SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 15 NO 6 / JULY 2014

The College of Surgeons of Australia and New Zealand

Alcohol & Society

Chair of the Australian National Council on Drugs stands with us on alcohol-related harm

2014

PROFESSIONAL DEVELOPMENT

WORKSHOPS & ACTIVITIES

workshop

August-October

Training Standards: Interpretation and Application (TSIA)

6 August, Sydney; 24 October, Melbourne; 29 October, Brisbane

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

Clinical Decision Making (CDM)

6 August, Sydney; 24 October, Melbourne; 29 October, Brisbane

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

Management of Acute Neurotrauma

7 August, Perth (the day before the WA, SA and NT ASM)

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

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

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. This activity is proudly supported by Bongiorno National Network.

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. Please note: Fellows will still need to attend AMA training to be accredited to use AMA guidelines. This activity is proudly supported by eReports.

Supervisors and Trainers for SET

16 August, Perth; 18 October, Newcastle; 21 October, Wellington; 20 November, Melbourne.

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

Keeping Trainees on Track (KTOT)

16 August, Perth; 9 September, Melbourne; 18 October, Newcastle; 22 October, Wellington

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

Polishing Presentation Skills

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

ACT

10 October, Canberra
Keeping Trainees on Track (KTOT)

NSW

5 August, Sydney
Non-Technical Skills for Surgeons (NOTSS)
6 August, Sydney
Clinical Decision Making (CDM)
6 August,
Training Standards: Interpretation and Application
13 August, Sydney
AMA Impairment Guidelines 5th Edition: Difficult Cases
5 to 7 Sept, Sydney
Process Communication Model Part II
25 September, Sydney
Polishing Presentation Skills
18 October, Newcastle
Keeping Trainees on Track (KTOT)
18 October, Newcastle
Supervisors and Trainers for SET (SAT SET)
23-25 October, Sydney
Surgical Teachers Course

NT

24 August, Darwin
Management of Acute Neurotrauma

NZ

13 August, Queenstown
Foundation Skills for Surgical Educators
21 to 23 August, Auckland
Surgical Teachers (STC)
23 September, Auckland
Non-Technical Skills for Surgeons (NOTSS)
21 October, Wellington
Supervisors and Trainers for SET (SAT SET)
22 October, Wellington
Keeping Trainees on Track (KTOT)

QLD

1 August, Noosa
Foundation Skills for Surgical Educators
7 August, Brisbane
Strategy and Risk Management for Surgeons
25 to 26 October, Brisbane
Preparation for Practice
28 October, Gold Coast
Non-Technical Skills for Surgeons (NOTSS)
29 October, Brisbane
Clinical Decision Making (CDM)
29 October, Brisbane
Training Standards: Interpretation and Application

SA

1 to 3 August, Adelaide
Process Communication Model Part I
13 November
Academy of Surgical Educators Forum

TAS

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

VIC

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

WA

7 August, Perth
Management of Acute Neurotrauma

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LEADING, BUT NOT LOSING

The importance of our 'social contract'

MICHAEL GRIGG
PRESIDENT

There are some very important discussions taking place at senior levels of the Medical Board of Australia, the New Zealand Medical Council and similar regulators. Perhaps frightened by the revelations of Bristol, Shipman, the Stafford Hospital scandal and more locally Patel, Bundaberg Hospital and others, regulators are being prompted by the community and by politicians to 'do something' to make sure that the health system is 'safe'.

The UK has introduced revalidation, but in a model that only the NHS structures could support. Recertification has been broadly imposed in the US. The questions we are left with include, does it prove the system is safe; does it reduce risk for the individual patient or provide greater reassurance to the community? They are important questions.

I am hearing more and more of the requirements of a 'social contract' for professions like surgeons. We value our independence because it allows us to provide the best care possible for patients – or at least advocate for it. We appreciate the primacy of the patient-doctor relationship – even when third parties contrive to disrupt it, but the consequence is that the profession regulating itself becomes increasingly important. This is our social contract. Avoiding the difficult issue of self-regulation by using the excuse of 'it is hard for a membership organisation' only provides greater impetus to the Regulators and the Politicians to ensnare us with increasingly bureaucratic constraints.

However, we cannot ignore our membership structure because we need to balance the requirement to lead our profession but in a way that the Fellowship of our College will follow. So how do we progress the issue of providing more reassurance about our high standards than that which our current Continuing Professional Development (CPD) programs provide?

It is something of a paradox that almost no surgeon would support decreasing the rigour and standards inherent in obtaining a FRACS qualification, yet there is a reluctance to increase the rigour around CPD. I am being told that medical knowledge is doubling every seven years and CPD 'needs teeth'. So as we look for those incisors, what shape should they take?

The College's CPD program has recently been changed to an annual basis and the number of Fellows being audited increased to approximately seven per cent. Most of the CPD requirements do relate to participation in ongoing educational activities which are vitally important to ensure Fellows stay up-to-date.

The College has also advocated for the compulsory involvement with Mortality Audits. The Mortality Audits are now available across Australia and the Australian Private Hospitals Association is now actively encouraging all Private Hospitals, particularly in NSW, to be included. Your involvement with Mortality Audits will be easy to determine and confirm.

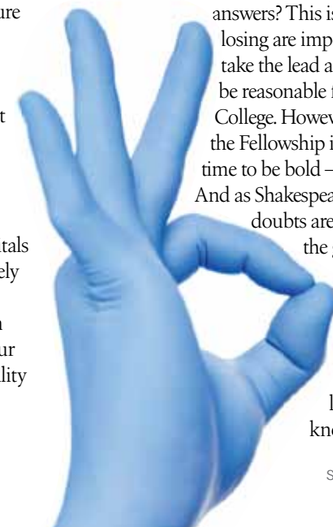
However, for many specialties, mortality rates are not a measure that is useful. So the development of morbidity audits and registries across various specialties has been important. Examples like the Vascular Audit, the Cardiothoracic Audit or even the College's MALT (Morbidity Audit and Logbook Tool) come quickly to mind. Some like the AOA joint replacement registry have been very well resourced from external funds, but most require data input to be maintained by the individual surgeon or hospital unit.

The challenge for us all is to ensure that we can maintain audit at a level that provides a worthwhile measure of our practice. Why and how do we do this? Well, "Why" is easy – it forms part of our social contract, but also audit provides an individual's best defence against suspicions of poor performance. "How" is more difficult. Should the societies make this compulsory, should the College enforce it more fully within our annual CPD program? Peer review is already included, but is it at a level that will reassure our colleagues, our community and the regulators?

I listen to other College Presidents also talk about patient and staff feedback. I must admit that I have a mixed record of enthusiasm for these, both at a practical implementation and usefulness level. As the Clinical Director of a large number of surgeons, ensuring that appropriate feedback and support is provided is always a challenge. How far do we go in ensuring that Surgeons seek out and obtain the feedback? But it needs to be considered.

So many good questions, but what are the answers? This is where leadership and losing are important. The College must take the lead and define what should be reasonable for the Fellows of the College. However, losing the support of the Fellowship is also so important. It is a time to be bold – there are many watching. And as Shakespeare actually wrote, "Our doubts are traitors, and make us lose the good we oft might win, by fearing to attempt" ('Measure for Measure').

But what do you think? What direction should the College leadership take? Let me know.



TELL US HOW IT IS

The importance of collecting data helps us draw a picture for future advocacy work

DAVID WATTERS
VICE PRESIDENT

Later this month the College will be conducting its fourth Surgical Workforce Census across Australia and New Zealand.

The key purpose of the Census is to determine the scope of work being done by Fellows of the College, track the number of hours worked in the public and private sector and document retirement intentions. The Census also gives us an opportunity to capture workforce details of Fellows working in regional, rural and remote locations.

The data we collect gives us the opportunity to look deeper at the changes in surgical workforce patterns and is an invaluable source of information that supports the College's advocacy work for a sustainable surgical workforce.

While there has been plenty of activity over the past few years trying to model a sustainable surgical workforce for the future, it has highlighted the need to also look closer at the workforce patterns for older Fellows.

