has been integral to all my work both in Australia and overseas."

Professor Ghabrial works across the Hunter and New England region of NSW, is a specialist in spinal surgery at the Royal Newcastle Centre and John Hunter Hospitals and was the 2007 recipient of the Australian Orthopaedic Association's Medal for his decades of service to the specialty.

Now the convener of the Orthopaedic Outreach program in Indonesia, Professor Ghabrial said in a presentation given last year that Bali had now become one of the six national centres for the Board of Orthopaedics exams.

As a further demonstration of their commitment to Indonesia, last year Professor Ghabrial and Professor Cumming also became the convenors of the first pre-exam course offered to Trainees in Bali which is open to all senior Trainees in Indonesia.

They plan to hold the courses twice a year and are in the process of developing Fellowships to allow Trainees to expand their skills in Australia.

Professor Ghabrial said: "We are very proud to have received this award which clearly represents a significant recognition from the Indonesian authorities and respect for our program."

Both surgeons said they wished to thank the Indonesian Orthopaedic Association, the National College of Orthopaedic Surgery and Trauma, the Universities of Indonesia and the orthopaedic surgeons and Trainees with whom they have worked.

IN MEMORIAM

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

John Dickson,
Queensland Fellow

John Grant,
NSW Fellow

Malcolm Douglas,
Victorian Fellow

John McIlwaine,
New Zealand Fellow

Daryl Nye,
Victorian Fellow

Richard McArthur,
Victorian Fellow

Patrick Browne,
Tasmanian Fellow

John J McCarthy,
NSW Fellow

Frank Szalassi,
Queensland Fellow

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

Informing the College

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

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

THAT'S NOT NICE AT ALL

Do you really need to know about my day?

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is meaningless words of "social lubrication" – I am sure that you know what I mean. "Have a nice day" is the worst offender. The words are not really offensive; it is the saying of them that offends curmudgeons and, I suspect, a large part of the population.

The person saying the expression could not give a damn if you are going to run over your cat, stub your toe or smash a bottle of Grange Hermitage. All the person wants is you out of their shop and on your way. They should be saying, "We have finished our transaction, now get on your way and out of my shop."

The expression "It has been so nice to meet you" often means, "What a pain you are and I am so glad that you are going. I am never asking you to dinner again." Or it may mean, "I now see why your husband/wife complains about you all the time." In any event, rarely does it express that it has been a pleasure to meet a person.

The word "nice" is a word that curmudgeons hate with a passion. It is overused. Everything is nice – parties, people, dinner and so on. I was delighted to learn that the original meaning of "nice" when it was first used 700 years ago was "unimportant or trivial". If you ever hear a curmudgeon using the word you can be certain that he is using the word in its original meaning, as in what a nice party, what nice people, the dish of Mongolian stewed sheep gizzards was nice.

That creates its own problem. If it has truly been a pleasure to meet someone how do we curmudgeons say it and mean it? "It has been so nice to meet you" will, after this article, be a very suspect statement as my readers (both of them) will know what I really mean.

Even worse in the social lubrication stakes are shop assistants (usually young women) who in the course of the transaction ask what you have done today or what are you are going to do today. I used to grunt and mutter something benign like cook the meat I have just bought. I have also contemplated saying something like, "This morning I found the cure for cancer and won the Nobel Prize for Medicine," but I suspect that would have been met with, "That's nice".

As I have matured as a curmudgeon, I have tried saying, "It is none of your business". The problem with that is that some of these twitty girls seem to take offence and you have to change butchers or bakers as the next week they avoid serving you. It is a good thing we don't need candlestick makers nowadays as there are some tempting retorts to the question of what are you going to do with the candles which you have just bought.

Mind the gap? Yes we do!

How do you view a reasonable fee?

DR BB G-LOVED

I thought this month I would share some of the issues raised to me by some of your patients. You are probably aware that patients do consult their GP about anticipated or real health care costs, particularly when facing large out of pocket expenses for surgical treatment. I hope you will appreciate their plight.

For years, often decades, they have faithfully subscribed to private health insurance always believing that the costs of private health care would be covered. Many pay small gaps and these rarely complain; it is rather the few patients who are charged substantial, seemingly exorbitant gaps.

Imagine the plight of Mr or Ms Ave Rage who had been referred to Dr Razor Sharp because he or she is 'the best'! Mr and Ms Ave Rage reside in suburbia, where they live prudently, have accumulated a few hundred thousand in super, still have a mortgage as well as supporting their kids at university.

Then tragedy strikes, one of them develops first a tumour, then within 18 months a recurrence, and is referred to Razor Sharp, who sports a reputation for doing what most other surgeons do not do – still offer some chance of a cure, though with the risk of significant complications. But then Mr Razor Sharp is 'the best', so he charges top dollar. The Ave Rage's were expected to pay many thousands of dollars gap. This was correctly divulged to them beforehand, financial consent was duly and appropriately given. Indeed the Ave Rage's were required to pay the gap before the surgery could be conducted.

They were desperate. Doctors like myself and the surgeon who first operated, could not and would not advise the subsequent procedure, but as the re-exploration offered a hope, albeit a small one, the straw was grasped. The Ave Rages increased their mortgage, I noted the procedure appeared to go well at least initially, but before long there were complications that required transfer to the public system.

Now they were under the care of a different team and Dr Razor Sharp kept a low profile secure in the knowledge they had been dutifully warned that some of these complications could occur. Some months later the terminal Ave Rage passed on, but the family were always grateful that 'everything possible' had been offered. They had paid top dollar for 'the best'. Dr Razor Sharp was thanked at the funeral.

Then I was consulted by the Diss Faceteds. The father of the house was suffering severe back pain without significant neurological impairment, consulted Mr Slit Quick who offered a prompt procedure, but with a gap of tens of thousands of dollars collected up front.

There was no wait and watch, no trial of physiotherapy or conservative treatment with adequate analgesia ... No the pain was great, the patient couldn't cope (he wasn't advised to), the need for a procedure was implied to be urgent, so Slit Quick found space on the next available operating list.

Now we know that the best patients to select for surgery with back pain have either urgent neurological indications or that nerve root pain has not responded over several weeks. Mr Diss Faceted consulted me two years later, with regard to significant ongoing pain. Maybe it was just bad luck. Mr Slit Quick assured me most of his patients are responders though he always warns them of the risks of ongoing pain, the dangers of loose prostheses and failure to fuse.

I did consult your College to read a Position Paper on excessive fees. This is not an issue only for surgeons, but it was acknowledged that some surgeons charge a great deal over the top of what a health fund will reimburse. Your patients are in a vulnerable position, particularly those with malignancy or severe pain.

They are often desperate, have difficulty comprehending all their options, or even the financial implications of their treatment. A specialist has an obligation to consider that a second opinion may be advisable or that a second consultation should be arranged before making a decision. Multi-disciplinary meetings (when available) offer an opportunity for peer review and shared decision-making.

The Code of Conduct of your College states:

"A surgeon will when charging a fee for professional services ensure that it is reasonable and does not exploit the patient's need."

The College informed me that they can't recommend any particular fee schedule, though there are reasonable fee schedules able to be referred to and the patient is entitled to be made aware of them. My surgical sources all wished to remain nameless, but none wanted to defend gaps that reach five figures.

I am happy to report also that most surgeons I refer my patients to either charge a small or reasonable gap. The cases discussed above are fortunately atypical, and relate to a small number of surgeons who I honestly believe are deliberately and determinedly milking the system for their own ends, with neither the best interests of their patients nor their profession at heart.

ACTIVE LEARNING WITH YOUR PEERS

There is sure to be something for you among the range of quality courses offered this year

JULIAN SMITH
CHAIR, PROFESSIONAL DEVELOPMENT
CHAIR, ACADEMY OF SURGICAL EDUCATORS

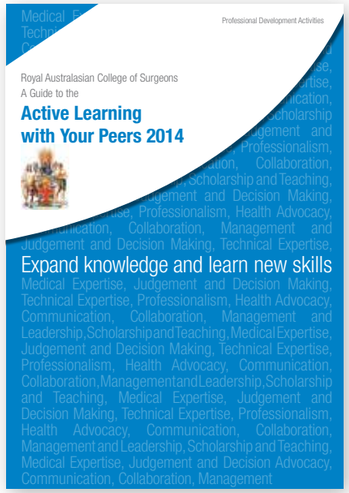
Early last December, you will have received a copy of the guide to College professional development activities for 2014, *Active Learning with your Peers 2014: Expand knowledge and learn new skills*. This booklet details an extended program with many exciting opportunities on offer – some for the first time – and which builds on a successful program in 2013 (almost 1100 participants in 59 face-to-face activities, plus a further 190 participants in online learning). The 2014 program continues to reflect the changing environment for health care professionals and offers a variety of learning and delivery modes focusing mainly on the non-technical competencies.

New courses and workshops

The College has been successful in obtaining funding from the Commonwealth Rural Health Continuing Education (RHCE) grants program to develop and deliver four workshops in rural and remote Australia that will help surgeons, anaesthetists and scrub practitioners to work together more effectively in the operating theatre.

The program is entitled ***NOTSS, ANTS and SPLINTS: Working together to help perioperative teams in rural and remote locations*** and will utilise material developed by the Royal College of Surgeons of Edinburgh, the University of Aberdeen and the National Health Service. The frameworks used are the Non-Technical Skills for Surgeons (NOTSS), Anaesthetists' Non-Technical Skills (ANTS) and Scrub Practitioners' List of Intra-operative Non-Technical Skills (SPLINTS), all of which were originally derived from studying teamwork in the aviation industry.

The first part of the workshop day will discuss human factors research, team work and team dynamics then discuss similarities and differences between the three different craft groups. The second part of the day will give you the opportunity to assess both yourself and your colleagues in the intraoperative setting. The NOTSS, ANTS and SPLINTS course will complement the NOTSS course, which will again be offered in several locations in Australia, New Zealand and at the Annual Scientific Congress in Singapore.



Clinical Decision Making: A Complex Competency is a three hour workshop designed to enhance understanding of your decision-making process and that of your Trainees or colleagues. The workshop will provide a roadmap of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision-making and has been developed to improve clinical decision making processes. It will be particularly useful for a supervisor dealing with a struggling Trainee or as a self-improvement exercise.

Training Standards: Interpretation and Application is also a three hour workshop designed to enhance supervisors' and trainers' understanding of the surgical training curriculum and how to foster competent and proficient surgeons. The course offers a framework and guide for the assessment of Trainees against the nine College competencies.

Early in the year, the Academy of Surgical Educators will be developing a ***Foundation Skills in Supervision and Facilitation*** course and piloting it in late 2014. The Foundation course in surgical education, will describe the basic standards expected of our surgical educators.

It is from this base that all faculty training can emerge, customised to the area of expertise required by the individual participant and the specific teaching activity. The Foundation Skills course is a generic course in supervision and instruction particularly suited to new supervisors and instructors and to late stage Trainees.

Developments to existing courses

As an extension to the Foundation Skills course for surgical educators, a number of revisions will also take place to existing courses that address the teaching and scholarship competence. These include a re-work of the ***Supervisors and Trainers for the Surgical Education and Training program (SAT SET)***, both online and face-to-face programming, along with the ***Keeping Trainees on Track (KTOT)*** program and translation of this into an online resource.

The ***Acute Neurotrauma: Enhancing head injury management amongst rural clinicians*** workshops will continue into 2014 following receipt of additional RHCE funding. This workshop provides the foundation for improved head injury management with the aim of equipping clinicians with the skills to deal with cases of neurotrauma using equipment commonly found in rural hospitals.

Workshops, focusing on training in burr–hole surgery for head trauma emergencies will be offered in two locations in the second half of 2014. An eLearning package consisting of a series of four modules is available on our website.

In 2014, the Professional Development Department will work closely with the Regional Offices to deliver the ***Preparation for Practice*** course. This two day workshop is a great opportunity for younger Fellows and late stage Trainees to learn about the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and external speakers. By attending this course, you will have the chance to speak to senior Fellows who have experience in starting up private practice and get tips and advice.

Other courses available

There is a suite of programs looking at improving our communication skills. This includes the very popular ***Process Communication Model*** course that gives great insight into how we can better understand, motivate and communicate more effectively with our colleagues, family and friends. Part 1 of the course will be held in both Melbourne and Adelaide and Part 2 (a more advanced course) in Sydney.

The majority of us are called on from time-to-time to deliver talks, lectures and other presentations to groups of colleagues or others; if you would like to hone your skills in this area, the one day ***Polishing Presentation Skills*** course would be an ideal way to do this and will be held in Brisbane and Sydney this year.

And finally, communication specifically with patients with cancer, are covered in depth in the ***Communication Skills for Cancer Clinicians*** courses, which will be held in Melbourne, utilising simulated patients to enable you to practise your skills.

Management and leadership can be challenging areas and ones for which few of us have been prepared. Two courses that are particularly useful for those of you who are considering taking on managerial roles in hospitals etc. are ***Strategy and Risk Management for Surgeons*** – a one day course to be held in Brisbane and Finance for Surgeons that is also a full day course and will be available in Adelaide.

Earlier in this article, I referred to the work being undertaken under the auspices of the Academy of Surgical Educators. In addition to the courses already mentioned, we will continue to offer the ***Surgical Teachers*** course in 2014. This is a substantial two and a half day course providing an in-depth look at principles of adult learning, teaching skills and giving feedback in the surgical workplace. It will be held in Auckland, Sydney and on the Gold Coast. 9

Other program developed specifically for our surgical educators include ***Graduate Programs in Surgical Education*** offered in conjunction with the University of Melbourne and which can lead to an exit ▶

level of your choice (Masters, Diploma or Certificate).

The ***National Simulation Health Educator Training (NHET-Sim)*** program, offered in collaboration with Health Workforce Australia, will continue with day long workshops in Sydney and Melbourne as will the webcast ***Academy Educator Studio Sessions***.

For those of you with an interest in medico-legal work, there will be an evening workshop in Brisbane in July on ***Writing Medico-legal Reports*** and the three-hour course ***AMA Guidelines 5th Edition: Difficult cases*** course will also be available in Sydney the following month.

Finally, we will be offering two ***Building towards Retirement*** courses – in Sydney and in Perth that may appeal to those of you contemplating a change in focus in the latter stage of your career. The full day program covers maintaining health and well-being, career options after surgery, superannuation and legal advice, community involvement and building post-retirement networks.

If you prefer an online learning experience, there are additional programs that are delivered in electronic format only. These include ***SET Selection Interviewer Training (SET SIT)***, an online module that takes approximately one hour to complete and that provides a wealth of information of value to Fellows involved in selection of Trainees onto the SET program.

Other online modules released during 2013 were the ***Australian Indigenous Health and Cultural Learning module and the Intercultural Learning for Medical Specialists*** module, both of which have been funded by the RHCE program and which will be valuable in developing health advocacy and interpersonal communication skills.

Sponsorship of professional development at the College

This year we welcome three global sponsor partners in Avant Mutual Group, Applied Medical and Bongiorno National Network. Other individual program sponsors include: mlcoa, Cancer Council Victoria, Rooms with Style, eReports and Covidien. I would like to thank these organisations for supporting the College professional development activities in 2014, thus ensuring that our programs are affordable and accessible.

So, as you can see this year is shaping up to be an exciting one as we attempt to address your needs by developing and delivering a range of new activities. I encourage each of you to consider attending one or more of these courses. Of course, we always welcome your ideas and comments about how we can continually improve the range and content of professional development initiatives.

Full details can be found in your Professional Development booklet or alternatively, please refer to the College website. Registrations are open now.

> *The 2014 program continues to reflect the changing environment for health care professionals and offers a variety of learning and delivery modes*

"Uneasy lies the head that wears the crown" *(Henry IV, Part 2, Act 3 Scene 1)*

POISON'D CHALICE

What doth the year hold?

PROFESSOR U.R.KIDDING

It was that glorious time around Christmas and New Year, where you are 'around', but you try and convince people you are 'not really around' and wasn't there someone else who could look at that case? (Conversely, trying to convince those that pay your salary i.e., the CEO, that you are around when you are not really!)

Certainly I didn't see any good reason to sit in my poorly air-conditioned office waiting for the time to pass. And so I was at home – using this 'quiet' time of year for some reflection. Unfortunately, I had been able to spend a good part of the afternoon thinking about the problems behind and the challenges ahead ... why was I doing that? Maybe I should have gone to the cricket and tried to barrack for the Poms – they had needed all the help they could get.

My better half walked in and saw the distanced look on my face and the glass almost empty before me. Filling it up, it was she who quoted Shakespeare at me! She was being provocative – I did have that sense.

"How's the head with the crown – uneasy?" Well, it was close, but then she is hardly a Bardophile.

"I am trying to balance the paradox of Shakespeare," I said. "You know how I strongly support his statements in 'All's Well That Ends Well', Act 1 Scene 1." She looked at me, not all that sympathetically. "You know, 'Love all, trust a few, do wrong to none'. Well it is almost impossible to balance with his lines from 'The Merchant of Venice', Act 4, Scene 1."

My better half who does not always have the patience of a saint, stared, sighed, took my glass and sat down. I continued with the line that says, "I am not bound to please thee with my answer." She took a substantial 'biopsy' of the liquid in the glass. It clearly passed the test because she kept hold of it. More was obviously expected.

I tried to verbalise what was troubling me. "You know my first principle of management – keep the people who don't like me away from those who are still undecided – well it is becoming harder with the changes that we are implementing." She frowned at me; she was very aware of the dangers of change management. In fact we had joked about change management gone wrong, and that "Hell is empty and all the devils are here" would be the outcome! ('The Tempest', Act 1, Scene 2). No wrath like a surgeon denied. "You're just feeling a little sorry for yourself," she replied. "So what is it that is really worrying you?"

Of course she was right. Whether people liked me or not was not a determinant, though I would of course prefer the former. No, what was worrying me was much more insidious – I had been sensing the coalescence of gathering dark clouds on the horizon for some time now. Clouds that threatened a storm with the capacity to engulf the professional world that I inhabited and had sought to strengthen.

Was the future of our profession truly at risk or was I just getting older? Probably both. Possibly the most important, most valued aspect of my professional life was the freedom, the autonomy to act in the best interests of my patients. It was a value that I had sought to instil in my Trainees and indeed the surgeons working in the health service. Could it withstand the gathering forces arrayed against this seemingly simple value? The truth was, I feared, not.

And then she surprised me again, as she has the endearingly irritating habit of doing repeatedly, with an entirely accurate quote: "The miserable have no other medicine but only hope" ('Measure for Measure', Act III, Scene I).

As she rose from the chair preparing to leave me somewhat open-mouthed, she turned and said, "Actually my favourite quote when I think of you is from 'King Richard III', Act 3, Scene 4."

"Which is?" I asked, regretting the words as soon as they left my lips.

"Off with his head!"

The phone rang, was I around?

NOT LONG NOW, SINGAPORE ASC

The College 2014 Annual Scientific Congress in Singapore is already generating great interest among the surgical and anaesthetic communities

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

The 2014 Annual Scientific Congress will be at the Sands Expo and Convention Centre at Marina Bay Sands. As well as exceptional conference facilities, the accommodation at Marina Bay Sands is first class so reserve your room as soon as you receive the provisional program because it will quickly book out.

In the previous article we mentioned some of the highlights of this Annual Scientific Congress (ASC), some of the named lectures and a short review of some of the section visitors and programs.

The Convocation and Welcome Reception is on Monday, May 5, at the Sands Expo and Convention Centre. At this convocation there will be two new honorary Fellows and eight other senior members of our profession who will be acknowledged for their outstanding contributions to surgery and the College. On this special occasion this will be a combined reception with our anaesthetic colleagues and an evening not to be missed.

The theme of the congress is 'Working Together for our Patients' and we will have several joint sessions with our anaesthetic colleagues. In addition to the named lectures we previously mentioned, there are further lectures of interest including:

BK Rank Lecture
Professor Joseph McCarthy
Rupert Downes Memorial Lecture
Air Vice-Marshal Assoc. Professor Hugh Bartholomeusz
Peter Jones Oration
Professor John Huston
Hamilton Russell Lecture
Assoc. Professor Carol-Anne Moulton
Edward (Weary) Dunlop Lecture
Mr Peter Sharwood
Archibald Watson Lecture
Professor David Watters

Program review

Upper GI and Bariatric
These sections have been convened by Professor Wendy Brown and Mr Paul Burton. The visitors include Professor Robert Mason who has a major interest in the palliation of dysphagia in oesophago-gastric malignancies. Dr Jaime Ponce from the US and Professor Weiner from Germany will discuss the evidence for various bariatric procedures.

Plastic and Reconstructive Surgery
Dr Mark Hanikeri is the convenor for this extensive section program. The visitors are Professor Joseph McCarthy, Professor Phillip Blandeel, Dr Filip Stillaert and Dr Marc Mureau. The extensive program overlaps with head and neck surgery, breast reconstruction, hand surgery, the international forum section, burn surgery and facial reconstructive surgery.

Orthopaedic surgery
Dr Richard Lander has assembled a program covering regional anaesthesia, shoulder surgery, foot and ankle surgery, paediatric orthopaedics as well as a segment on current practice and updates in orthopaedics.

In addition to the above sections there will be section programs from the International forum (Dr Glenn Guest), Senior Surgeons (Professor Bruce Waxman), Younger Fellows (Dr Jason Chuen), Women in Surgery (Dr Kate Drummond) and the Trainees Association.

We sincerely trust you will join us in Singapore for what is shaping up to be our most memorable ASC joined by our anaesthetic colleagues.
Register now through the Congress website **asc.surgeons.org**

Buckingham Scholarship

Scholarship recipient attends the American College of Surgeons 2013 Annual Meeting in Washington DC

LAURA WANG
TRAINEE, NSW

As the 2013 recipient of the John Buckingham Travel Scholarship, I was privileged with the opportunity to attend the American College of Surgeons (ACS) meeting this year, as a representative Trainee of the Royal Australasian College of Surgeons. It was Dr Buckingham's vision to foster closer personal and academic relationships between our two countries and the mission of this esteemed grant.

This was my first attendance at an ACS conference and I was very excited to attend a meeting with more than 5000 other surgical attendants. Members of the Residents and Associates Society (RAS) were extremely welcoming and involved us completely in its academic and social activities during the four-day conference.

I arrived on Sunday to a very quiet Washington DC; the US federal shut-down, meant that there were no politicians or lobbyist and very few tourists in town, much to the dismay of the many taxi drivers in the city. I attended the RAS meeting with its members and three other international Trainees from Italy, Lebanon and Ireland.

I was thoroughly impressed at the size and level of organisation of the RAS committee. We heard many impressive campaign speeches prior to the election of the new RAS committee. In the evening, an informal cocktail event at a local bar allowed consultants and Trainees alike to relax and mingle.

Each day was packed with many interesting and provoking academic sessions. Many concurrent sessions for each subspecialty were run by the who's who of international leaders of each field. In addition to the academic and scientific sessions, I was struck by the number of sessions on cost-effective healthcare, leadership and life-balance sessions at the American College meeting.

The international attendants were invited to attend special lunch and dinners organised specifically to facilitate international relations. I had the pleasure of meeting many international and Australian surgeons at the meeting including the recipient to the John Murray scholarship, Dr Julie Howle and Dr Stephen Smith. I also was pleasantly surprised to find many of these events to be run by Australian Fellow, Stephen Deane.

In summary, it was an absolute honour and privilege to be awarded the John Buckingham Scholarship this year. The ACS meeting was not only academically interesting, but also a unique opportunity to meet Trainees and consultants from around the world. The academic and social networking events were very well organised and I would not hesitate to encourage other Trainees to apply for this grant in the coming years.

COLLABORATION IN ADELAIDE

Forum and dinners held alongside the College Academic Section and the Surgical Research Society meetings complemented the quality of presentations over three days

RICHARD HANNEY
CHAIR, SECTION OF ACADEMIC SURGERY

Late last year, Stephen Tobin, the College's Dean of Education, and Professor Julian Smith convened an inaugural Forum for the Academy of Surgical Educators in Adelaide on Wednesday, November 13, addressing the Future Direction for Surgical Educators.

Cutting edge insights provided at a well-attended dinner-based function complemented the established meetings of the College Academic Section and the Surgical Research Society held on the following two days.

Michael Cadogan, an Emergency Department physician from Perth, provided visionary insight into 'e-innovations in Medical Education'. Opening more doors than just Facebook and Twitter, his illustrations of contextual learning highlighted approaches to cut through the white noise of unsubstantiated opinion on the internet to share valuable discussion between respected peers.

Websites such as the Healthcare Hashtag Project (http://www.symplur.com/healthcare-hashtags) provide a starting point for exchanges with informed colleagues. Margaret Bearman, from Monash University, discussed the role of 'Communities of Practice' in medical education. The term thoughtfully refers to the multiple collaborations with which we work each day in the operating room, in our offices and lecture theatres. Rick Iedema, Professor of Communication from Sydney, closed out the evening discussing 'Promoting Progressive Independence in your surgical Trainees'. He provided a series of valuable illustrations of lessons learned from video recordings of clinical teams in action.

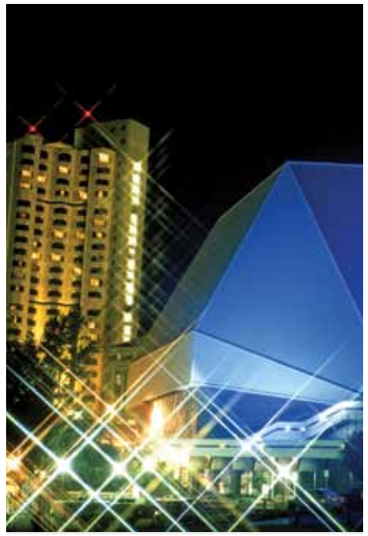
The Academic Section meeting on Thursday convened an inaugural mid-career workshop for academic surgeons, an initiative of Professor Andrew Hill from Auckland. Ian Bissett described his thoughts when considering 'Do I want to be a Head of Department?' before Professor David Hackam from Pittsburgh discussed 'Research training for the Surgeon-Scientist'.

Remarkably, these two erudite gentlemen from different hemispheres and specialties each reflectively illustrated their talk with the same African proverb: "If you want to go fast, go alone. If you want to go far, go together." No other advice is so consistently provided from academic meetings, nor is any truer in clinical practice. We will always achieve more and better in collaboration than we will in professional isolation.

Guy Maddern spoke to 'The shadowy world of academia' as only he could. The afternoon sessions usefully considered attributes of different models of teaching hospitals in an environment of increasing accountability and governmental intrusion into training processes.

Professors Glyn Jamieson and Andre van Rij spoke at a delightful 50th anniversary commemorative dinner of the Surgical Research Society of Australasia that evening, before the Society meeting the following day. There, nearly 60 attendees were privileged to hear original work from aspiring academic surgeons in many surgical specialties as well as exciting seminal work in paediatric surgery.

Leigh Delbridge convened the meeting where David Hackam spoke again,



this time describing exciting genomic work defining and working towards potential elimination of devastating necrotising enterocolitis in premature infants. Professor Chris Breuer described a thrilling journey in tissue engineering that has led to synthesis of 'neovessels' for venous, arterial and congenital cardiac deficiencies. If ever current research has remarkable clinical and financial implications, this was it. Marc Gladman's unit from Concord Hospital and the University of Sydney had six posters and podium presentations, more than any other.

The three-day series of meetings, helpfully sponsored by Covidien, will next year likely be concertinaed into two, providing every academic surgeon the opportunity to benefit from experience such as this year's. The Academic Section defines an academic surgeon as a leader who has chosen:

- to acquire specific training and experience in research and/or education, and
- to make these dimensions a significant part of their career.

We welcome all surgeons looking to broaden their own perspectives, as we look forward to next year's meetings being even more interesting than this year's, if possible.

Developing a Career in Academic Surgery

Monday 5 May 2014, 7:00am – 4:00pm
SANDS EXPO AND CONVENTION CENTER
MARINA BAY SANDS, SINGAPORE

Provisional Program

7:00am Registration and Breakfast

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

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

9:00am MORNING TEA

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

SESSION 2: CAREER DEVELOPMENT 9:40am - 11:20am
Chairs: Julie Ann Sosa (Durham, USA) and Philip Crowe (Sydney)
9:40am I want to be an academic surgeon. What can I do as a:
Medical Student . . . . . *Arthur Richardson (Sydney)*
Trainee – The pros and cons of fulltime surgical research during training. . . . . *Tarik Sammour (Auckland)*
Fellow . . . . . *Vincent Lam (Sydney)*
Consultant. . . . . *Mark Smithers (Brisbane)*

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

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

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

Workshop 1: Tools of the Trade
Chairs: Julie Ann Sosa (Durham, USA) and Wendy Brown (Melbourne)
Bedside to bench to bedside
John Windsor (Auckland)
Basic science
Michelle Locke (Auckland)
Randomised clinical trials
David Watson (Adelaide)
Outcomes research
Niraj Gusani (Hershey, USA)
Surgical education and research
Stephen Tobin (Dean of Education, RACS)

Workshop 2: Career Development Q & A
Chairs: Caprice Greenberg (Madison, USA) and Russell Gruen (Melbourne)
Multiple faculty
Frank Frizelle (Christchurch)
Michelle Locke (Auckland)
Timothy Pawlik (Baltimore, USA)
Andre van Rij (Dunedin)
Wei Zhou (California, USA)
and others
Attendees to bring along their own current or past research challenges for a masterclass with the faculty

Workshop 3: Presenting Your Work
Chairs: Guy Maddern (Adelaide) and Ian Bennett (Brisbane)
Writing an abstract
Julie Margenthaler (St Louis, USA)
Writing a paper
Timothy Pritts (Cincinatti, USA)
Presenting a paper
Sandra Wong (Ann Arbor, USA)
The ANZ Journal of Surgery – What the Editor wants and where the Journal is going
John Harris (Sydney)

2:40pm AFTERNOON TEA

SESSION 4: A CAREER IN ACADEMIC SURGERY 3:00pm - 4:00pm
Chairs: Timothy Pawlik (Baltimore, USA) and Frank Frizelle (Christchurch)
3:00pm Choosing and being a mentor . . . . . *Andrew Hill (Auckland)*
3:20pm Work-life balance . . . . . *Julie Howle (Sydney)*
3:40pm On the shoulders of giants . . . . . *Russell Gruen (Melbourne)*

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

Register online at www.racsanzca2014.com or email dcas@surgeons.org for a registration form.