Fellows are currently grouped into the broad categories of 'active' and 'retired' and these categories have been previously used to inform workforce planning efforts. However, we know that there is a growing group within the 'active' Fellowship that continue their practice with a reduced clinical workload as they transition towards retirement. How long this transition period lasts, as well as the types of changes to their workload, is largely unknown and certainly poorly understood, at least for the Fellowship as a whole.

The data collected will greatly improve our workforce planning models and the support we provide to senior fellows in the future. Prior to the 2014 introduction of subscription categories based on activity, the College had limited information of the activity of older Fellows. This Census will inform us all as to how much clinical, medico-legal, academic and management work is being done by our older cohort of Fellows, and the various patterns of transition towards retirement.

The geographical distribution of the surgical workforce is another source of concern in health workforce planning. We have re-designed this year's Census questions to collect more detailed data regarding the distribution of our regional and rural surgical workforce.

While our annual College Activities Report shows the distribution of Fellows based on their self-reported primary address, we know that Fellows may service several regional and rural towns. The College and government agencies have undertaken various programs and initiatives to encourage a career in regional and remote areas. The data collected in the Census will aid us in evaluating how successful the collective efforts have been in retaining surgeons in these areas of need.

Another key focus of the Census this year is the mental and physical health and well-being of the Fellowship. The Australian mental health organisation *beyondblue* released the findings of their National Mental Health Survey of Doctors and Medical Students in October 2013. The survey found a higher percentage of psychological distress in medical doctors and students compared to the general population, as well as a perceived stigma among doctors and medical students that disclosure of mental illness would affect their appointment to future career roles. While the prevalence of mental ill health in surgeons was found to be lower compared to the other medical specialties in the survey, the College is using the opportunity of the upcoming Census to determine the need for a College-based approach to mental health among the Fellowship.

THE 2014 CENSUS GOES ONLINE

The Surgical Workforce Census will be conducted as an online survey and will take approximately 10 minutes to complete.

The link to the Census will be sent in the upcoming weeks to the email address you have provided to the College. We encourage you to check that your email address is up-to-date, which can be done by logging onto the members' section of our website **www.surgeons.org.**

Fellows without a valid email address will be sent a hard-copy Census form to complete. You may also complete a hard copy of the Census form if you prefer, and further details on how to receive a paper form will be made available closer to the launch date. As participation is voluntary we appreciate the time taken to complete the survey and we will be offering prizes to randomly selected participants as a token of our appreciation.

Our previous Census achieved a 70 per cent response rate from our Australian Fellowship and 75 per cent from our New Zealand Fellowship. We hope to surpass this percentage this year.

The findings of the 2014 Census will enable us to gain a more informed and accurate picture of the present and future requirements of the surgical workforce in Australia and New Zealand. It will also serve as the basis of the College's ongoing efforts to inform and guide government health workforce planning departments and agencies across Australia and New Zealand.

A full report will be distributed to the Fellowship as well as highlighted features in a future edition of Surgical News. I encourage all Fellows to contribute to this valuable project.

More robots, better surgery

An audit of robotic surgery has led to better outcomes for patients, with a push to use the procedure in the public sector. A group of urologists from the Peter MacCallum Cancer Centre, led by Declan Murphy, looked at more than 5000 cases of radical prostatectomies over the past three years. While the take up of the procedure has grown, it remains true that the learning curve for surgeons is steep. However, the benefits are shown in the evidence.

"Our large-scale analysis shows the average hospital stay after a robotic assisted radical prostatectomy was 1.4 days compared with 4.8 days for an open procedure, with 85 per cent being discharged the day after surgery."

***Australian Financial Review*, June 4**

Dunedin surgeon honoured

Dunedin-born plastic surgeon Sir Archibald McIndoe has been honoured with a bronze statue unveiled in England.

The pioneering surgeon is best known for his rehabilitation work with severely burned aircrew and servicemen in World War 2.

He also focused on social reintegration, starting up the 'Guinea Pig Club' for his patients who had plastic surgery, numbering 649 at the end of the War.

Princess Anne unveiled the statue in East Grinstead where McIndoe lived from 1939 until his death.

***Otago Daily Times*, June 11**

Insurers tighten plastic surgery

Plastic surgeons have voiced their concerns on the increased tightening of insurance payouts for plastic surgery. In an effort to crackdown on 'fake' cosmetic surgery, patients must have procedures pre-approved. However, this will lead to insurers making the ultimate decision rather than health professionals or patients, the Australian Society of Plastic Surgeons say.

"If the patients do get denied, they'll still go on and our concern is that they'll be done in non-accredited facilities and perhaps not as safely."

***The Sun-Herald*, June 22**

Bravery awarded

Ballarat urologist Lydia Johns-Putra has been recognised with a New Zealand Bravery Award following her role in saving a man's life during the Christchurch earthquake in 2011.

Dr Johns Putra felt she had no choice to help the man and worked with a police officer, fire-fighter and anaesthetist to sever the man's legs and free him from rubble.

"I have a very strong sense now about making the most of life and the opportunities life presents us," Dr Johns-Putra said.

***The Age*, June 23**


Operating Suite team in Phitsanulok

SHARING THE BENEFITS

Recipients of the College's Weary Dunlop Boon Pong (WDBP) Exchange Fellowship are showing leadership back home

Thai Cardiac Surgeons who received a College-funded Scholarship to extend and enhance their training in Australia are now showing transformational leadership skills, particularly in their efforts to develop local paediatric cardiac surgery, according to Professor David Winlaw.

Professor Winlaw, a Paediatric Cardiac Surgeon at the Children's Hospital at Westmead, has supervised and mentored a number of Thai Scholarship recipients and late last year visited Thailand to gain a first-hand understanding of the impact of the Australian training provided.

While there he visited four Cardiac Surgeons who received support to travel to Australia through the Weary Dunlop Boon Pong (WDBP) Exchange Fellowship, which commemorates the bond forged between Australia and Thailand during the brutal construction of the Thai-Burma railway during WWII.

Since its inception, more than 70 young Fellows of the Royal College of Surgeons in Thailand (RCST) have been sponsored to visit Australia to advance their training across all specialties.

Professor Winlaw's visit occurred in December last year and was coordinated in Thailand by Dr Jessada Methrujpanont, the most recent WDBP Fellow to train at the Children's Hospital in Westmead.

He also spent time with other WDBP Fellows Dr Jarun Sayasathid, Dr Suksan Kanoksin and Dr Teera Simpatanapong.

While there, he visited regional, metropolitan and university hospitals, assisted in a number of complex cases such as tetralogy of Fallot, provided informal hospital-based lectures and gave a presentation at the Horizon in Cardiology 2013 conference, co-organised by the Society of Thoracic Surgeons in Thailand.

Professor Winlaw said that while metropolitan and university hospitals were now conducting complex paediatric cardiac surgery, regional hospitals often lacked the specialist ancillary skills necessary to make such surgery viable, such as anaesthetists skilled in paediatric care, perfusionists and Intensive Care staff.

He said that this was in part driven by low volumes of complex cases, a Thai health system which had not encouraged subspecialisation and a lack of specialist neonatal ICU staff.

Leadership skills

However, he said all the WDBP Fellows were actively working together to progress and advocate for the development of paediatric cardiac surgery across the country.

"It is clear that the WDBP Fellowship program has given these surgeons an opportunity to work in high volume centres and gather the necessary experience to take paediatric cardiac surgery forward in Thailand," Professor Winlaw said.

"It has given them a common framework to discuss and mould the specialty in a way that continues to be of benefit to the country years after their sponsored visit.

"While I was struck by how complex it is to create a sub-specialty like paediatric cardiac surgery in a country like Thailand which does not have such a well-coordinated health system, I was also particularly struck by the close collaboration that exists between the WDBP Fellows.

"This common bond of having trained in Australia means that those surgeons who are conducting paediatric cardiac surgery in cities and regional hospitals now collaborate on cases and in their training of junior surgeons because they have seen what is possible in Australia and have the same aspirations for Thailand.

"Their leadership skills are now transforming hospital systems and patient care which I believe proves the value of this Exchange Program.