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

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

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

AAS Association for Academic Surgery

Royal Australasian College of Surgeons,
Section of Academic Surgery

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

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

Brian Smith Memorial Award Grants Program - Colorectal Disease

Applications are invited for funding in 2014 towards research and surgical training in the area of colorectal disease.

Brian Smith was a leading Melbourne surgeon whose main surgical interest was disease of the colon and rectum, and this Award seeks to support medical research and further enhancement of the surgical skills and knowledge of researchers and practitioners having a special interest in colonoscopy, colonic cancer and the applied anatomy, physiology or pathology of the colon or rectum.

Up to $30,000 is available per award. More than one award might be made. Travel costs may be funded as part of an Award.

Applications will be evaluated by a specialist committee and should be made as follows:

Application Form and Lodgement: Email trustapp@anz.com to obtain an Application Form with lodgement details set out therein.

For further information telephone ANZ Trustees: (03) 8655 8083.

The closing date for applications is

12 March 2013.

CASE NOTE REVIEW

Death from sepsis and multi-system failure after delayed diagnosis of a perforated duodenal ulcer

GUY MADDERN
CHAIR, ANZASM

A middle-aged patient was brought in by ambulance to the ED of a major metropolitan hospital with sudden onset of severe thoracic back pain while using a transcutaneous electrical nerve stimulation machine for chronic fibromyalgia.

The patient had a number of comorbidities including type 2 diabetes, asthma, scoliosis, anaemia and a history of renal calculi. The patient was on multiple medications. Chest x-ray was said to be normal and ventilation/perfusion scan was negative for pulmonary embolism. Analgesia was given and the patient was admitted to the short stay ward for observation with no definite diagnosis.

Overnight there was hypotension at times, responding to intravenous fluid boluses. The following morning the ED Consultant suggested the possibility of renal colic in view of past history. The patient was then referred for an abdominal CT scan which showed free intra-abdominal gas and fluid.

The surgeons were consulted and the patient prepared immediately for theatre. Triple antibiotics were given. The patient was hypotensive on induction of anaesthesia. At operation a perforated anterior duodenal ulcer was found with gross peritoneal contamination. Repair of the perforation and peritoneal washout were performed. The patient required inotrope support throughout. Full ICU measures were instituted postoperatively, but the patient continued to deteriorate and died shortly after admission.

Assessor's comments

There was a significant delay in diagnosis of a perforated viscus in this case (nearly 24 hours) and this is highly likely to have contributed to the death of this middle-aged patient. However, the presentation (acute thoracic back pain) was very atypical. The abdomen was noted to be soft and non-tender.

I have never seen an anterior perforation of a duodenal ulcer present in this way. It appears that free sub-phrenic gas was not seen on the chest x-ray. An erect chest film to include the diaphragm is necessary to see this, and the chest x-ray might have been supine.

The following morning, renal colic was considered, leading to the abdominal CT scan that showed the free gas. There would not, on the face of it, have been a clear indication for an abdominal CT prior to this, but a patient presenting with severe thoracic back pain often has serious pathology (e.g. an aortic dissection) and a chest CT should have been performed. This also might have picked up the free sub-diaphragmatic gas.

Once the diagnosis was made the surgical and ICU management appears to have been exemplary. Unfortunately the patient's gross sepsis and comorbidities proved insurmountable.

My view is that the diagnostic delay was understandable; however, an erect chest x-ray or a thoracic CT might have allowed earlier diagnosis. When a chest x-ray is performed it should be, wherever possible, an erect film with diaphragm views.

Member of the Victorian Regional Committee, Dr Nicole Yap praises the qualities of her home town

A SURGEON'S GUIDE TO Melbourne

Victorian Breast, Endocrine and Melanoma surgeon Dr Nicole Yap credits her good fortune in being offered an opportunity to work under the supervision of renowned breast surgeon Professor Krishna Clough at the Clinique Bizet in Paris as providing the opportunity to change her approach to breast surgery.

Dr Yap, who works from St Vincent's Hospital and the Lorna Sisley Breast Clinic, Monash Hospital in Melbourne, said she uses her knowledge of plastic and oncology surgery to create a holistic approach to patients with breast cancer. She said that while she performs a complete oncological outcome, attention to the aesthetic result was considered from the outset of treatment.

"In my view, the breast is the symbol of womanhood, reproductivity and female sexuality," she said.

"Surgery to the breast is akin to defiling this empowerment by destroying body image and many women feel depressed and anxious after such surgery, yet breast oncoplastic surgery offers such women a way to overcome this.

"Many Fellows will know of the work done by Professor Clough because he has been an invited speaker many times.

"He taught me to concentrate on the final result, not just post surgery but also in relation to adjuvant treatment outcomes, in the treatment of breast cancer.

"Instead of starting down the path of treatment and then seeing what we can do to improve the outcome later, we consider a range of plastics procedures at the outset, such as using breast reduction surgery to reduce the effects of radiation treatment post lumpectomy.

"Some women have always wanted breast reduction surgery for example, and when I tell them I can treat the cancer and conduct such reduction surgery in one procedure they are delighted.

"We also undertake mastectomy procedures followed by breast enhancement reconstruction and when it is complete, many patients feel better about themselves than they did prior to surgery.

"I feel incredibly fortunate to have received such training and support both in Australia and Europe, but I take the most pleasure from having happy, healthy patients."

Dr Yap is on the Executive Committee of the Victorian Regional Committee of the College and was recently re-elected for another term after already serving four years.

She said she joined the Committee to give back to the College and the profession in recognition of the support given to her through her training and early days in practice.

She said the Victorian Committee was investigating a number of surgical care issues such as the establishment of a paediatric transitional care service to enable better management of children with congenital abnormalities as they move into adulthood, and the benefits or otherwise of concentrating certain specialties such as transplant surgery into specific centres.

"We are not lobbying for or against such matters, we are simply discussing the likely impact of any change to the current health model in Victoria," she said.

"Our focus, as it is with the College as a whole, is to determine if any changes can improve patient outcomes."

Dr Yap is also the current President of the Australian Chinese Medical Association of Victoria (ACMAV), her second time in the position.

In 2011, Dr Yap, with the assistance of the ACMAV committee, organised a small medical team to visit Xian, China, to treat orphaned children with congenital abnormalities.

"Plastic Surgeon Ian Holton from Geelong was instrumental in allowing this visit to go ahead," she said.

"We worked in collaboration with Starfish Orphanage, who take in children who have been abandoned because of deformities.

"We had 20 children lined up for surgery but, unfortunately, chicken pox broke out so we could only treat 15. It was still an amazing experience to not only meet the children and be able to help them, but also to grow professional relationships between Australian and Chinese surgeons. This was consolidated when we were asked to share our knowledge of our particular specialities by giving presentations to the hospital medical staff."

Born and raised in Melbourne and widely travelled, Dr Yap said it was Melbourne's dynamic multicultural atmosphere that she loved the most, an urban culture expressed from fine dining to the cafe culture, from high fashion, to world sport, and from the arts to street graffiti.

This is Dr Yap's guide to what makes Melbourne so marvellous. ▶

summer lifestyle

FOOD FABULOUS FOOD

Melbourne's population of a little over 4 million residents is made up not only of people from all over the world, but also the descendents of earlier arrivals with 140 distinct cultures now represented in Victoria's capital city. Nowhere is this global influence felt more often and more deliciously than it is in the food culture of the city from the tucked away Tapas Bars, to world-class Japanese, Chinese and French restaurants, to the pizzas of Little Italy in Carlton to the dim sum and doughnuts of open-air markets. A self-confessed "foodie", Dr Yap listed her current favourites as Koko at Crown, Shoya in Market Lane, the Flower Drum, Shanghai Dynasty, Guy Grossi's Florentino, Vue de Monde, France Soir and Mo Vida. She said: "I absolutely love eating out in Melbourne because there are so many cuisines to choose from and also because there is such a deep appreciation for good and interesting food here. There is the option of dining at well known and highly regarded restaurants, but it can also be an adventure finding the new places that are constantly opening up both in the CBD and tucked away in suburbs."

A SMORGASBORD OF SPORT

It might involve a tiny ball lofted over the fairway, a fluffy ball smashed over the net or a hard leather ball belted into the boundary. It might be a ball danced down the pitch, punted through the big sticks, knocked out of a scrum or hooped into the net. It might involve human pedal power, the horse power of potent engines or plain old horse power itself, but if a sport can be played, there is every chance it is not only played in Melbourne, but passionately followed. Now the city plays host to some of the most important sports events on the world calendar including the Formula One Grand Prix, the Australian (Tennis) Open, the Melbourne Cup Carnival and, of course, the mighty Boxing Day Cricket Test. Dr Yap, who cycles and plays a poor but valiant game of golf, said she loved the atmosphere in her home city when the circus comes to town.

"I enjoy going to watch some of the major golf tournaments – mainly to see what a good game of golf looks like – but I really love the Melbourne Cup," she said. "It's a wonderful experience and I've been to Ascot which doesn't even come close. If you haven't experienced the fun, the glamour and fashion, I'd recommend you find time to visit Melbourne during the first week in November."

A FASHIONISTA'S FANTASY

Melbourne is renowned for its world class fashion and design with global brands and local labels attracting customers from around the country and the region. With annual fashion highlights including the Summer Fashion Week and the fashion frenzy that is the Melbourne Cup Carnival.

Melbourne's more temperate climate lends itself to stepping out in style. Some of the unique big labels that now call Melbourne home include Alannah Hill, Dolce & Gabbana, Karen Millen, Paul Smith, Prada, Scanlan & Theodore, Zara, Claude Maus, Alpha60 and Arabella Ramsay, while the major department stores such as David Jones and Myer remain in permanent competition to attract the best from around the world.

Dr Yap recommended visitors take their time to wander the laneways and arcades of the city where hidden design gems could be found, stopping frequently for coffee. "I love the laneway and coffee culture of Melbourne as much as I love its fashion, so I highly recommend combining the two," she said.

"The fashion available in Melbourne is incredibly good and I often find when I travel overseas that Melbourne buyers pick the best of the best on offer in Europe which is excellent for time-poor people like me."

LIVING THE GOOD LIFE OUTSIDE THE CITY LIMITS

Dr Yap also said that no visitor's guide to Melbourne would be complete without a mention of the nearby wine regions such as the Yarra Valley (pictured) and the Mornington Peninsula, both of which are easy day trips from the city provided a designated driver can be found. Both districts offer not only fine wine, but good food, local markets, lovely vistas, historic gardens and galleries. And finally, no-one should visit Melbourne without driving the Great Ocean Road. Carved in rock and winding around the rugged southern coast of Victoria, the Great Ocean Road is one of the most spectacular war memorials in the world, having been built by soldiers who survived the horrors of the First World War.

WHERE THE WILD THINGS ARE

While Melbourne often boasts about its "liveability" status, it is not only the inhabitants of the human variety who enjoy what the city and surrounds have to offer. The Melbourne Zoo, located only kilometres from the city centre, is Australia's oldest and now houses 320 animal species. With a particular focus on conservation, the Zoo is highly regarded for its Orang-utan Sanctuary and Asian Rainforest, while the Australian Outback and the Butterfly House are perennial favourites. In the city centre itself is the Melbourne Aquarium where visitors can get up close and personal with such cute creatures as penguins and seahorses or, for more of a thrill, dive with sharks. Outside Melbourne to the East is the Healesville Sanctuary while to the West is the Werribee Open Range Zoo. As the brochure says, why travel thousands of kilometres for a taste of Africa when it is available just 30 minutes from town?

FOLLOWING FORTUNE

General Surgeon Mr Derek Brockwell makes best use of his skills in rural and regional locations

BY **DEREK BROCKWEL**

When the youngest child of General Surgeon Mr Derek Brockwell left home for university 15 years ago, he and his wife Helen decided to leave home also to live and work wherever fortune took them.

They packed up their life in Pietermaritzberg, an elegant, Victorian city that lies between Johannesburg and Durban in South Africa and first settled in Grand Cayman where Mr Brockwell worked as a general surgeon before they moved again to allow him to take up a rural posting on the South Island of New Zealand.

One year later, with the two still in the grip of wanderlust, Mr Brockwell first came to Australia to work in Alice Summers before he successfully applied for the position of General Surgeon at the Mersey Community Hospital in Tasmania.

There they have remained for the past 13 years, but just one year into his retirement, those itchy feet have returned and now Mr Brockwell has taken to picking up locum work one week per month in regional and rural towns upon the mainland.

So far he has worked in Broken Hill, Bega, Gladstone and Port Hedland and is planning an upcoming visit to Lismore.

"I started doing this as a way of exploring mainland Australia and to have the opportunity to live and work in places that I would otherwise never get to see," he said.

"Many of these small regional hospitals are mostly run by locums now which adds a different challenge to the work because you have to develop a team from scratch, understand quickly what skills are available and determine the work you can and can't do safely as a team.

"Most of my work consists of triaging patients, deciding which patients need immediate transfer to larger centres, such as trauma and cancer patients or elderly patients with co-morbidities with a responsibility to make the most efficient and effective use of the Royal Flying Doctor Service.

"I also deal with the general procedures you'd expect such as appendix, hernias, endoscopies and laparoscopies.

"I enjoy this work a great deal. I like exploring the new towns and their surroundings, meeting surgeons from around the world who also undertake this locum work and, of course, doing my best to help the patients."

Mr Brockwell grew up in Zambia before moving to South Africa where he did his under-graduate medical training at the Cape Town University before working for a short while as a GP.

Deciding to pursue surgery, he did his surgical training through the same university and at the Groote Schuur Hospital, a large, public, teaching hospital situated on the slopes of Devil's Peak in Cape Town.

"This hospital was where the highly acclaimed Professor Chris Barnard conducted the first heart transplant in the world and to study and learn under him felt like a great privilege," Mr Brockwell said.

"In those days we were given very broad, very extensive training before the modern era of early sub-specialisation and we did cancer, vascular, abdominal, head and neck surgery and one of the first operations I assisted on was a heart transplant.

"I have always been very glad for this broad-based training because rural areas all around the world still need general surgeons, so in a way it has allowed me to have the life I wanted, not just in terms of being able to travel and work, but to help a broad cross-section of patients.

"Young surgeons often find this range of work quite confronting which is one of the reasons that Australia now has such a problem attracting and retaining surgeons in rural and regional areas.

"Yet, at the same time, Australia has been fortunate to have had the skills and services of surgeons and medical specialists from many countries including from India, Iran, Russia, South Africa and even Romania to fill those gaps.

"I have greatly enjoyed meeting and working with these surgeons and specialists and would even describe it as being one of the highlights of my time in Australia.

"I believe that people in rural, regional and remote areas benefit from the skills brought by people like me who have decided to leave their own country, many of whom are highly trained senior specialists.

"Once language may have been an issue, but not so much anymore and I think this cross-pollination across countries is a wonderful thing, both for the profession of surgery and the care of patients."

A former marathon runner and now enthusiastic cyclist, Mr Brockwell lives with Helen and the family dog at Leith, a small town that lies at the mouth of the River Forth, 300 km north of Hobart.

Each year, they travel back to South Africa and New Zealand where they have children and grandchildren.

Still, despite all this globe-trotting, there are still places he wishes to visit and work in.

"I'd like to work in the smaller countries of the Pacific such as Samoa and Tonga just for that experience and to do what I can for people there," he said.

"I would have liked to have been involved in some of the College's service visits to these countries, but when you work in a smaller hospital that has only two surgeons you can't really put your hand up, even though you want to, because it puts too much pressure on your colleague.

"Since I've been here, indeed for all my working life, I've worked a 1 to 2 on-call roster meaning I have only ever had every second Christmas off and every second Easter and that has been quite tough, but now that I have the time I very much like to use it."

Mr Brockwell said that along with that extra time came both a more difficult adjustment to retirement than he had expected and a growing yearning to go home.

"I found to my surprise that I wasn't as secure in retirement as I thought I'd be," he laughed.

"I thought I'd enjoy the relaxation and peace, but I found it hard to deal with the fact that all of a sudden people didn't need my help any more.

"My family needs me, my dog needs me and my garden needs me, but that's not quite the same.

"I have also found that with this extra time, I'm thinking more about the past, looking through old photographs and such, and the desire felt by both Helen and I to be closer to our children and grandchildren is growing stronger.

"I'm still registered in South Africa and I'd like to work in parts of East Africa I haven't explored yet, so we will see.

"Maybe next year we'll move back home. Life is full of possibility, which is really wonderful."

With Karen Murphy

summer lifestyle

FROM THE HEART

Dr Anantha Ramanathan speaks of the stress relief in writing poetry in his native language

Regional NSW vascular surgeon Dr Anantha Ramanathan was born in Sri Lanka and spent most of his childhood there before moving to New Zealand, where he completed the majority of his surgical training.

Moving to Australia three years ago, Dr Ramanathan retains his links to the culture of his birth by writing poetry in Tamil, one of the oldest languages in the world. Last year, a collection of his poems was published in India, Australia and Canada. He talks to Surgical News about the beauty of the Tamil language and the serenity he finds in poetic inspiration.

When did you start writing poetry and what do you enjoy about it?

This all began about 30 years ago from my school days in Sri Lanka. There is a strong culture of poetry there and we were encouraged to create poems based on traditional Tamil themes and rhythms.

I fell in love with both the intellectual endeavour of it and also the satisfaction of expressing ideas as clearly and as beautifully as possible. Then, once you have the idea you work on it again and again until it is as good as it can be and the finished product feels like the birth of a child, in a way.

Why do you write in Tamil?

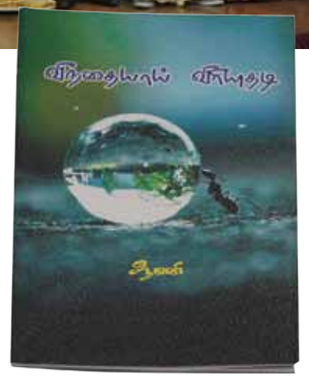
Tamil is my first language and I was taught to write poetry in Tamil, but more than that it is a wonderful language to work with. It is very phonetic, it has lots of nuances in that the same word can mean different things in different contexts. Tamil poetry is also very flexible in that the rhyme can be in the first words, or last and it uses a variety of metres and rhythms.

Tamil poetry has a tradition spanning back over more than 2000 years and Tamil itself is one of the oldest living languages in the world alongside Hebrew and Old Chinese. It is also a beautiful looking script and I get great satisfaction being part of that tradition, even in just a small way.

Do you find it hard to work in Tamil when you spend your working days in an English-speaking environment?

It is a challenge to retain the richness of the language when I use English all day, but I speak Tamil at home with my wife which helps. I also keep up-to-date with the culture and Tamil poetry through the Internet and my friendships with other Tamil writers.

Ceylon sunset on lake in Sri-lanka



When and where was your book published?
It was first published in India last January and later in Australia and Canada, both countries that have very vibrant Tamil communities. We chose to publish in India first, however, because that is where all the experts and pundits in Tamil poetry are to be found and fortunately I received mostly praise from them.

I did receive some criticism, though, because I coined a new word which is not altogether accepted in such an historic, traditional art form and also contravened some rules in some of my poems. I also sent a copy to the teacher who first inspired me to write poetry who still lives in Sri Lanka and he said it was of a professional standard which was pleasing.

What themes do you write about?
About half the poems are about romantic love with others about nature, spirituality, philosophy and politics. Even though the civil war in Sri Lanka is considered over, writing political poems does make me a bit nervous at times, but still I think poets need to be bold.

What reactions have you received for the poems in Australia?
There is a bustling Tamil literary scene in Sydney and after the publication of the book I got invited to present poems at a number of venues which I appreciated. In September, I presented a poem at an International Conference in Sydney. Part of that poem describes the Australian landscape and birds and was set to the beat of a Kookaburra birdsong. It won acclaim from the visiting academics.

Before that I presented another poem about a girl with Down's Syndrome who is raped during the war. She is unable to express her feelings to others because she cannot talk, but nevertheless she has the same feelings as any other human being. This poem also touched the hearts of a lot of people.

Do you find it hard to find the time to write poetry as a busy surgeon and does having such an interest enhance your working life?
I can always find the time; it's waiting for inspiration to strike and the idea to arrive that is the frustrating aspect of poetry. Yet, when it does arrive and the words flow and you get the beat you can work on the idea in the car or even in the gym.

Writing Tamil poetry is a passion of mine and there is no doubt that it provides great stress relief. It allows me to forget about all the day-to-day stuff and immerse myself in a very different world and in a different way of viewing the world. It gives me great sustenance and allows me to go back into my surgical life renourished.

What other artistic endeavours are you working on now?
I have recently finished writing a novel in Tamil that will be published in February. The literal translation of the title from Tamil is 'I am my Father', but the idea best translates into English as 'It is all Within Yourself'.

With Karen Murphy

Study surgeons' non-technical skills

Discover how your non-technical skills influence patient outcomes and the team you lead in the Operating Room

GUY MADDERN
CHAIR, ANZASM

A shared understanding and goals between all members of the team are essential elements to be developed to maximise patient safety in the Operating Room (OR). Studies have shown that while surgeons frequently give feedback on the technical skills of Trainees, there is hardly any feedback given on non-technical skills, which have an equally significant impact on patient outcomes.

Non-technical skills include:
- situation awareness, gathering information and anticipating the future course of the operation;
- making decisions based on the available options, implementation and review;
- communicating with the team, coordination and developing a shared understanding;
- leadership, support and maintenance of standards.

Non-technical skills are vital for safe intraoperative patient outcomes, but are not addressed explicitly in the training of surgical Trainees. Trainees have traditionally learnt in an unstructured manner in the OR by watching the good, and sometimes bad, habits of their mentors.

The Research, Audit and Academic Surgery Division (RAAS) has conducted a year-long project of research into the use of simulation to teach non-technical skills of surgery to Trainees. A significant amount of data has resulted from 160 simulations. The next step is to develop benchmarks for performance of these non-technical skills.

At the 2014 Annual Scientific Congress in Singapore, I invite Fellows three to 13 years post Fellowship to step into the OR and participate in live research into this fascinating field. Set aside 45 minutes to immerse yourself in an engaging OR simulation and it may change the way you practice.

Help in the development of benchmarks, view your performance on video, receive one-on-one feedback from a skilled debriefer and assist your College in this important research program. This valuable opportunity is without cost to you and it is anticipated that sessions will fill fast.

To book your session contact: Assoc Prof Wendy Babidge, Research, Audit and Academic Surgery at wendy.babidge@surgeons.org or T: +61 8 8219 0917.

Foundation for Surgery
Passion. Skill. Legacy.

WHEN 'SORRY YOU HAVE CANCER' HITS HOME

On any given day in Australia, 300 people will hear the phrase, "Sorry, you have cancer."

Many of them will be told by surgeons.

For many of you this is a phrase you say to patients; it is not one you think you will ever personally hear. Certainly, with a young family, you never believe you will hear, "Sorry, your two-year-old son has cancer."

In 2005 Michael was undertaking an orthopaedic Fellowship in Auckland. Life was fabulous with two gorgeous children and another on-the-way.

One day our son Conor complained of a 'sore tummy'. Michael felt an enlarged liver and the next day an ultrasound revealed he had liver cancer. We desperately hoped he 'only had localised liver cancer', but the CT scan revealed metastatic hepatoblastoma.

Our world changed. One day we had an active happy two-year-old, the next we were told he had a 50 per cent chance of survival.

Conor had 15 months of treatment at the Royal Children's Hospital in Brisbane, involving many rounds of chemotherapy, countless hospital admissions, numerous CT and MRI scans and multiple operations including removal of 70 per cent of his liver.

He did all this with the cutest smile on his face and he was always incredibly brave. Sadly, he was not one of the lucky ones and in July 2006, aged three, our beautiful son died leaving a hole in our hearts and a suffering so intense that no parents ever imagine will happen to them.

It is our personal journey and it is our direct involvement with both the Foundation for Surgery and philanthropic cycling organisation, Tour de Cure that makes us proud to announce a new collaboration between the two groups.

Through the combined expertise of the Foundation for Surgery and the dynamic and driven team at Tour de Cure, the intention of the collaboration is to establish a perpetual cancer research scholarship.

To enable this, Tour de Cure has committed to fund an annual surgical grant, administered through the College, to advance a cure for cancer.

Tour de Cure is a highly successful and professionally managed organisation that, since its establishment in 2007, has expanded its annual calendar of fundraising activities from a 1500km 10-day Signature Tour to hosting four-day country tours in Queensland, New South Wales and Victoria, partnering with Iron Man Melbourne and other major corporate events.

So far this dedicated team has funded 137 cancer research, support and prevention projects and carries the 'Be Fit, Be Healthy, Be Happy' educational message to schools in the towns they cycle through.

Projects they have funded in past years include The Melanoma Institute of Australia's effort to identify the biomarkers that are related to the development of resistance in each patient's melanoma and understanding the genetic and epigenetic mechanisms in Colorectal Cancer (CRC) through work at the QIMR Berghofer Medical Research Institute in Queensland.

They have funded many other surgical projects, but it is this exciting new collaboration with the Foundation for Surgery that will help them access the full breadth and depth of surgical expertise in Australasia.

Since 2011, in memory of our son Connor, our family has raised more than $120,000 to assist Tour de Cure to fund these important research projects. Much of this support has come from members of the surgical community and it is rewarding to see our family, friends and surgical colleagues support our involvement with Tour de Cure.

Being on a cycling tour with Tour de Cure is a fantastic experience that allows you to meet many wonderful riders and support crew and to hear the stories of cancer survivors, families who have lost loved ones to cancer and from those currently undergoing treatment.

It is a great reminder of the privilege and responsibility of being a doctor and a surgeon.

There is always a need for further donations to continue to support cancer research projects. Tour de Cure invites the surgical community to support this collaboration by making a donation to the Foundation for Surgery Tour de Cure Cancer Research Scholarship and to perhaps also consider becoming a rider or part of the support crew on one of their upcoming tours.

Donations can be made on the donation form in this, and each issue, of *Surgical News*. All donations are tax deductible. For more information on Tour de Cure please visit tourdecure.com.au

We don't shoot

Remember, there is more to deadlines than you think

SIMON WILLIAMS
CENSOR IN CHIEF

During the American Civil War, both sides sometimes imprisoned captured soldiers in areas defined only by a boundary drawn around them. These soldiers were warned by their captors that if they crossed the boundary they would be shot. That boundary became known as the deadline.

The College too has deadlines, and while going over them has consequences, being shot is not one of them.

Each year, particularly around the time for applying for a place on the Surgical Education and Training (SET) Program and registering for examinations, my colleagues and I in the College Education portfolio get pleas from people who have missed the deadline.

College deadlines are not imposed overnight. Notice is given via the College website, with additional reminders usually published in the weekly email newsletter Fax Mentis. Examination timetables are published months in advance, with well-established (perhaps even 'traditional') sitting times each year.

Missing a deadline can be devastating to the individual, but it is not fatal. In the vast majority of cases it simply means waiting until the next opportunity. The Fellowship Examination is conducted twice a year, as are the Clinical and Surgical Sciences exams. Selection is once a year.

It is understandable that people who miss deadlines will seek any opportunity to get an extension to the deadline. However, anyone seeking such an extension should also be prepared to accept that it may not be given.

Entry into the SET program is competitive. Each program lists the prerequisites for applying, that if not met make the candidate ineligible. Remembering to register in the four to five week registration period, and then, if approved to apply, lodging an application in the three week application period, is as important as having undertaken a mandatory rotation in an emergency department.

The doctor who wants to become a surgeon and who organises themselves so that they meet specified deadlines should be rewarded for doing so. Allowing a doctor to register after the closing date and compete for a training place is not fair to those who do the right thing. Nor is it fair – albeit to a much lesser extent – to those who also missed the deadline and simply accepted that they had missed the boat.

The deadlines for examinations are less about fairness than about planning. Anyone who has been an examiner will know that putting on a College exam is no easy feat and requires extensive planning.

Examination deadlines are put in place so that the Examinations staff can get Board sign-off of candidates and once the final number of candidates is known, prepare schedules, confirm venues and accommodation and engage examiners.

Not just in education, but across the College, we have engaged staff to perform our administrative duties. Our policies and procedures are designed to produce transparency and certainty and also to ensure the efficient use of staff time. The efficient use of staff is important in keeping our costs to a minimum.