"One of the problems facing Thai surgeons and specialists is the Thai language which is very complex and rarely spoken elsewhere. English is not commonly learnt and this is an impediment to participation in international networks and learning in the global environment.

"At one hospital, a WDBP Fellow has mandated that the operating team converse only in English for one day a week, part of an outward looking approach designed to be a springboard for further learning."

During his visit, also sponsored through the WDBP Exchange program, Professor Winlaw spent two days in Phitsanulok, in Thailand's north, where he assisted Dr Jessada at the government-run Buddhachinaraj Hospital.

While there, he also visited Dr Jarun at the University Campus Hospital.

He then spent time in Bangkok at the Ramathibodi Hospital, a major tertiary centre affiliated with Mahidol University, which is one of three centres in the city that performs complex and neonatal paediatric cardiac surgery.

"The Weary Dunlop Boon Pong (WDBP) Exchange Fellowship … commemorates the bond forged between Australia and Thailand during the brutal construction of the Thai-Burma railway during WWII."


WDBP Fellows dinner in Phitsanulok

In both these centres, Professor Winlaw assisted and supported the principal operating surgeons.

Later in his trip, he travelled to Ubon Ratchathani in the East where he attended the cardiology conference and gave a presentation on the Ross Pulmonary Autograft procedure.

He said that while Dr Jessada was doing small volumes of low and moderate complexity paediatric cardiac surgery in a hospital environment of limited resources and support, Dr Jarun was undertaking larger volumes of similar work with more resources in a hospital with a vision of developing paediatric cardiac surgery.

He said the two surgeons, although working in different circumstances, collaborated closely.

"The Thai surgeons I have been associated with are all good technical surgeons and have sufficient knowledge of clinical sciences to be excellent paediatric cardiac surgeons," Professor Winlaw said.

"However, their aspirations are limited because of structural issues within the Thai health system which make it difficult to develop paediatric cardiothoracic surgery.

"These include local referral practices and fear of bad outcomes in less experienced centres, a financial need by surgeons to conduct adult cardiac surgery and insufficient case volume to support the development of related specialists in perfusion and anaesthesia.

"The WDBP Fellows are aware of these constraints and are working to overcome them."

Professor Winlaw said some of these constraints may be eased if the WDBP Exchange Fellowship was broadened to involve other Australasian Colleges.

Upon his return to Australia, he wrote a report to the College suggesting that additional funding sources be found to allow a small team of perfusion, anaesthetic or intensive care specialists to visit Australia at the same time as Thai surgeons.

"In my field of practice, I can see that the WDBP program is facilitating the development of medical services and therefore benefiting the Thai community," he said.

"However, I believe we could get additional benefit if we focussed the program on one regional centre and one Bangkok centre and allowed the local surgeons to nominate the support services they wish to develop through education and training in Australia.

"This would allow a paediatric cardiac surgeon to visit an Australian hospital with their anaesthetic, ICU or perfusion colleagues so as to broaden the base of expertise in this developing specialty."

Professor Winlaw has also provided training and support through various visits to Myanmar and Cambodia and said the facilities in Thailand and the skills of Thai surgeons could allow that country to become a regional leader in the development of paediatric cardiac surgery across South East Asia.

"Other groups from Japan and Singapore are also active in their support of paediatric cardiac surgery in Thailand, but much of this is limited to the operating room rather than addressing the system in which the surgeons must work," he said.

"If we can tailor our support to a specific tertiary centre and a regional hospital we could help build a system similar to ours where the very sick neonates are cared for in Bangkok and older children requiring less complex procedures can be treated in a regional centre.

"This is the aspiration of the WDBP Fellows and it would be rewarding to help them attain it."

The WDBP Exchange Fellowship is named after Sir Edward "Weary" Dunlop, one of Australia's greatest wartime heroes and life-long humanitarian, and Mr Boonpong Sirivejbhan, a local Thai who helped the prisoners of war forced to build the railway by the Japanese.

With Karen Murphy

The College seeks expressions of interest from departments of surgery or heads of units of any surgical specialty, who feel they can offer a milieu in which young Thai surgeons can obtain experience. Please contact the RACS Global Health Department on +61 3 9249 1211 or email international.scholarships@surgeons.org

ITODDLERS – IKIDS UNOT

Remember to live in the world you are in

DR BB G-LOVED

The early years of life are so important. It is always such hard work to compensate later for what is missed in those first years; the effects of a lack of love and attention often become manifest in the behaviour of childhood and adolescence.

Doctor BB G-loved was recently in Queenstown. It is a popular convention centre for GPs, but there was an opportunity to slip off with a colleague to enjoy a 'real' cup of coffee on the water's edge (Curmudgeon would be impressed). We found ourselves sitting next to a family whose two children were absorbed with an iPhone and an iPad.

The iToddler of the family was in a push chair, learning nothing from the social milieu of the coffee shop, but whose thumbs were desperately tap, tap, tapping. The older kid, perhaps 5 or 6 years of age, had their gaze fixed watching iPad delivered cartoons and appeared unrousable. Children should be seen and not heard – wasn't that the mantra of the Victorian era?

Nonetheless when food arrived they were indeed heard, because when the parents tried to remove the iThings, encouraging their children to eat, the toddler had a tantrum, spitting food over the table and disturbing everyone by screaming. Meanwhile the cartooned-out iKid twisted and turned in disgust at the interruption, elbows accidentally overturning a soft drink. What had held the potential for a moment of relaxed ambience, deteriorated into iChaos – screams, mess, scolding, and, I am sure, many negative iFeelings.

Technology not a babysitter

The children of professionals, including those from families with a medical parent, are no strangers to behavioural problems. I have never been able to understand why so many 'tertiary educated' parents do not make themselves aware of the evidence about the adverse effects of electronic media and TV on early development.

The evidence (in reputable peer reviewed journals) suggests TV has significant adverse effects on under-3-year-olds. This is a period when the brain is rapidly developing. One only needs to consider how much a child is learning during this period to be alert to the dangers.

Television may be a convenient baby sitter, a means of entertaining a bored or active toddler, delivering half an hour of peace for a knackered parent; yet there is ample evidence that TV impairs language and social development, and is associated with problems in attention, reading and mathematical proficiency. Violent television viewing is also associated with anti-social behaviour during school age. It would be safer to have no TV for under-3-year-olds than to end up watching too much.

But what about the iApps that prompted this article? Recent evidence suggests there is an association between use of electronic media (television, games and devices) in pre-school children and poor well-being outcomes. Although no child is going to be damaged by occasionally 'colouring' on your iPhone, just think what habits might be developing if it becomes 'the norm'.

Instead of children looking around them, so appreciating what they hear, see and sense, they glue their attention to a screen, ignoring what's round about. Perhaps some parents think their children are destined to become the Anakin or Luke Skywalkers of the future and so need to master 'the force' of the modern world.

How sad to see even adults sitting in a café – apparently together, but in reality staring at separate iScreens. I scream (or rather would like to)! Do we really need to send yet another SMS or update our friends on Facebook with the menu? Especially in front of our children who learn by watching us! Some busy parents like to pontificate about quality time. That usually means 'not much time'.

Children need quantities of time, not just a parent's perception of when it is quality. Children need to enjoy emotional well being, feel secure (to acquire self-esteem), and are then able to positively engage with the world around them. This needs us to establish boundaries, and ensure limited access to iDevices and TV controls.

Today's iKids deserve to grow up learning that there is much more than the world of "i". Their sense of belonging should be connected to the people in their home and neighbourhood and school. We are not raising Kidbots, but rather children who will become adults who we want to feel secure, happy, content, even able to keep their fingers still, learn patience, enjoy creativity, and experience the richness of the real world. As I sat in that café, I thought those iKids would be much happier in the long run just being kids. I think the staff who were clearing up the mess thought so too.

CASE NOTE REVIEW

Pulmonary embolic death following trauma

GUY MADDERN
CHAIR, ANZASM

A middle-aged patient with no known significant comorbidities was admitted after a motorcycle accident, which resulted in fractured left ribs four to nine and a fractured left scapula. A CT of the head, neck, chest and abdomen was performed.

There was timely treatment in ED and the surgical high dependency unit. No form of thromboembolic prophylaxis was given, and the patient's course was uncomplicated until the second post-admission day.

Following physiotherapy, the patient suffered a cardiac arrest and underwent successful CPR and was then transferred to ICU with subsequent support with adrenaline and noradrenaline.

A transthoracic echocardiogram demonstrated thrombus in the inferior vena cava and right atrium. Tenecteplase was administered and further CPR was required. After a second dose of tenecteplase a haemothorax was diagnosed by chest x-ray. There was a three minute period of asystole. The patient was reviewed by a cardiothoracic Consultant; a pigtail catheter was inserted and approximately two litres of "bloody fluid" were drained. A total of four units of blood were administered. Further asystole culminated in death.

Assessor's comments:

Thromboembolic prophylaxis was not used, probably due to concern relating to bleeding from fractures. However, such patients are vulnerable to deep vein thrombosis (DVT), although it is most unusual to have this occur so soon after the injury. Therefore, some form of prophylaxis is advisable. The risk-benefit of prophylactic doses of clexane would be positive. It is unlikely that prophylactic doses would precipitate significant haemorrhage and if so, the haemothorax can be drained. Pneumatic compression stockings are an alternative, but do not affect the pelvic veins.

If the hospital had a cardiothoracic service, pulmonary embolectomy could have been considered on the basis that:

a. the original pulmonary embolus (PE) caused cardiac arrest;
b. the patient demonstrated persisting hypoxia;
c. the patient demonstrated thrombus in the right atrium and inferior vena cava.

Admittedly, such surgery has a very high risk in this setting. However, thrombolysis is even more unlikely to be successful in this situation. Regardless, such a course of action required a call to the cardiothoracic team at the time of diagnosis, rather than three hours later.

Essentially, this patient was unlucky to have had such an early DVT and PE. The likelihood of survival after a PE massive enough to cause arrest and persisting hypoxia is low, because of associated acute right ventricular failure. The situation was desperate. In hindsight, surgery may have been successful. Thrombolytics are unlikely to resolve this clinical situation. Within those parameters, management of the patient was acceptable.

Join the discussion http://www.surgeons.org/my-page/racs-knowledge/blogs/all-blogs/anzasm-case-note-reviews/2014/anzasmcnrjuly2014/

FOOD COMPLEXITIES

But is it so simple?

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is food. Now don't get me wrong, not all food just some food, particularly food and in particular as it is sometimes presented. When I was a lad (before I became a curmudgeon) food was meat and three veg. There is nothing wrong with that at all. Food was on a plate and what is more was spread out evenly and easily accessible. It was easy to get a bit of lamb chop with some peas and mash on the fork in one go.

Now it seems that vertical food is needed. You know what I mean – a bed of mashed potatoes (but usually called something else such as garlic infused puree pomme de terre – Robuchon style,) then the green vegetables (often asparagus with the spears intersecting so that they cannot be easily pulled apart) and then the meat atop. The whole thing will often stand 10 centimetres high. The higher the better seems to be the rule.

It is very obvious, even to we curmudgeons who usually do not cook, that the meat will need to be either cut up first which will squash the whole contraption, or the whole vertical tower will need to be dismantled in order to eat it.

There are two even more annoying variations to this tower. The bottom layer is chips (sorry, I mean French fried potatoes), which when infused with the sauce results in a soggy mess. Ugh! Chips should be crisp and slightly firm, not the consistency of mash.

The other ugly variation is the plate size. It seems that the more expensive the restaurant, the larger the plate size and the higher the tower. At least there is one benefit namely that when the tower falls over there is room for the food on the plate. The final product is meat and three veg spread evenly, albeit a little mangled, on the plate.

I was delighted to read in the frequent flyer club of a well-known airline a menu that stated the meal was "de-constructed". We curmudgeons like simplicity, so a simple meal was just what I needed. However, a tray of bits of cheese and slices of meat sausage and pastry base was not what I had in mind when I read of the "de-constructed pizza".

IN MEMORIAM

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

Peter Anderson,
NSW Fellow

Murray Wallace Melville,
Queensland Fellow

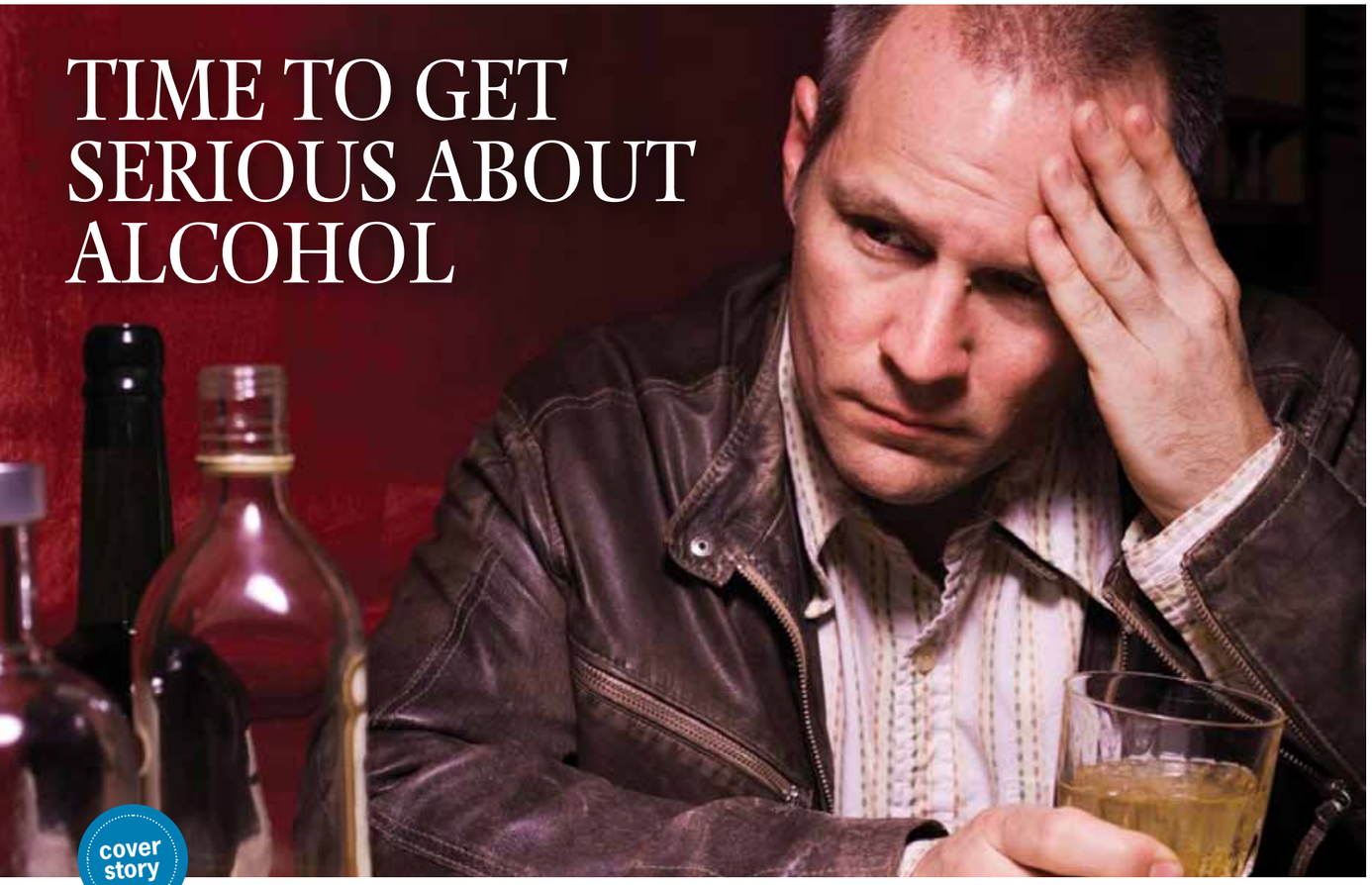
We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org** go to the Fellows page and click on In Memoriam.