It is important to remember that one of the nine College competencies is professionalism. Although the College will teach this during the life of the training program, the attainment of that competency begins in medical school, if not before. An element of professionalism is accepting accountability for one's own decisions and actions.

College office bearers are however not without compassion, and nor does the College aim to crush the aims and aspirations of Trainees, IMGs and doctors wishing to join our profession.

Forgetting, leaving things to the last moment, not knowing about published information, and contacting multiple Fellows at the same time does not generate sympathy. Raising a legitimate issue with the College before a deadline has passed may, and could lead to a solution.

But always remember, we won't shoot you.

COVER STORY

ADVOCATING BEST PRACTICE

Ways which the College is working to improve matters that impact you and improve the care of our patients

GRAEME CAMPBELL
CHAIR, PROFESSIONAL STANDARDS COMMITTEE

The College has been engaged in a variety of activities throughout 2013 to ensure that our voice is heard on matters that impact surgeons and the care of our patients.

Elective Surgery Urgency Categorisation

The College recently worked with the Australian Institute of Health and Welfare (AIHW) on elective surgery categorisation. This collaboration follows a request from the Council of Australian Governments for the AIHW to work with the College to propose national definitions and a package of measures that will produce greater consistency for elective surgery urgency categories for all Australian public hospitals, enabling consistent application across all states and territories. The project is just one example of the College's on-going efforts to increase its engagement with government to ensure that health policy that directly impacts our profession is developed in consultation with surgeons who are best positioned to advise on the realities of surgical practice.

Setting the Standards for Excellence in Patient Care and Professionalism

A number of important position statements were developed by the professional standards portfolio in 2013.

Intensive Care Units

The Areas of Responsibility and Control of Patients in Intensive Care Units position paper addresses intermittent concerns raised by some surgeons regarding who has control and responsibility for patients admitted to a hospital under the care of a surgeon and then transferred to an intensive care unit (ICU). The preparation of the paper involved consultation with specialty societies and the College of Intensive Care Medicine of Australia and New Zealand (CICM) to deliver a statement that has applicability across specialties and which promotes the importance of multidisciplinary collaboration in patient care.

Drug Use

The College is aware that many members of society may voluntarily use a range of drugs that have a pharmacological effect for personal pleasure or satisfaction rather than medicinal purposes. The position paper makes it clear that the College does not condone the use of illicit substances by Fellows, Trainees or International Medical Graduates (IMGs) under any circumstances and outlines the consequences to surgeons if they engage in this conduct at both a College and regulatory authority level.

Excessive Fees

While the College has not received any complaints about this issue from patients, there are anecdotal reports of a small number of surgeons charging extremely high fees for surgical procedures. While surgeons can make their own judgement on the fees they charge for their services, the paper recommends that a surgeon ensures that the fee is reasonable and does not exploit a patient's need. Discussion of surgical procedures with a patient and their family can be emotionally charged and the paper emphasises the importance of gaining informed consent, including allowing sufficient time for the patient to contemplate the procedure and fee before undertaking a course of treatment.

The development of these position papers demonstrates to regulatory authorities, our colleagues in other specialty fields and the public that we are both able and willing to set expectations around professionalism beyond the operating theatre. These papers outline the expectations we place upon ourselves as Fellows of the College and the steps that may be taken to address poor conduct when there is a breach of these standards.

Designing a Flexible and Streamlined Approach to CPD

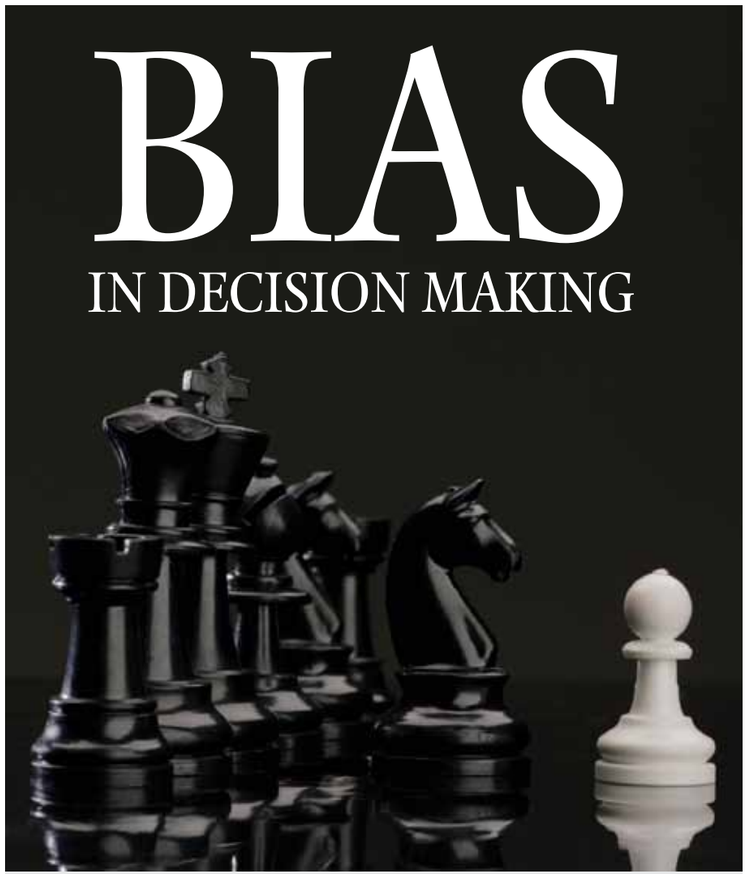
The CPD program is integral to maintaining professional standards and reinforces not only our commitment to our patients, but also defines Fellowship of the Royal Australasian College of Surgeons as representative of excellence in surgical care. This year has seen a transition from a triennial program to an annual model. The change to the program will make it simpler for Fellows to participate, enables the College to better support those Fellows who may be struggling with their requirements and provides the basis for a more responsive approach to adjustments to the CPD program as required. In addition, the CPD Online diary has recently been upgraded and streamlined to make it easier to record activities and it is hoped that the transition towards online recertification will make it easier for Fellows to verify participation.

What to look for in 2014

In 2014 we will continue to explore avenues to improve the services offered by the College to Fellows. Participation in CPD will remain a focus of our activities in 2014; particularly minimising the time taken for Fellows to enter their CPD and exploring technologies that can support streamlined processes. As we transition towards a digital College, this will include the development of a CPD app that can be used on iPhones and iPads.

We will also be releasing a Multi-Source Feedback e-Tool based on the College Surgical Competence and Performance guide. This will be available in the first half of the year and will be accompanied by an e-Learning module to support and encourage Fellows to monitor and reflect on their performance. Participation in this multi-source (360°) performance review will contribute significant points towards CPD requirements.

As a Fellowship-based organisation, our voice is only as strong as the contribution of our members. We have recently launched a Professional Standards page on the College website to highlight some of the important contributions that we all make in advocating for better health outcomes in the community. On this page you will find details on how to contact your Professional Standards Department who are available to assist all Fellows. I encourage you to get involved with the College and provide feedback on the issues impacting you, your practice and your patients.



BIAS
IN DECISION MAKING

Increasing challenges to College decisions and allegations of bias

PHIL TRUSKETT
CHAIR, BSET

Increasingly, College Education decisions are being challenged, with Trainees and International Medical Graduates engaging legal representation to assist them. In response to this the College now has the services of an in-house counsel to provide advice and assistance to the specialty training boards. Bernadine McNamara, the In-House Counsel, made a presentation to the Board of Surgical Education and Training regarding bias, which is an issue that has been raised in some recent appeals. I have asked Bernadine to summarise her presentation for 'Surgical News'.

The College Education portfolio makes many decisions in relation to Trainees, IMGs and others (such as applicants for SET). Decisions may be made through Specialty boards or other College boards or committees, or by individuals. Many of these decisions may be subject to judicial review, meaning that they can be challenged in a court of law. As an alternative to proceeding straight to the courts, the College offers an internal avenue of appeal via the Appeals Committee.

One ground on which a decision of the College may be challenged – either in an appeal or the courts – is by alleging "bias" on the part of the decision-maker. In this context, bias extends to what is termed "apprehended bias" as well as "actual bias". This means that even if a decision-maker was not in fact biased, but a reasonable argument can be made out that the decision-maker could have been perceived (apprehended) to have been biased, then this alone may constitute bias.

Meaning of bias

The meaning of bias has been considered in numerous court cases. In summary, bias means a closed mind on the part of the decision-maker as to the outcome of the matter being considered. Effectively the decision-maker has pre-judged the matter. Natural justice demands that the decision-maker must bring an impartial and unprejudiced mind to the matter to be decided.

While sometimes bias may be demonstrated during a hearing of the matter (e.g. at a board or committee meeting, or in an interview with the complainant), more commonly a challenge is based on alleged apprehended bias arising from the decision-maker's previous involvement with or consideration of the matter. For example, if a member of a College panel or committee convened to make a decision about a person:

- has participated in the making of a previous decision about the same person,

or

- has supervised, or is related to, the person,

that member (or proposed member) may be alleged on appeal to have been biased, in the sense that there was a reasonable apprehension of bias in the circumstances. Unfortunately, a successful allegation of bias on the part of one member of a decision-making body will taint the decision of the whole body. Such a decision may be directed by the Appeals Committee or court to be re-made (i.e., made afresh) by a differently constituted body.

Proof and defences

An allegation of apprehended bias does not by itself mean that it is proven, however. Apart from any dispute as to the underlying facts, there are defences available to the College and the decision-maker. Organisations such as the College, as opposed to Ministers of the Crown, government departments and statutory authorities, have sometimes been held to be subject to a less strict form of the rule against bias. Of particular significance may be the practicalities of decision-making in a complex, member-based structure, which have given rise to the principle of necessity. Sometimes it is unavoidable, for instance, to have a particular member on a panel because of a lack of a reasonable and suitable alternative appointment.

Further, a decision-maker's mind does not have to be a blank. An unbiased mind is not necessarily a mind which has not given thought to the subject matter or one which, having thought about it, has not formed any views or inclination of mind upon or with respect to it, as held by the High Court of Australia.

A high threshold

The High Court has also held that what has to be shown by the party making the allegation of apprehended bias is that the decision-maker's mind was incapable of alteration. This is a high threshold to meet. So it is not every involvement which a College decision-maker (or member of a decision-making body) may have had previously with the matter or related matter which will give rise to (apprehended) bias. Being aware of a previous decision, having views on the standards required of Trainees and IMGs, being aware of a Trainee's or IMG's past performance and having read the person's file are examples of circumstances which should not amount to apprehended bias.

If, as a board or committee member, supervisor or clinical assessor you are in doubt about the potential for bias or apprehended bias, the best option is to seek advice before commencing the decision-making process. You should contact the secretariat of the relevant board or committee who will either be able to clarify your concerns or refer the matter to In-House Counsel for further consideration.

Bernadine McNamara is the College In-House Counsel, providing legal advice to the College, its boards and committees, particularly in relation to Trainee and IMG matters, and contracts.

DEPRESSION RISK AMONG TRAINEES

The largest survey of doctors ever undertaken anywhere has revealed that medical students, junior doctors and Trainees are experiencing significantly higher rates of depression, anxiety and suicidal thoughts than the general Australian community

WITH **KAREN MURPHY**

In a world-first study, the National Mental Health Survey of Doctors and Medical Students was undertaken late last year for the independent national mental health agency beyondblue.

The survey analysed the responses to a detailed questionnaire completed by more than 14,000 medical personnel across Australia.

Conducted by Roy Morgan Research, the survey found that while surgeons experienced relatively low rates of depression and anxiety compared to colleagues in other specialties, junior doctors who worked longer than 50 hours per week suffer significantly higher rates of psychological distress, think more often about suicide, and are more burnt-out than their older colleagues.

While oncologists and specialist paediatricians experienced the highest rates of depression and anxiety among qualified specialists, surgeons and emergency medicine specialists were found to be the most likely to drink at moderate risk levels.

The survey also found that female doctors had higher rates of anxiety than their male counterparts and that the medical profession as a whole retained significant levels of stigma towards people with a mental illness.

Specific findings of the survey include:

- One in five medical students and one in 10 doctors had suicidal thoughts in the previous year, compared with one in 45 people in the wider community;
- Oncologists are the most psychologically distressed specialists while doctors, such as researchers and administrators, who do not deal with patients think about suicide more often;
- Male doctors work longer hours and engage in more risky drinking behaviours, but female doctors are more psychologically distressed and think about suicide more often;
- Perceived stigma is rife with almost half of respondents thinking doctors less likely to appoint doctors with a history of depression or anxiety and four in 10 agreeing that many doctors think less of colleagues who have experienced a mental illness;
- Doctors aged 30 and under work the longest hours of any age group and are the most likely of any group within the medical profession to have a current diagnosis of depression or anxiety, are the most likely of any age group to have suicidal thoughts and rate highest on the three burnout factors of high emotional exhaustion, high cynicism and low professional efficacy;
- 4.5 per cent of respondents listed bullying and 1.7 per cent listed racism as causes of stress and distress.

While the survey indicated that surgeons experienced relatively low rates of anxiety and depression in comparison to other medical colleagues, beyondblue CEO Ms Kate Carnell AO said that all indices of psychological distress across medicine were far too high.

She said the survey indicated that the surgical profession had higher levels of risky drinking than other sectors of medicine while having the fourth highest rates for bullying listed as a cause of stress.

She called on all medical colleges to read the findings of the survey and consider strategies to limit the distress being experienced by colleagues, particularly young doctors.

"This is the biggest survey of its kind ever undertaken and there is no doubt now that the medical profession has a major problem and it is time to act," Ms Carnell told *Surgical News*.

"beyondblue is calling on all medical colleges and medical schools to put this at the top of their agenda, because it is up to the medical profession to stand up and come up with ways to reduce stress and improve the quality of work life for all medical professionals."

Ms Carnell said medical schools should teach students how to deal with stress and also how to manage patient expectations, professional disappointment and competition.

She also called on senior consultants to remain mindful of the psychological health of Trainees as they moved through their training programs.

"One of the key factors relating to the mental distress being experienced by young doctors is long working hours, but another relates to the type of people attracted to medicine," Ms Carnell said.

"Most are highly intelligent and many are perfectionists who have very high expectations of themselves who often end up working in environments where they have limited control.

"That is a potent mix, and when such doctors can't achieve the outcome they are aiming for, they often internalise that frustration and distress.

"Competition also appears to be a factor because many medical students have grown up as children being the brightest in their cohort until they join a cohort of the brightest.

"Our survey suggests this can lead to levels of psychological distress which are double that of the general population.

"The medical profession as a whole needs to design ways to reduce the stress suffered by young doctors and give them the support they need during a particularly stressful time in their lives."

Ms Carnell also said responses to questions relating to the stigmatisation of mental illness within the medical profession were particularly concerning.

She described it as "confronting" to find that four out of 10 respondents believed they would be thought less of if they admitted to suffering from some degree of psychological distress.