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

TIME TO GET SERIOUS ABOUT ALCOHOL



cover story

The following speech was given by Dr John Herron, Chair Australian National Council on Drugs, at the Medico-legal Society Dinner at The Brisbane Club earlier this year. This is an edited version of the speech as it relates to alcohol-related harm

Alcohol has always been a problem in our society, but it has got worse in recent years.

There is probably no need to remind you of the increasing numbers admitted to our emergency departments in hospitals as a result of random acts of violence, domestic violence, and injuries related to the excessive consumption of alcohol.

You would be aware that the Australian Medical Association, the Royal Australasian College of Surgeons and Police Commissioners are all calling out for action.

Research shows that 60 per cent of all police attendances, including 90 per cent of late-night calls, involve alcohol.

Twenty per cent of Australians drink at levels that put them at risk of lifetime harm from injury or disease.

Of all drinkers, 36 per cent say their primary purpose when drinking is to get drunk and 61 per cent of those between 18 and 29 say their main purpose in drinking is to get drunk.

Twenty five per cent of Australians report having been a victim of alcohol-related verbal abuse and 21 per cent of those under the age of 18 report having been harmed by another's drinking. Alcohol-related physical abuse is reported by 1 in 12 Australians.

Alcohol consumption among young people is significant.

Sixty per cent of students aged 12 to 17 reported consuming alcohol in the past year and 23 per cent in the past week. Twenty-two per cent of hospitalisations and 13 per cent of deaths of people between the ages of 18 and 29 are attributed to alcohol.

Fifty-two per cent of alcohol-related road injuries and 32 per cent of alcohol-related hospital admissions for injuries from violence involved 15 to 24-year-olds.

Harmful consumption is not confined to the young – one in five people over the age of 65 drink excessively and alcohol has been causally linked to 60 different medical conditions.

The last available statistics show that liver cirrhosis, strokes, heart problems and falls are the most common causes of alcohol-related hospitalisations and deaths in people over the age of 65.

Mental health, homicide and suicide are inextricably linked with excess alcohol consumption. Six people a day suicide, a number which exceeds the number killed on the roads and the majority of murderers and their victims are affected by alcohol.

The level of alcohol-related damage occurring in our communities is simply appalling.

Alcohol abuse is the third-highest cause of death or disability in Australia.

Our professions are not immune – a Jepson Foundation survey revealed that 22 per cent of solicitors and 12 per cent of barristers suffered from depression and up to 10 per cent admitted to being alcoholics. The figure was slightly lower for medical practitioners, but both were higher than the general public.

We need to 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.

We all understand the culture of drinking and intoxication has a long history in Australia, but the overwhelming majority now agree that these levels of harm are unacceptable and it is obvious that there needs to be a culture change.

Well there is an answer and my acronym is HOTELS.

H stands for hours. We need to restrict the hours of drinking in public establishments. It is absurd to expect that people can drink to 5am and still behave sensibly.

O stands for outlets. The number of outlets per head of population varies considerably from state-to-state and city-to-city, but research has shown that disturbances are more likely to occur in the vicinity of an outlet and the level of violence is directly related to the density of outlets in the area.

T stands for taxes. Taxes on alcoholic drinks should be related to the alcohol content in that particular drink – in other words there should be higher taxes on high alcohol content drinks and lower taxes on low alcohol drinks.

E stands for education. Education should be in the home and we should educate parents to understand that alcohol damages the developing brain and it starts before childbirth. A quarter of women who know that they are pregnant continue to drink alcohol despite knowing about Foetal Alcohol Spectrum Disorder. There is increasing evidence that this effect continues into early adulthood.

L stands for laws. Random breath testing has been extremely effective. In Queensland (recently) over a 24-hour period, 1,800 drivers were breath tested randomly and only one returned a positive. The road toll has dramatically decreased as a result of speed restrictions and random breath testing.

S is for Society and by that I mean the general public, as well as ourselves. Major changes require majority support. We know that 75 per cent of the general public believe that something should be done, but few understand the steps that must be taken to bring about change.

Nobody wants prohibition, but we do want restrictions on public drunkenness and aggressive behaviour.

What I am suggesting is not just theoretical. The experiment has already been carried out in Newcastle, Fremantle and Perth.

In 2008 closing hours of pubs in central Newcastle were restricted. Previously pubs had been permitted to open until 5am. This measure was introduced in response to public complaints about violence, damage to property and public disorder.

A study investigating the effects of this restriction found a relative reduction in assaults of 37 per cent, in comparison to a control area at nearby Hamilton. Assaults after 3am decreased most dramatically by two thirds.

This demonstrates that we need to develop local level interventions to reduce alcohol-related harms.

THE MORBIDITY AUDIT AND LOGBOOK TOOL

Your questions answered

IAN BENNETT
CHAIR, LOGBOOKS AND CLINICAL AUDIT OVERSIGHT COMMITTEE

Those who attended the College's Annual Scientific Congress in Singapore this year may have seen the MALT staff at the College stand. Robyn McGeachie and Kylie Harper were there to answer your questions.

They were delighted to hear how much Fellows are appreciating the system and all the new features that are being added. The team is working hard to provide an easy-to-use system that meets your needs.

This article summarises some of the questions that were asked of Robyn and Kylie at the Congress. If your question about MALT is not answered below, feel free to contact the Helpdesk at malt@surgeons.org or +61 8 8219 0939. They are there to support you.

Why is the procedure I want to enter not available in MALT?

The procedure lists in MALT vary by specialty. The procedures in each International Medical Graduate and Fellow Logbook have been based on the Surgical Education and Training (SET) Logbook for that specialty. A number of specialty societies also utilise MALT for Fellows sub-specialising. These Fellows have a custom procedure list set by the specialty society.

The Fellow Logbooks for the nine specialties will be amended and enhanced as we receive feedback from Fellows on what should be available for that specialty. Please let us know if you think a procedure is missing.

A list of procedures for each SET Logbook is available on the MALT web pages. To see what is available in your specialty, go to www.surgeons.org/MALT and click on your specialty under the Trainees section of the page.

Alternative names for a procedure can also be accommodated in MALT. This will allow you to search for a procedure under the name you most commonly use. Please let us know if there is an alternate name you would like added.

Your suggestions for improvement will be forwarded to the MALT governance committee for consideration to appear in future enhancements to the system.

Why was SNOMED chosen for MALT rather than other coding systems such as CMBS?

When MALT was being designed, the decision was made to use SNOMED-CT (Systematized Nomenclature of Medicine – Clinical Terms) as it is an internationally recognised clinical terminology.

The College represents both Australia and New Zealand so MALT cannot rely on a code that would be applicable for Australia only, such as the Commonwealth Medical Benefits Schedule (CMBS). SNOMED has been endorsed by the Australian and New Zealand governments as the preferred national terminology in both nations.

With millions of terms, SNOMED-CT has a great depth and coverage of health care. As the preferred coding system for a vast number of nations in the western world, it allows for consistent collection and comparison of data across applications, regions and nations.

MALT has been designed to display the procedures and diagnoses in MALT as commonly used clinical phrases while recording the associated SNOMED code automatically in the background. This approach balances the utility of an established clinical terminology with the useability of the interface.

How can I use MALT for peer-reviewed audit?

The College requires all Fellows to participate in peer-reviewed audit as part of their Continuing Professional Development (CPD). MALT can be used as a tool for this.

The expanded dataset in MALT includes fields that support an audit of surgical outcome.

The new custom reporting tool within MALT allows individual users to display their data in the way that is most meaningful to them. Users can customise reports to show the particular fields and categories they need for audit purposes and can choose how they want to display the data (e.g. tabular, graphed). This makes it very useful for reporting on audit data.

You can use MALT to collect and report on your data, but you must organise the peer-review aspect of the audit for CPD.

How can I record cases where surgery was performed in my private rooms?

Each case in MALT must have a hospital recorded. The system does not currently cater for situations where surgery was performed elsewhere, such as in a surgeon's private rooms. This issue is being investigated and we expect to have a solution in place this year.

Why does the MALT Dashboard say I have cases to review when I do not?

Fellows who supervise any Trainees, IMGs or Fellows sub-specialising have access to view cases where they have been recorded as the supervisor.