"For the medical professional to hold such views is quite confronting and makes you wonder what they think of their patients," she said.

"In this era, clearly you would expect doctors to understand that conditions such as depression and anxiety are clinical conditions that can be treated and managed, particularly if they are addressed early.

"Junior doctors need support not stigmatisation; they need sufficient downtime to remain psychologically robust and they need to be taught how to deal with stress – and the time to act is now."

Ms Carnell said the high rates of depression and anxiety could be addressed by the medical profession developing a mental health strategy, designing new guidelines around working hours and providing better mental health education in universities to reduce stigma and increase psychological resilience.

FELLOWS IN NEED

The Executive Directors of Surgical Affairs can help

JOHN QUINN
EXECUTIVE DIRECTOR OF SURGICAL AFFAIRS (AUSTRALIA)

The College aims to be of service to all Fellows, Trainees and International Medical Graduates (IMGs) on a pathway to fellowship through all phases of their surgical career. To that end the College supports Trainees and IMGs throughout their training or period of oversight, younger Fellows with preparation for practice and all Fellows with continuing professional development, sectional interests, the path to retirement, senior surgeons and much more.

The College is also aware that crises of various types can impact on surgeons at any time. The College wishes to help Fellows in need. There are two Executive Directors of Surgical Affairs (EDSA) – one in Australia, Dr John Quinn and in New Zealand, Mr Allan Panting. Either of the EDSAs may be able to offer assistance, as discussed further here, but first what do we mean by a Fellow in need?

It is not unusual for Fellows to seek help at the time of a personal crisis. The crisis could be the result of

- a significant practice related threat or challenge,
- difficulty with colleagues or 'competitors', or in the workplace generally,
- ill health,
- a legal matter – perhaps the accusation of malpractice or more commonly a complaint from a patient or relative about communication,
- less than expected outcomes.

However, there are a plethora of scenarios that can lead to a distressing situation where assistance or guidance is required, or simply an opportunity to discuss the situation with a supportive independent colleague.

It is recognised that Fellows appreciate being able to confidentially discuss matters with a practising surgeon with the breadth of experience of the types of crisis that surgeons may face. It is fair to say that some Fellows may have reservations about contacting or seeking advice from the EDSA on the basis that the discussion might in some way be used against them. While conflicts may occasionally exist you may be reassured that confidential discussions will never be used against you. Please don't hesitate to seek help from the EDSAs, in the first instance.

How can the EDSA help? Of course for many Fellows in need, their lawyer, health professional, financial advisor or close surgical colleague should be the first port of call. The EDSA is not a substitute for any of those personal advisors/mentors. However, the EDSA can sometimes help by serving as a sounding board – to hear the problem and the proposed course of action and to offer advice or comment.

In some situations the EDSA may be able to help mediate a path for parties to a dispute, to navigate College or regulatory authority systems, or to connect Fellows with appropriate sources of help in the health sector. Sometimes the EDSA becomes involved in issues relating to the cognitive impairment of a Fellow, often unrecognised by the surgeon themselves.

The College is keen to know how it can help Fellows in need. In the future you should expect a Fellowship survey question on this subject, but before then please write to either EDSA on the kinds of help you see as appropriate, and how the College can be the "first port of call in a storm".

The College maintains the 'Support for Surgeons' web page accessed via the Member Services footer of the www.surgeons.org web site. This page is predominantly focused on health issues impacting surgeons including self-care, support networks and surgical friends, encouragement to regularly visit a general practitioner and peer support networks.

We are reviewing this page to see that it has the resources required by Fellows in need. Again your suggestions in this field are encouraged.

Please contact either EDSA – Dr John Quinn (Australia) or Mr Allan Panting (New Zealand) – on any Fellows in need matter. Email john.quinn@surgeons.org or allan.panting@surgeons.org

Who Wields the Scalpel?

SURGERY IN AUSTRALIA

The Australian surgeon in times past

PETER F BURKE
SPECIALTY EDITOR-SURGICAL HISTORY, ANZ JSURG.

The cover story of 'The Bulletin' magazine in May 1965 was, "Surgery in Australia". Sam Lipski wrote, "Who wields the Scalpel? The passing of the God-surgeon.

"The day of the scalpel virtuoso the 'God-surgeon', so beloved of novelists and so unloved by hospital staff has gone. For a start the most distinctive feature of surgery in Australia is that not much is done by surgeons with higher qualifications but by general practitioners: some put the figure at higher than 50 per cent.

"More surgeons and indeed the whole medical profession must try to grapple with the answers to the fundamental question – is the Australian patient getting the best surgery possible? The answer seems to be that at its best it is very good, that much of it is fair to good, and some is inexcusably bad.

"Critics of the NHS place the blame on the way the Government 'puts a price' on just about every removable organ, an appendix will fetch £22.10s ... the human being has about £300 worth of dispensable tissue," one conjectured.

In 1963 Sir Theodore Fox, Editor of 'The Lancet', wrote of "The Antipodes, Private Practice Publicly Supported," quoting a cynic, "round here, the indication for hysterectomy is any woman over 40 who still has her uterus".

The Australian scheme paid the same subsidy for an operation whether the operator was an internationally famous specialist or a recently qualified man in general practice.

With the 'retrospectroscope', we can now evaluate the opinions expressed then and compare them with current practice.

Foundation Professor of Surgery at Monash University, Hugh Dudley, observed, "Because in 90, 95 or 99 per cent of cases it is possible to get away with an operation of varying degrees of magnitude when one lacks wide surgical experience, either technical or in the field of pre-operative or post-operative care, there is no reason, argument or excuse for doing it. Surgery is difficult and dangerous; its practice to a high standard of excellence requires the diligence and discipline of whole-time activity".

Professor Dudley believed that both the public attitude, which does not demand specialist care, and the lure of the cash register conspire.

He pointed out that any tighter post-graduate training program in surgery would mean many changes: "A sterner accreditation for hospitals, with insistence on the maintenance of standards of record keeping, seminars and clinicopathological conferences, the grouping of hospitals both metropolitan and country so that such a standard can be maintained, staff can all participate in training and more patients can become available for training purposes; willingness of practitioners to yield their surgical cases to those whose bent and training is in surgery."

Professor John Dunphy, then President of the American College of Surgeons, considered the standards quite high; however, there was a great need for the development of expert 'firms', specialised units to deal with specific fields like vascular, thoracic and gastroenterological surgery.

In order to accumulate experience, to innovate, to undertake research and to teach, the time has come for the development of university hospitals: "Post-graduate surgical training has been virtually non-existent in Australia. All but two of the Professors of Surgery are foreign graduates and it is not possible for a young surgeon to complete his training in Australia ... there was too much emphasis on examination and not sufficient on training in the present Australian system.

"Most general practitioners who practise surgery maintain that they confine themselves to simple operations; to tonsils, appendices and minor repairs. It is doubtful, of course, whether there is such a thing as 'simple surgery'." Asks one Macquarie Street surgeon: "What happens if a GP opens you up for an appendix and finds a carcinoma of the bowel?"

The defenders of the honorary system believe that staff positions would mean the first foot in the door towards allowing the nationalisation of medicine and would not attract the best surgeons.

The tradition of "having a go" at a "bit of surgery" runs very deep in the Australian medical profession and is one of its deepest, although rarely discussed, divisive influences.

Geographically, the argument for allowing GPs to continue to perform surgery, is the strongest.

One eminent surgeon of world standing in his field had strong doubts, pointing out that there were very few places in Victoria or New South Wales, for instance, that are so isolated that patients cannot be brought to major surgical centres or surgeons brought to them. Queensland has set a lead here with the flying surgeon who works as a consultant to the general practitioner.

One specialist, recently returned from overseas, noted: "Besides, I am worried when I have to spend most of my day in my car instead of seeing patients; more concentration of patients, better postgraduate teaching, more research, less timidity in getting off our backsides within the profession – that's what we need."

Evaluating the value and impact

The Victorian Audit of Surgical Mortality (VASM) under the direction of the Australian and New Zealand Audit of Surgical Mortality (ANZASM) seeks to review all deaths associated with surgical care. VASM outlined its commitment to the audit in the October issue of the ANZ Journal of Surgery 2013. The following is the abstract.

BARRY BEILES
CLINICAL DIRECTOR, VASM

Since the Victorian Audit of Surgical Mortality commenced in 2007, 95 per cent of Victorian Fellows have agreed to participate and have provided data on the deaths of patients receiving surgical care. All public and the majority of private hospitals involved in the delivery of surgical services in Victoria have been submitting data on deaths associated with surgery. De-identified reports on this data are distributed in regular annual reports and case note review booklets.

Although informal feedback on the perceived value of the audit was encouraging, a formal review of all aspects of the audit was felt important. Consequently, an independent formal appraisal of VASM governance, documentation, datasets and data analysis was performed, in addition to a survey of 257 individuals (surgeons and other stakeholders) on the perceived impact of VASM.

The external review recognised increasing participation and acceptance by surgeons since the inception of the project. Governance mechanisms were found to be effective and acknowledged by stakeholders and collaborators. Robust participation rates have been achieved and stakeholders were generally satisfied with the quality of feedback. Suggestions for improvement were provided by some surgeons and hospitals.

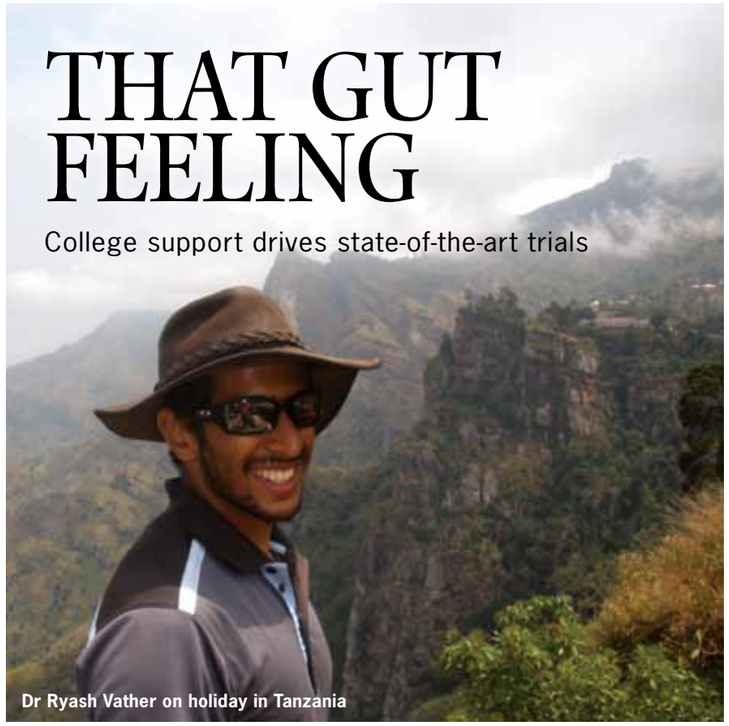
The findings of the external review of VASM processes and procedures confirmed that the audit was operating effectively with robust quality control and achieving the trust of stakeholders. The educational value of the audit to the surgical community was acknowledged and areas for future improvement were identified.

Karthikesalingam and P.J. Holt in a letter to the editor of the Journal recommended that a detailed study of the relationships between VASM participation and risk-adjusted surgical mortality, emergency readmission rates, re-intervention rates, post-operative complication rates, mortality after complications ("failure-to-rescue") and length of hospital stay should be still evaluated to underpin the value and impact of the VASM.

VASM acknowledges that the external independent audit has highlighted that VASM has reached the stage where ongoing monitoring of the audit value and impact can be implemented and some of the recommendations made to the editor within the scope of the mortality audit will be taken into consideration during future VASM evaluation and analysis processes.

THAT GUT FEELING

College support drives state-of-the-art trials



Dr Ryash Vather on holiday in Tanzania

WITH **KAREN MURPHY**

Research now being conducted at Auckland City Hospital could eventually allow surgeons across a range of specialties to better predict the likelihood and manage the occurrence of gut dysfunction following abdominal surgery.

General Surgical Trainee Dr Ryash Vather is conducting PhD research into the pathophysiology and management of Post-Operative Ileus (POI) via use of state-of-the-art fibre optic technology and the performance of a randomised controlled trial respectively.

Dr Vather said that while most patients undergoing abdominal surgery experienced some degree of post-operative gut dysfunction, particularly following bowel resection, up to 25 per cent suffer from a 'prolonged' ileus with symptoms lasting up to a week or longer.

He said prolonged POI – which includes symptoms of nausea and vomiting, inability to tolerate a solid diet and absence of bowel movements – have been shown to slow patient recovery and increase the risk of developing post-operative complications, with the cost of its management estimated at $1.5 billion in the US alone.

He said that while POI may be attributed to three cardinal factors – handling of the gut during surgery, use of narcotic analgesia and derangements in neurohormonal activity – much remained unknown.

Dr Vather's research incorporates the use of sophisticated High Resolution Manometry (HRM) technology, creation of a purpose-built risk stratification database for patients undergoing elective colorectal resection, and performance of a randomised trial.

"I chose to investigate post-operative gut dysfunction because it is an aspect of surgical care which has not been well characterised – from pathophysiology to risk factors to therapeutic management – perhaps a reflection of the ambiguity with which it is defined and reported," he said.

"It is also exciting science because HRM is a new technology only recently translated to humans and has not been used before to investigate this condition.

"Previous methods of gastrointestinal interrogation, either barometry or Low Resolution Manometry, have been encumbered by bulky recording devices which are logistically difficult to use in the peri-operative setting.

"However, HRM uses a fibre-optic catheter that quantifies pressure changes in real-time at 1cm intervals. When placed within the gut lumen, it can provide detailed information on pressure wave amplitude, direction, velocity and extent.

"At this time we still don't know if the clinical symptoms which herald gut dysfunction are underpinned by intestinal dysmotility, hypomotility or the complete absence of motility. We hope that by developing an appreciation of changes in peri-operative gut contractility, we may improve pathophysiologic understanding of this condition.

"This knowledge may serve as a platform for identifying new therapeutic targets and treatments."

Dr Vather is using HRM as part of a two-armed in vivo study: the first investigating the effects of healed distal colorectal anastomoses on motility and the second looking at changes in colorectal motility before, during and after colectomy.

He said research on the first cohort of patients has already been completed at Auckland City Hospital, with the study showing for the first time evidence of anastomotic nerve regeneration and a preserved meal response in humans following anterior resection.

He said that the second arm of the study is underway with hopes of reaching the proposed recruitment target by the middle of this year.

He also said that recruitment for the risk stratification database and randomised trial are progressing well.

"We know that increasing age, male gender, peri-operative narcotic consumption and intra-operative blood loss have all been associated with the occurrence of POI," he said.

"However, these findings are based on retrospective studies with varying definitions of ileus.

"We are working to more accurately identify relevant factors by prospectively collecting information for a risk stratification database.