The MALT Dashboard has a list of logbooks to which you have access. Tiles on the dashboard indicate the number of cases you have access to view, categorised by status.

The "For review" tile on your supervisory logbooks shows the number of cases in that particular logbook that are currently in a status of "For review" against which you have been listed as a supervisor. MALT has two types of supervisor: the Nominated (who oversees training) and Alternate (the surgeon in theatre). Only one of these supervisors will need to approve MALT cases (the training board decides which one for that specialty).

If you click on the tile, you will be taken to the Journal view and given a list of cases that have been referred to you for review/approval. If this list is smaller than the number of cases stated on the tile, the remainder of the cases are currently with another supervisor for review/approval. This means you are listed as a supervisor within these other cases, but you are not being asked to approve them. You can view these other cases by removing the filter at the top of the page that says "allocated to me" and clicking "search".

Log in with your College username and password at https://malt.surgeons.org to see what MALT can offer you. The system enhancements are highlighted through the Fax Mentis e-newsletter and on the College website at **www.surgeons.org/malt** If you have a question or suggestion, why not contact the MALT team? We are always happy to receive feedback. MALT HelpDesk malt@surgeons.org or +61 8 8219 0939

> *“Through the development of this novel technique of tumour tissue placement, we have managed to improve the efficiency of tumour transfer to nearly 95 per cent.”*

IMPROVING THE ODDS

Dr Matthew Read has used his scholarship to develop the knowledge on an extremely aggressive cancer

Surgical Trainee Dr Matthew Read has designed a novel in-vivo model for researching oesophageal adenocarcinoma (OAC) and its precursor condition, Barrett’s oesophagus (BO).

Using his surgical skills, Dr Read solved a problem facing many researchers in the field of OAC by designing a technique that allows patient-derived tumours to grow and develop in intra-muscular pockets of immunocompromised mice.

By implanting tumours in a more vascular environment than the previous subcutaneous location, Dr Read has dramatically improved the success rates of patient-derived OAC tumour xenografts from 35 per cent up to an efficiency rate of nearly 95 per cent.

He said that while OAC was an extremely aggressive cancer with a poor prognosis, the design and development of new therapies was being hampered by the difficulty in studying the disease and the consequent lack of knowledge relating to the biology of the cancer.

“One of the most powerful research models currently being used in other cancer streams is the patient derived tumour xenograft (PDTX) which have been well characterised and shown to be representative of the original patient tumour,” he said.

“However, there has been only minimal success in generating PDTX from OAC with only five studies reporting the successful generation of PDTX in OAC with a success rate ranging between 30 to 35 per cent.

“Through the development of this novel technique of tumour tissue placement, we have managed to improve the efficiency of tumour transfer to nearly 95 per cent. This is because the improved blood supply within the intramuscular environment supports the tumour until it can develop its own blood supply. Validation has since confirmed that this model is representative of the original tumour with respect to tissue architecture, molecular and genetic profile and tumour biology.”

Dr Read, a SET4 Trainee, said there was a growing urgency to advance research into OAC because it had the fastest rising incidence rate of any solid cancer over the past four decades. As a result, there were six laboratories in Australia alone now collaborating on OAC. That urgency also extended to enhancing understanding of BO, a precursor condition in which the normal stratified squamous lining of the lower oesophagus is replaced by columnar epithelium.

He said that while BO occurred in five per cent of the population, it conferred between a 30 to 100-fold increased risk in the development of OAC, which has a current five-year survival rate of only 16 per cent.

Dr Read said one of the great advantages of the new in-vivo model was that it would allow for the rapid growth of multiple patient-derived tumours upon which to test new drug therapies, a process that would otherwise have taken years given the previous low successful tumour transfer rates.

Dr Read said he was using the new in-vivo model to investigate both ends of the disease spectrum in Barrett’s carcinogenesis.

“I am using this model to determine the frequency of tumour initiating cells within OAC,” he said.

“These cells have important implications for disease recurrence as they maintain the ability to form new tumours.

“I am also in the process of conducting a series of experiments in an attempt to identify a potential stem cell responsible for the formation of Barrett’s oesophagus in the hope that it may lead to advances in the treatment of the condition before it becomes OAC.”

Saw impact of cancer

Dr Read is conducting his research as part of a PhD and received support from the College in 2013 through the Francis and Phyllis Thornel-Shore Memorial Scholarship. He is now receiving funding via the Sir Thomas Naghten Fitzgerald Scholarship offered through the Faculty of Medicine at the University of Melbourne.

Dr Read said that he decided to become involved in research while training under his current research supervisor, Mr Cuong Duong at the Western Hospital.

“As a surgical Trainee I witnessed first hand the terrible impact that cancer has on patients and their families.

“That experience spurred me to accept that only new treatments will improve patient outcomes and that those future treatments depended on current research.”

Dr Read is conducting his research work through the Surgical Oncology Laboratory at the Peter MacCallum Cancer Centre under the leadership of Professor Wayne Phillips and research scientist Dr Nicholas Clemons.

He said that such was the interest, a number of Upper GI Fellows supported his work by allowing him to take tumour tissue at the same time as they conducted patient biopsies or operated to remove OAC tumours.

“Associate Professor Val Usatoff, Mr Paul Burton and Mr Marty Smith at Cabrini, Mr Hai Bui at the Western Hospital and Mr Cuong Duong, Mr John Spillane and Mr Stephen Barnett at the Peter MacCallum have all been extremely helpful and I offer them my thanks,” Dr Read said.

“Professor David Watson in Adelaide has also been a great contributor to this research as we attempt to establish PDTX from cryopreserved tumour samples.”

Through these collaborations, Dr Read has now grown and studied more than 30 patient-derived tumours using his new in-vivo model.

He is now in the process of writing up papers on his OAC in-vivo research and his BO results, which are unique given that he has successfully xenografted pre-tumour tissue.

He has presented his findings at the ASC in Singapore this year, last year at the ASC in Auckland and at the 13th World Congress of the International Society for Diseases of the Oesophagus held in Venice in 2012.

A father of three, Dr Read said that while it was hard to take the plunge into full-time research, the support he received made the move not only viable but also exciting.

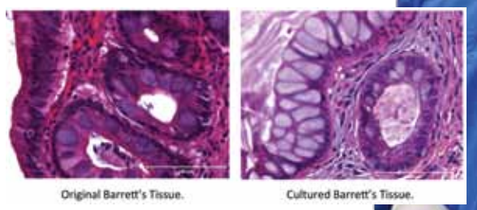
“It’s a massive gamble to take research on during training, because you have to make the commitment before you have any guarantee of funding, so I felt very fortunate to receive the scholarships,” he said.

“It’s great that the College funds such research at an early stage because in some ways that support is worth more than its dollar value because it represents professional support for your endeavours.

“I have found this research both fascinating and rewarding and it is very exciting to solve a problem and develop a tool or technique that could have a number of applications in a number of research streams.”

The Francis and Phyllis Thornel-Shore Memorial Scholarship was established to promote medical research, has an annual value of $60,000 and is open to both Fellows and Trainees of the College.

With Karen Murphy



Original Barrett’s Tissue. Cultured Barrett’s Tissue.

SCHOLARSHIPS

2012 & 2014
Sir Thomas Naghten Fitzgerald Scholarship, Faculty of Medicine, The University of Melbourne

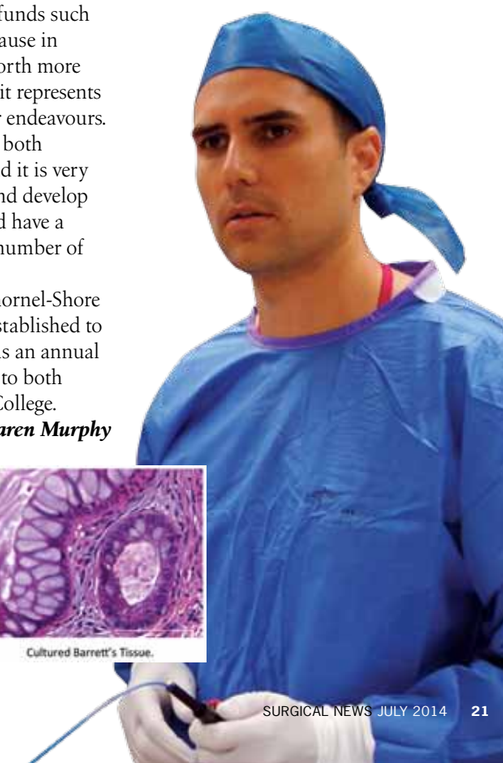
2013
Francis and Phyllis Thornell - Shore Memorial Scholarship - Royal Australasian College of Surgeons

AWARDS

2014
Best Trainee Presentation, Upper GI Surgery Section, Annual Scientific Congress, Singapore.

2013
Prof Robert Thomas Translational Research Award, The Peter MacCallum Cancer Centre.

2013
Best Trainee Presentation, Surgical Oncology Section, Annual Scientific Congress, Auckland.



OPPORTUNITIES ABROAD

The experience of an overseas Upper GIT Fellowship at the Royal Infirmary, Edinburgh, aided by the Covidien Travelling Fellowship Grant and the Younger Fellows Committee

PHILIP LE PAGE
COVIDIEN TRAVELLING FELLOWSHIP GRANT RECIPIENT 2013

My family and I arrived in Edinburgh, Scotland in the depth of winter in January 2013. The trip over was 30 hours and I had my flailing 2-year-old son on my lap the whole way. After arriving sleepless at our unit around 3pm, we all got ready to head out for a real meal as darkness was approaching. It took an hour for us to rug up and leave the unit… only to turn straight back inside again, after three steps, as the hail and freezing wind battered us. Along with the effort of packing up our lives in Sydney and the bureaucratic hassles of the UK registration system, we wondered what we had got ourselves into… that was only a momentary thought. We relished the year overseas.

I had always wanted to work briefly overseas; virtually all my mentors had done so, and I knew that the different experience would be both enjoyable and beneficial. My impressions were that it was becoming an increasingly difficult challenge to arrange a foreign Fellowship. I had undertaken two post-General Surgery Fellowship training years with the Australian and New Zealand Gastro-Oesophageal Surgical Association (ANZGOSA) and had been enquiring about opportunities. ANZGOSA was newly offering two overseas Fellow training posts in the UK so I saw this as an ideal opportunity. I was fortunate to be selected into the reputable Edinburgh Unit headed by Simon Paterson-Brown.

Around the same time I read an article about the Covidien Travel Grant offered through the Younger Fellows Committee of the College. The purpose of this was to provide assistance to Younger Fellows seeking further training overseas. I realised this would help me get the most out of the year, especially aiding attendance at UK and overseas scientific meetings. I also saw this as an encouragement for Younger Fellows to acquire and bring back specialist skills to Australia. Following my application, I was fortunate to be selected.

At the Royal Infirmary in Edinburgh the training system was very well organised and the consultants and registrars were very supportive. They had planned how all Trainees' experience could be optimised. On my first day it was straight into theatre for an Ivor Lewis Oesophagectomy. Over the year I would be involved with 40 gastro-oesophageal oncology resections (the other Fellow doing a similar number) and it was great to refine standard Ivor Lewis techniques with three of the surgeons, but still have the opportunity to develop laparoscopic and thoracoscopic resectional skills with two others.

This was the major benefit of my overseas Fellowship, given the centralisation of oncology services in the UK meant a large number of cases from the region were "funnelled" into one centre, facilitating training. Additionally, with the large number of cases being done, I had extensive exposure to dedicated multidisciplinary meetings, aftercare and complication management.

Other case mix particular to the unit included common bile duct exploration (often involving lap. choledochotomy) and benign OG work (lap. intrathoracic stomach/fundoplication; Heller's; Bariatrics including lap. Gastric bypass). Given I was rotated through the acute surgical unit (and the night shifts) there was plenty of interesting laparotomies (fancy a samurai sword through the liver and IVC?) and thoracotomies (difficult acute Upper GIT referrals in the region, such as Boerrhave's, were sent there).

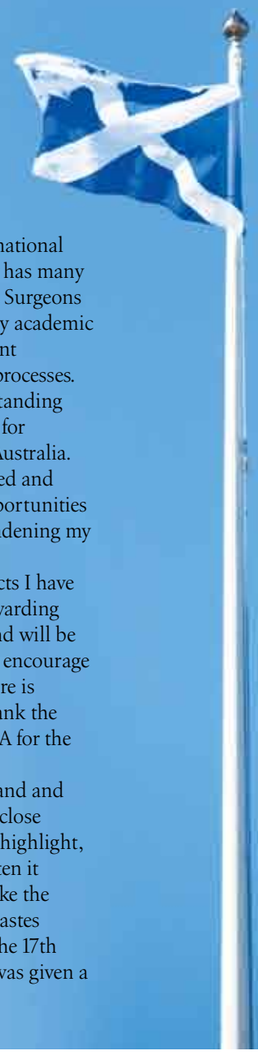
Uniquely, the colorectal unit is based at a separate hospital in Edinburgh, which meant we were undertaking general acute work – kept the general and emergency skills up and made me really think about if and when to refer for subspecialist treatment. With a seemingly increasing number of acute General Surgical Units opening in Australia, this was a highly useful aspect of the year.

Experiencing a different health system both at the national NHS system level and locally was invaluable. Surgery has many of its roots in Edinburgh, as can be appreciated at the Surgeons Museum, where everyday tourists visit. It is also a very academic university affiliated hospital, translating into significant involvement in clinical research and dedicated audit processes.

Simon Paterson-Brown has been integral in understanding service delivery and in educating non-technical skills for surgeons, and collaborated on this with Surgeons in Australia. Being central to Europe and the US, I not only travelled and presented to local UK scientific meetings, but had opportunities to present at US and European meetings, further broadening my horizons.

The professional collegiality, friendships and contacts I have made with some Scots and English people is both rewarding and invaluable to me. I am maintaining these links and will be applying the acquired skills back home in Australia. I encourage others to consider the overseas Fellowships if the desire is there (contact me if you have any questions) and I thank the Younger Fellows Committee, Covidien and ANZGOSA for the opportunity.

Naturally, we had some time to travel around Scotland and a little of Europe. The history, the Highlands and the close proximity to fascinating towns and places were a real highlight, although travelling with the kids was a challenge! Often it was best just to stay local and enjoy the local treats, like the Edinburgh Festival, haggis and of course the diverse tastes of Scotch whisky. Which seems appropriate given in the 17th century, the Guild of Surgeon Barbers in Edinburgh was given a monopoly license to whisky production!



> *"Virtually all my mentors had done so, and I knew that the different experience would be both enjoyable and beneficial"*

VALUE YOUR AUDIT

Participation in the College's Mortality Audit and CPD – a harbinger for the future

JAMES AITKEN
CHAIR, WESTERN AUSTRALIAN AUDIT OF SURGICAL MORTALITY

The College mortality audit is now established in all Australian states and territories. Participation was initially voluntary, but is now a mandatory part of the College Continuing Professional Development (CPD) program. Fellows have to confirm their participation when completing their annual CPD return.

Since participation has become mandatory almost all Fellows have registered to participate. However, participation by some Fellows has been in spirit rather than practice and a few do not return any forms while others only return a proportion of their forms, some of which are completed in a less than satisfactory manner. This sort of involvement does not meet the College's clear definition of participation. Yet it appears that these Fellows have indicated they have participated when completing their annual CPD return.

Armed with their College CPD certificate, these Fellows then confirm in their annual AHPRA registration that they are compliant with the College's CPD program.

While some Fellows undoubtedly make an innocent mistake, the harsh truth is that some Fellows have 'gamed' their participation and without doubt have completed this part of their College CPD return knowing they had not fully participated in the mortality audit. They have then registered with AHPRA. Because these Fellows were not selected for a CPD audit, their apparent abuse of process has not been detected.

Fellows who knowingly provide AHPRA with inaccurate information are unwise. Not least as AHPRA itself will now be auditing 15 per cent of registrations. These Fellows also put the College in an impossible position as it knows, or would be expected to know, that this is occurring. The College cannot afford to condone or even appear to be silently complicit in such activity. It has no option other than to address this.