"Approximately 90 peri-operative variables are being recorded for each patient undergoing elective colorectal resection at Auckland City Hospital with all patients subsequently being independently and uniformly assessed for the occurrence of an ileus.

"We are also currently undertaking a double-blind randomised controlled trial investigating gastrografin versus placebo for the therapeutic management of prolonged POI," he said.

Dr Vather said that if this randomised trial was positive, its findings would first need to be validated by other centres in other populations before gastrografin could be used clinically for this condition.

"In this specialty we see a small but significant group of patients who suffer enormously because of post-operative gut dysfunction," he said.

"If we can better understand its pathophysiology and risk factors, we'll be much closer to being able to prevent and hopefully treat it."

Dr Vather's research has been supported by the College through the Foundation for Surgery Scholarship for 2012 and 2013 and is being conducted under the supervision of Associate Professor Ian Bissett from the University of Auckland.

He said he has greatly enjoyed his time conducting scientific research and that the support of the College had been invaluable in lending credibility to research objectives and hypotheses.

"I am grateful for the unfaltering support, counsel and encouragement provided by Associate Professor Bissett throughout my research," Dr Vather said.

"I am also fortunate to have received academic guidance from Dr Tarik Sammour, Dr Arman Kahokehr and Dr Greg O'Grady, all College Trainees who have completed doctoral research at the University of Auckland."

DR VATHER'S CAREER HIGHLIGHTS

> 18 peer-reviewed publications
> 17 refereed conference proceedings
> Louis Barnett Prize, NZ Annual Scientific Meeting (2012)
> Best General Surgical Presentation, RACS Annual Scientific Congress (2013)
> Runner-up Travel Award, RACS Surgical Research Society Meeting (2013)
> Best Oral Presentation, NZ Society of Gastroenterology Annual Meeting (2013)
> $100K project-related funding raised

Why social media matters

A view from an actively tweeting Trainee

HELEN FREEBORN
UROLOGY SET 1, RACSTA QLD REPRESENTATIVE

As a Urology SET 1 who has been placed in a General Surgery position with no specific urological services accessible in the hospital, social media (a.k.a. SoMe) has played a large and often underappreciated role in keeping me motivated and connected to the wider world of Urology.

SoMe, in particular Twitter, has enabled an avenue of communication and knowledge expansion via a connectivity that has yet to be cemented in my medical life to date. By following multiple Trainees, consultants and journals, my knowledge and understanding of Urology is kept current. Twitter also creates an environment for posing questions and queries about various aspects of Urology and current evidence enables answering from consultants and Trainees worldwide.

To date, the most useful element of SoMe has been the creation of an International Urology Journal Club. Not too dissimilar to a regular hospital based journal club, once a month a recent urological article is selected by the International Urology Journal Club #urojc and a time frame is allocated for questions and discussions on this article. Merit on the methodology, outcomes and if or why a change in clinical practice are considered.

The international flavour of Twitter provides brilliant networking with fellow Urology Trainees and specialists from around the world. At an upcoming international Urology meeting, due to engaging with the Urology Twitter community, an invitation was forthcoming for a select group of the 'twitterati' to attend a networking event. An opportunity that would not have transpired without an involvement on SoMe.

I am pleased to be a part of an innovative specialty, which values the role of SoMe in educating and developing its members worldwide. There is a number of other email or internet based surgical discussion groups across many specialities. These forums are particularly useful for Trainees and surgeons alike who are isolated by geography, but equally can also connect a group of Trainees across the same city.

I would recommend to all my SET colleagues in a similar position to sign onto Twitter and join in the discussion.

ACADEMY OF SURGICAL EDUCATORS

What a year it has been!

JULIAN SMITH
CHAIR, PROFESSIONAL DEVELOPMENT, CHAIR, ACADEMY OF SURGICAL EDUCATORS
STEPHEN TOBIN
DEAN OF EDUCATION

What a great year 2013 has been for the Academy of Surgical Educators (ASE) with the establishment of a membership base of more than 500 people and around 900 attendees participating in our activities and courses.

The Academy was established to support, enhance and recognise surgical educators within the College. Since its inception it has evolved into an active community of practice and this year will start to reward and recognise the contributions of its members.

The Academy offers a range of educational activities, resources and recognition to its members in order to support them in their role as a surgical educator. Educational activities include the Academy Forum, National Simulation Health Educator Training program, the Graduate Programs in Surgical Education, Supervisors and Trainers for Surgical Education and Training, Keeping Trainees on Track, Surgical Education and Training Selection Interviewer Training, Non-Technical Skills for Surgeons, Surgical Teachers Course and the Educator Studio Sessions. The Academy is supported by an eLearning platform that houses recorded presentations, podcasts, journal articles, calendar of events, discussion forum and eNewsletters.

In 2014 the Academy will initiate its reward and recognition program and address its primary purpose of thanking the educators that tirelessly support the College. These include the awards of Supervisor or Mentor of the Year, Instructor of the Year, Examiner of the Year, Training Hospital of the Year and the Sir Alan Newton Education Award. There will also be recognition for commitment with lapel pins and certificates awarded to supervisors, mentors and instructors after three, six and nine years.

The Academy hosted its inaugural Forum in Adelaide last year with presentations from renowned medical educators. This year it will include the presentation of the Academy Awards.

The Educator Studio Sessions showcase presentations from renowned medical educators on topics of interest to members. The next session is on Tuesday, March 11, in Melbourne with Assoc Prof Victoria Brazil, Academic Lead for integrated Clinical Practice, Faculty of Health Sciences and Medicine, Bond University, on 'A Health Service's Approach to Education and Training'.

'The National Health Education and Training in Simulation' is a program for surgical educators who use or intend to use simulation as an educational method to support the education and training of surgeons. The Academy ran four courses in 2013 and has three more scheduled this year.

The 4th Conjoint Medical Education Seminar on 'Revalidation' will be held on Friday, March 14, at Hilton on the Park, Melbourne. It will be hosted by the Royal Australasian College of Surgeons, Royal Australasian College of Physicians and Royal College of Physicians and Surgeons of Canada and will involve international and domestic presenters including Sir Peter Rubin, Dr John Adams, Mr Barry Beiles, Dr Craig Campbell, Dr Linda Snell, Dr Joanna Flynn, Prof Liz Farmer, Dr Jocelyn Lockyer and Dr William Pope.

The joint Graduate Programs in Surgical Education offered by the University of Melbourne and the College offer a suite of programs that address the specialised needs of teaching and learning in a modern surgical environment.

The Academy is supported by an interactive online learning community where members can gather ideas, share interests and research, find resources and keep abreast of upcoming events. The environment is supportive, collaborative and fosters enthusiasm in surgical education. It includes: a discussion forum, resources, links to articles, eNewsletters, grant information and research opportunities, listings of workshops and courses, pathways to become trainers and supervisors and award information.

Membership of the Academy is open to all Fellows and Trainees and external medical educators who have strong educational interests and expertise. For more information on getting involved in Academy activities or how to become a member please contact Kyleigh Smith on +61 3 9249 1212 or ase@surgeons.org

The Academy of Surgical Educators welcomes its 500th member

Mr Kareem Marwan FRACS
General and Colorectal Surgeon

Firstly, congratulations on becoming the Academy's 500th member. Could you please give us a short introduction about yourself?

I am a consultant general surgeon with a specialist interest in colorectal (lower gastrointestinal) and laparoscopic surgery. Currently I have a public hospital appointment at Eastern Health and a specialist surgical practice based at Knox Private Hospital (in Victoria).

I obtained my FRACS in General Surgery in February 2012 after training at St Vincent's, the Alfred and Monash Medical Centre. I spent 18 months in Colchester, UK where I undertook a Fellowship followed by a consultant post in colorectal and advanced laparoscopic surgery.

What is your background in surgical education?

I had a five year honorary appointment as a lecturer with Monash University, contributing to undergraduate teaching and research. Overseas I was part of a team of trainers at the state-of-the-art, purpose built ICENI centre in Colchester, UK. As a training hub, the ICENI centre holds various surgical training courses aimed both at Trainee and trainer. This includes Masters courses in minimal invasive surgery, training the trainers and many others.

How did you get involved?

Upon my return to Australia, I decided to continue my role as a surgical trainer and educator alongside building my clinical practice. I am privileged to be accepted as a member of the ASE; this involvement was suggested and supported by my colleague Fellow Roger Wale, who acted as my mentor during my training years and continued on as an important source of valuable advice.

Why is surgical education important to you?

While overseas as a surgical Fellow, I came to realise that our surgical training is second to none. This was not just a personal impression, but also based on feedback from British trained surgeons who have had some form of surgical training in Australia. Maintaining excellence in surgical training and education is becoming more challenging with more Trainees, economic pressures, increasing hospital safety regulations and the need to comply with safe working hours directives.

Certainly, in that respect, the UK may be seen as our crystal ball to the future of training. Few would argue that the factors aforementioned have not impacted negatively on the quality of surgical training. In order to avoid this happening to us; we need to be innovative in our use of exciting resources such as digital simulation, webinars and online training videos to increase efficiency of time and place. Of equal importance is our training culture.

Do you think it is important to have a supportive community of practice in surgical education and why?

Those who have the interest and natural ability to train need to be sought, trained and empowered to form a cohesive and creative team which will guarantee the future of our surgical training. I believe this is what the Academy of Surgical Educators stands for.

I am passionate about 'smart surgical training', and helping Australian surgeons reach the fine balance required of the surgeon/trainer role. My aspiration for our surgical training is to be exemplary, and I am confident we will get there.

HENRY SIMPSON NEWLAND AND THE ROAD TO SIDCUP

Despite his career as a General Surgeon, Newland was important in advancing plastic surgery

ELIZABETH MILFORD
ARCHIVIST

Lindsay in studio

In 1964, College President Kenneth Starr commented on Sir Henry Newland's contribution to the facio-maxillary section of the 'Official History of the Australian Army Medical Services 1914-1918', saying that it "reads like a modern textbook on plastic and reconstructive surgery".

Born in 1873 and educated at St Peter's College and the University of Adelaide, Sir Henry Newland's encounter with plastic surgery was brief, influential and determined by the exigencies of the 1914-1918 war.

As was common in an era before surgical specialties, Newland was a general surgeon. In 1901 his postgraduate studies found him at the 'Septic Block' of the London Hospital which gave him experience in the treatment of infected wounds. In the same year, following visits to Dr Theodor Kocher in Switzerland and Dr George Crile at the Cleveland Clinic, he became interested in new techniques of thyroid surgery. And a later visit to Europe and America, led to an enduring fascination with neurosurgery.

However, like so many others, Newland's surgical career was put 'on hold' by the outbreak of World War 1. He enlisted in late 1914 and was posted as a Major with the 1st Australian Stationary Hospital (1ASH). After a brief stay in Egypt, his unit was sent to establish a 200 bed hospital at Lemnos.

Newland's first task was to survey the site for the hospital and in company with General Birdwood, he spent a night aboard a naval cruiser. By the end of July 1915, the 1ASH had expanded to 1,000 beds and in October, it was decided to move the hospital to Gallipoli. Once again, Major Newland was sent to survey the site.

"We then went to Anzac and were there during the famous storm [torrential rain which flooded the trenches, then snow and extreme cold which caused the ground to freeze]. I went all around the lines with the man who wrote the Australian history of the war, CEW Bean ..."

Newland was sent to France in 1917 and he says, "It was a beautiful spring and we went up to Rouen and from there to Estaires. We were there for some months, and then went to the Somme and Passchendaele."

Working as a surgeon with the 3rd Australian Casualty Clearing Station based at Grévillers and later Brandhoek, Newland specialised in abdominal cases. However, the slaughter during the Ypres campaign meant that this "first class surgeon who was as strong as a horse" gained experience in all kinds of military surgery.

He also encountered Charles Bean again and there is an intriguing image in Newland's photograph album in the College Archive which shows Harry Gullett, John Masefield, Will Dyson and Charles Bean peering over a ridge at a desolate, treeless battlefield. Perhaps this liaison with two war correspondents, a poet and an artist was in what Newland's friend, George Bell described as a "quiet period". He says that during an occasional respite from the operating tent, Newland "took plenty of exercise and even took part in a cricket match in which I remember he bowled very good length balls".

At the end of 1917 Lieutenant-Colonel Newland was appointed as commander of the Australian section at the Queen Mary's Hospital at Sidcup in Kent. Set in the idyllic grounds of Frognal House – once the home of Viscount Sydney – the hospital had been established by Harold Gillies who "did more than any other man towards establishing plastic surgery as a specialty". Consisting of sections from Britain, Australia, New Zealand and Canada, the hospital specialised in facial and jaw injuries.

Henry Newland with patients at the Queens Hospital, Sidcup

Digs La Touche, Fay Maclure and Daryl Lindsay

Captain Charles Bean

After a period spent observing the work of the British section, Newland was able to report that he had performed his first operation in January, 1918. He also said that "One sees a great number of fractured jaws and the work is very interesting and promises to give great scope to originality."

The work at Sidcup was undoubtedly very innovative and the hospital employed a variety of staff ranging from surgeons, dentists and technicians to war artists such as Daryl Lindsay in the Australian, and Henry Tonks in the British, section.

In order to create a comprehensive picture of individual patients, everything was meticulously documented. And much of this significant material including the watercolour sketches Lindsay produced at Sidcup and X-Rays, diagrams, black and white photographs are in the College Archive.

On the advice of his brother-in-law, Will Dyson, Daryl Lindsay promoted himself as a war artist and probably met Henry Newland in early 1917. At some stage Newland gave his World War 1 photograph album to Lindsay who subsequently donated it to the College. The album combines photographs from the Western front with a record of the staff, patients and surrounds of Sidcup.

Pictures of patients in their Sidcup (blue and red) uniforms vie with a rare image of Daryl Lindsay with his artist sister Ruby Lind who succumbed to the influenza epidemic in 1919. Another photograph shows Lindsay working in his 'studio', surrounded by images of damaged faces and plaster casts. Newland is captured hard at work in his office and posing with patients and Lindsay is shown with surgeons, Alfred Fay Maclure and William Digges La Touche.

After representing the AAMC at the Inter-Allied Surgical Conferences in Paris in 1918, Newland left Sidcup in the middle of 1919. Prior to his departure, his friend George Bell wrote: "Went down to Sidcup and saw Colonel Newland do a bone graft of a jaw. Technique excellent." And a contemporary account stated that: "... many a man whom would have dreaded to look in the mirror owes the fact that he can shave himself without a suicidal shudder to the Adelaide surgeon who goes about his work so quietly".

But although Newland is remembered for his work at Sidcup, he was not destined to practice as a plastic surgeon. Despite the advances made at Sidcup, the fledgling specialty had no following in Australia. Thus, Newland enriched by his experiences during the war, returned home to work as a general surgeon at the Adelaide Hospital and the Adelaide Children's Hospital. He was knighted in 1928 and was very active in the early College, firstly as a Founder then as President from 1929-1934.

LETTERS FROM HEIDELBERG

Reflections with Don Marshall on Benny Rank and the evolution of Plastic Surgery in Australia.

Opus XXX

FELIX BEHAN
VICTORIAN FELLOW

Alistair Cooke's weekly radio program 'Letter from America' described personalities and events over 58 years of broadcasting. Similarly my weekly conversations with Don Marshall led me to reflect on his pearls of wisdom, over a career in surgery which is really a tapestry (like the Bayeux) of his surgical life.

Yes, Don recalls Benny Rank (BKR) often, who lived in Heidelberg and was a hard taskmaster. Once he criticised a speaker from Sydney at an early College meeting when the presentation did not meet BKR's level of excellence, commenting publicly, "If this is the standard we are going to adopt for future (College) meetings, we are doomed to failure."

Surgical fees surface repetitively in our discussions. This led Don to recall the story of a well known British surgical figure, a Lord, consulting a patient in the Home Counties by train from London. He was pre-eminent on the London scene, reflecting the adage ... "successful surgeons have a low complication rate and their opinions are highly valued".

He saw the patient, organised his management and caught the train back to Paddington that evening. The following day discussing this with his surgical team, his regular anaesthetist, cautiously and even tentatively, inquired: "What would one charge for such a consultation?" Without hesitation (in the days when fees were quoted in guineas), he responded "£21 -17s -7½d". His anaesthetist replied, "That's a somewhat unusual amount. How did you arrive at it?"

"Quite simply," the surgeon said. "That's all they had."

We are all aware of Aesop's fable of the goose that lays the golden egg; and health funds are not a bottomless pit, to quote Brendan Coventry of Adelaide. As we have seen in the press recently, the Medicare system is under increasing pressure financially, with GP proceduralists costing the system up to $20 billion, quoting Professor Brooks in the Age. What must the figure be for specialists?

This is unsustainable with an ageing population and fewer taxpayers. It begs the question, "What has this to do with surgery?" Nothing! However, financial management reflecting costs affects us all. At one extreme, a microvascular breast reconstruction for a little under a five-figure sum creates the platinum card level of surgical elegance and perhaps, one hopes, total patient satisfaction. Others do it for less.

Yet in the public system, the less privileged are not always so fortunate.

Only recently, a major US health fund, conscious of spiralling costs, set the rebate fee for any form of breast reconstruction at $2000 regardless of the procedural details. Cost containment invades the surgical decision-making process, which is wrong, but they control the purse strings. Consequently surgeons have reverted back to traditional implants and flap reconstructions unless the patient pays the difference.

Where do we sit in Australia? Most are cognisant of the fees charged in private practice. The young surgical Trainee is exposed to this and the MBS schedule numbers as well, so costs (and therefore income) are not hidden, perhaps creating the expectation of a substantial income once their training is finished.

Don quotes the story of the late Barry Milroy in Sydney, who was asked by his academic mentor, "Now you are going into practice, Barry – are you going to become an academic surgeon or a merchant surgeon?"

Some surgeons embark on elaborate and expensive microvascular reconstructions when simpler alternatives may be available. Never forget Occam's razor principle – simplicity is often best. At a recent International Microsurgical meeting, some of the cases presented caused one attendee to state to me, "Some were just reinventing the wheel" – and possibly gilding the lily.

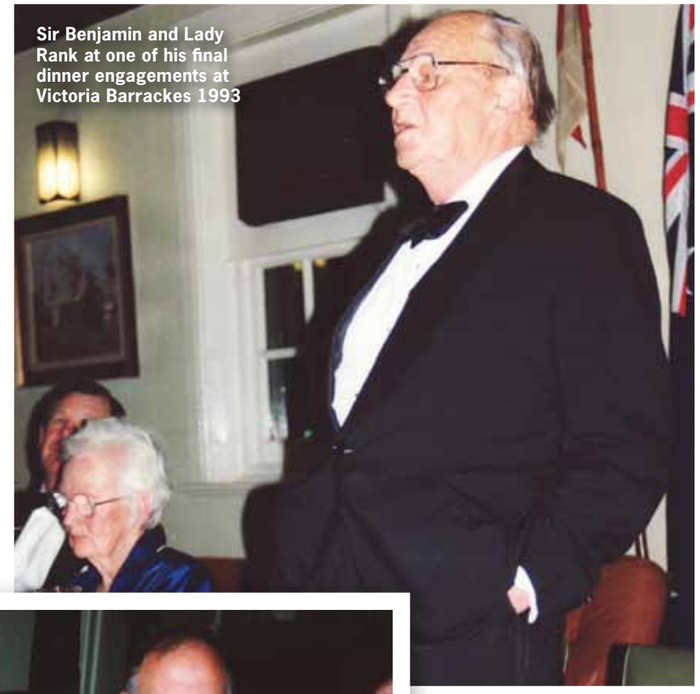
Our discussions in the Age touched on our duty of care and service to patients for optimal outcome. In both the public and private systems we are now burdened with the legal necessities of reams of paper and umpteen signatures as the basis of Informed Consent to cover legal liabilities.

On reflection it is apparent that by spending a little extra time in consultation with the patient, repeated pre-operatively in the anaesthetic bay and reviewing the surgical proposals, problems may be solved before they commence. In the public system this process breaks down when non-clinically qualified administrators fill vacant lists for operating surgeons without the benefit of pre-operative outpatient consultation. Without prior knowledge, the surgical decision may be inappropriate.

In aesthetic surgery, Benny warned the plastic surgical group that all such procedures are best separated from the MBS schedule to prevent marginalisation, which we see happening now. How does one determine the quality of surgery to match the price? Complications inevitably will occur, as reflected in the Marsden adage, "Only liars don't get complications."

Any patient who has paid a high fee has high expectations of success and conversely similar levels of redress when things go wrong. Recently in London a seven-figure sum was paid to a prominent businesswoman following a facelift complicated by division of a branch of the facial nerve. Imagine the personal strain inherent in such legal processes going on for years, enough to lift the linings of your coronaries or your gastric mucosa.

Following settlement, the MBAs at the next board meeting of the insurance ▶



Sir Benjamin and Lady Rank at one of his final dinner engagements at Victoria Barrackes 1993

Don also in attendance

company divide this settlement cost amongst the members, raising premiums – yes, we pay for our mistakes. Be aware of the Pareto principle (1906) that, "80 per cent of the effects come from 20 per cent of causes" including costs and complications. There are regular offenders in surgical medico-legal settings.

Never forget the patient 'is always right', the principle adopted by César Ritz, the King of Hoteliers in Paris and London years ago. He came to Paris in 1867 for the Universal Exhibition, working at a high class restaurant 'Voisin', waiting on the likes of Gautier, Alexandre Dumas and even Emil Zola (we are enjoying the series 'The Paradise' on television at the moment).

His code of excellence embraced the following: seeing without looking, hearing without listening and anticipating without being presumptuous. He believed the contract with the service provider was where the provider must always be subservient to the paying customer, a concept relevant to patient management.

And another story about fees. A Director of Surgical Services was contacted by an Adelaide patient regarding a lipectomy to be done by a local plastic surgeon, checking on the surgeon's qualifications and standing. She was reassured of the surgeon's competency to do a Pitanguy lipectomy, but as a closing comment was asked about the price. Without hesitation, embarrassment or equivocation, she quoted a sum of $8,000. The response was "That's interesting. You know you can get a heart transplant for $4,000."

When I was Director of Surgical Services with Bob Thomas at the Western

Oliver Wendell Homes

Hospital, the idea of doing an MBA crossed my mind. My interest waned when I discovered the time taken would detract from my clinical teaching and publication (a Companion volume to the Keystone text is coming out with Elsevier in March 2014). Thus treating a patient, no matter what their social status, goes hand in hand with a teaching commitment as every patient teaches us something equating to experience.

Time for reflection

In the 1890s, Oliver Wendell Homes said, "A good clinical teacher is himself a medical school." Osler's epitaph reads, "I desire nothing else. I taught medical students in the wards and I regard this as the most important and useful work I have been called upon to do." Similarly Charlie Mayo in the Proceedings from Mayo Staff Clinic (1927) said, "The safest thing for a patient is to be in the hands of a man engaged in clinical teaching. In order to be a teacher, the doctor must always be a student."

I note 2014 is the 150th anniversary of the establishment of the Mayo clinic in Rochester, Minnesota, where the best for the patient and the best available expertise, using the most modern methods are all considered paramount. Incidentally Munificence with Beneficence can sustain the Ailing (my clinical 'MBA'). Don also recalls his brother Bob's famous statement, "If you are sick overseas, go to the University Department's second-in-charge (who does all the emergencies) to get the best possible outcome."

I have mentioned principles of life in clinical practice from Osler to Mayo to Wendell Holmes. No biography of these gentlemen or their peers ever reflects financial rewards, i.e, without any arrière pensée. Adoption of a teaching ethic brings a harmonious balance to professional practice. Another Benny statement was, "To operate as a surgeon is a fulfilling and satisfying existence, amply rewarded, and even puts fruit on the sideboard."

If I had not heard these tales and more from Don (acting as his amanuensis), often quoting Benny, many would have been lost to history. Benny taught us the importance of a commitment to a public hospital practice, including teaching.

If a patient cannot afford a procedure, the public system should be the alternative. Benny invited Don into partnership to become, in turn, the reflective voice of plastic surgery in Australia (if not its conscience), as etched in these redacted vignettes.

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

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

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

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

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

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

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

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

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

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

Tenure: 3 - 12 months

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

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

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

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

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

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

Tenure: 3 - 12 months

Application forms and instructions are available from the College website:
www.surgeons.org

Closing date: **Monday 2 June, 2014.**
Applicants will be notified of the outcome of their application by **30 October 2014.**

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

Welcome to the Surgeons' Bookclub

WILEY BOOKS NOW UP TO 35% DISCOUNT

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Lead & Influence: Get More Ownership, Commitment, and Achievement From Your Team

Mark Fritz
9781118732885 | Hbk | 208 pages | November 2013

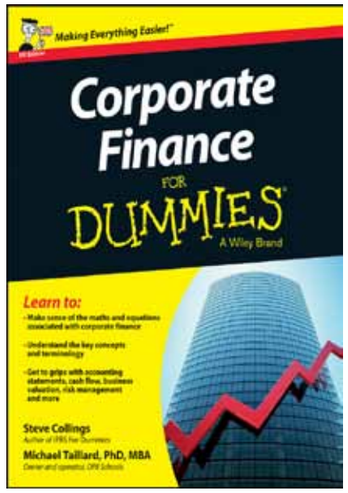
~~AU$29.95~~ | **AU$19.47**
Member Price

Lead & Influence explains how to use the power of ownership to become even more successful in leading your organization. Based on thirty years of leading and influencing across distances and cultures, author Mark Fritz has identified key leadership mindsets and habits that create a culture of ownership. It begins with a leader's personal ownership. Second, it's about enabling personal ownership in others. Third, it's about enabling team and organizational ownership. Why? Because you want your people to not just do their job, but also to own the achievement (the outcomes).

- Explains how executives and managers can successfully lead across distances and cultures
- Author Mark Fritz is an international speaker focused on helping executives and managers successfully lead across distances and cultures . . . and still have a life

A leader's performance and quality of life is in direct proportion to the level of ownership their people to deliver the results.

25% Discount



Corporate Finance For Dummies

Steven Collings
9781118743508 | Pbk | 376 pages | October 2013

~~AU$27.95~~ | **AU$24.67**
Member Price

The maths, the formulas, and the problems associated with corporate finance can be daunting to the uninitiated, but help is at hand.

Corporate Finance For Dummies, UK Edition covers all the basics of corporate finance, including: accounting statements; cash flow; raising and managing capital; choosing investments; managing risk; determining dividends; mergers and acquisitions; and valuation. It also serves as an excellent resource to supplement corporate finance coursework and as a primer for exams.

Inside you'll discover:

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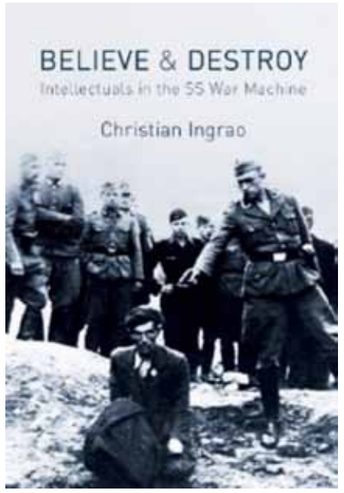


Believe and Destroy: Intellectuals in the SS War Machine

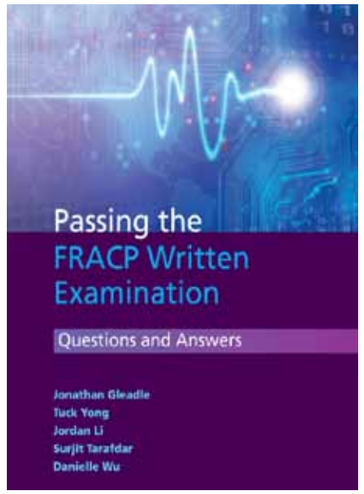
Christian Ingrao
9780745660264 | Hbk | 432 pages | June 2013

~~AU$47.95~~ | **AU$31.17**
Member Price

There were eighty of them. They were young, clever and cultivated; they were barely in their thirties when Adolf Hitler came to power. Their university studies in law, economics, linguistics, philosophy and history marked them out for brilliant careers. They chose to join the repressive bodies of the Third Reich, especially the Security Service (SD) and the Nazi Party's elite protection unit, the SS. They theorized and planned the extermination of twenty million individuals of allegedly 'inferior' races. Most of them became members of the paramilitary death squads known as Einsatzgruppen and participated in the slaughter of over a million people.

Based on extensive archival research, Christian Ingrao tells the gripping story of these children of the Great War, focusing on the networks of fellow activists, academics and friends in which they moved.

25% Discount



Passing the FRACP Written Examination: Questions and Answers

Jonathan Gleadle, Tuck Yong, Jordan Li, Surjit Tarafdar, Danielle Wu
9781118454954 | Pbk | 472 pages | October 2013

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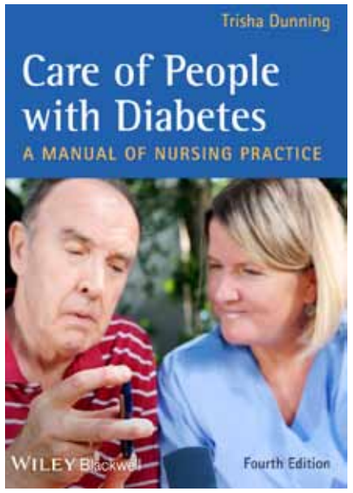

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