The databases of the state mortality audits and the CPD department will shortly be linked. The CPD department will then be able to confirm individual Fellow participation in real time. Fellows who indicate in their annual CPD return that they have participated when they have not will be instantly detected and advised they are not CPD compliant. Online reporting in the Mortality Audit will mean that incomplete cases cannot be closed and Fellows will be advised they will remain non-compliant until fully completed. These Fellows will not receive a CPD certificate and so will not be able to complete their annual AHPRA registration.

Some Fellows may see this as draconian. It would be better if they accepted this is the way of the future.

UK Standard

There is a growing body of evidence demonstrating that good quality care saves money and it is inevitable that payment for services will increasingly be linked with achieving quality standards. In his President's lecture at the 2014 Singapore Annual Scientific Congress Keith Willet explained how up to 19 per cent of NHS payments for some orthopaedic operations are now dependent on hospitals achieving all six agreed quality standards.

In England, the Health Quality Improvement Partnership supervises data collection for nine national surgical audits and Consultant Outcome Publication data is available on the NHS Choices website. When asked at the Congress how hospitals ensure full surgeon participation Sir Bruce Keogh, Medical Director of the NHS in England, merely shrugged his shoulders and said, 'If they do not return the data, they do not get paid'.

Australia has started down this road. In WA the Health Department already pays public hospitals a bonus for the management of some conditions, including fractured neck of femur, if agreed quality standards are achieved. Australian private hospitals and health funds have a strong incentive to link hospital and even individual surgeon payment to the collection of high quality data. Medicare could do likewise. Surgeons can expect the pace towards these goals to be fast.

The College and its Fellows have two options. The first is to resist these developments. Not only will that fail, it will reflect poorly on the profession and when it has to bow to the inevitable, its position will have been greatly weakened.

The alternative is for the College to lead and build on its mortality audit and on the well-established audits (vascular, colorectal, breast and so on) that its specialist societies have already started. However, they too are hampered by incomplete participation.

Fellows Responsibilities

Fellows must accept that where such audits exist they have a responsibility, indeed an obligation, to fully participate and ensure a complete and accurate dataset. These audits will increasingly involve some form of external peer review process, such as being a first and second line assessor, and future participation must include a commitment to undertake such reviews. Hospitals must accept that they have an obligation to facilitate the necessary data collection.

The surgical community in the UK was fortunate that Sir Bruce, a highly respected cardiothoracic surgeon, was appointed to a position from which he could influence both the profession and the health department. The surgical community in Australia may not be so lucky and the College must grasp the initiative and influence its future. To do this, it will require full support from its Fellows. Self-regulation is a privilege not a right and the few Fellows who jeopardise the commitment of the vast majority should not expect any support or sympathy from the College.

James Aitken has organised the Western Australian Audit of Surgical Mortality since its inception. The views expressed in this article are a personal perspective and may not be those of the Royal Australian College of Surgeons, the Australian and New Zealand Audit of Surgical Mortality or the Western Australian Health Department.

A CHANGING GAME

With health insurers covering patients, the College reinforces the importance of knowing the risks

The College re-issued a public statement warning of the risks facing patients who travel abroad for cheaper cosmetic surgery in the wake of a health fund offering offshore plastic surgery packages.

In March, the NIB fund launched a package offering patients plastic or dental surgery in accredited medical facilities here or overseas and post-operative care coverage for one year following surgery.

Both the Australian Medical Association and the College have urged patients to use caution when considering having any surgery conducted overseas, warning of risks such as the use of unidentified implants, contracting multi-drug resistant infections and fragmentation of care.

While the College statement said that all surgery involved a degree of risk, no matter where it was performed, that risk was reduced through continuity of care, appropriate consultation with the treating surgeon concerning all treatment options, discussion of the risks involved and post-operative recovery.

The College has been concerned about the rise in medical tourism for some years and in 2012 developed a position paper authorised by the College council.

It said that all countries had different standards of medical care, surgical training and credentialing of medical practitioners and that it could be difficult for patients to satisfy themselves of the qualifications, experience and accreditation of the surgeon performing their surgery in another country.

It called on Fellows to inform patients considering travelling overseas for medical treatment of the potential risks and urged State and Federal Governments to continue to work to reduce waiting lists for surgery which it believes contributes to the demand for medical tourism.

In the public statement issued following the launch of the NIB's Options package, the College made clear that medical care outside Australia and New Zealand involved such risks as:

- **Poor or non-existent documentation of the surgical procedure performed which can make post-operative care, especially on return to Australia or New Zealand, more difficult;**
- **Use of unidentified implants which could cause problems if follow-up care was required;**
- **Fragmentation of care;**
- **Contracting infections which may be difficult to treat upon return to Australia or New Zealand;**
- **Lack of family and community support which can add to the stress of undergoing medical procedures away from home;**
- **Language barriers which could limit care or post-operative treatment and increase personal isolation;**
- **Capacity of some medical procedures to limit fitness to fly commercially in the post-operative period;**
- **Possibility in the event of a deterioration in health that patients may need to be evacuated at significant cost.**

The NIB's treatment package covers cosmetic surgery in Australia or Thailand and includes treatment by a qualified plastic surgeon, treatment in an accredited medical facility, anaesthetist, theatre and hospital stay, post-[illegible] appointments, accommodation and access to information about recommended international specialists and medical facilities.

The College is urging medical tourism consumers to conduct as much research as possible to determine the qualifications and experience of the surgeon selected to conduct the procedure, and not merely rely on advertising.

In the most recent statement the College also advised people considering such surgery to ensure that they and their surgeon had similar expectations as to the final results and to have a plan in place in the event the surgery goes wrong with details of who to call in the event of post-operative illness.

It also suggested that patients travelling overseas for surgery understand what additional costs may apply if they become ill post surgery and find out from their travel insurer if they are fully covered if the surgery goes wrong and medical evacuation is required.

In the public statement, the College advised such patients to seek out internationally accredited facilities for their surgical care and listed the following as useful resources:

- The International Society of Aesthetic Plastic Surgery
- The Joint Commission International
- The Trent International Accreditation Scheme.

With Karen Murphy

The southernmost Australian city is experiencing a renaissance

A SURGEON'S GUIDE TO Hobart

Colorectal surgeon Mr Carey Gall first spent time in Tasmania as part of a training elective. He returned as an intern in the mid 1990s, and ultimately made the permanent move to Hobart eight years ago when the opportunity arose to join Mr John Oakley in private practice and take up a VMO position at the Royal Hobart Hospital.

Throughout that time he has watched Australia's southern-most capital shrug off the challenges posed by its relative isolation to enter what he describes as a "renaissance" driven by the opening, three years ago, of the extraordinary Museum of Old and New Art (MONA).

He said that while he had always enjoyed the lifestyle available in Hobart, the excitement and attention generated by MONA had acted like a wave in picking up and pushing forward all aspects of the tourism, hospitality and entertainment sectors in both the city and across the state.

"Hobart has undergone an arts-inspired renaissance in the past few years that has been quite transformational," Mr Gall said.

"While it has always been a beautiful city in terms of its natural landscape with the harbour and Derwent River in the foreground and Mount Wellington looming up behind, it now has a more worldly cosmopolitan and sophisticated culture driven, in part, by the thousands of tourists travelling here to visit MONA.

"This one drawcard, which has become known as one of the most spectacular contemporary art galleries in the world, has utterly changed not just Hobart, but the entire state.

"While Tasmania has always boasted some of the best produce available in Australia, in the past there hasn't been the local population base or tourism trade to allow the hospitality trade to fully flourish, but that is changing now.

"We have a very strong food and wine culture in Hobart with top class restaurants, hotels and wine bars scattered around the Salamanca Place district and the wider city."

Mr Gall lives in the suburb of Sandy Bay with his wife Seana, an epidemiologist at the Menzies Research Institute, and his three-year-old son Elliot.

With a home close to the harbour and less than five kilometres from the city, he said he particularly appreciated not having to spend precious time in traffic and being able to leave work and be out on the water in their boat within half an hour.

"Everything came together to allow us to move here in terms of not only enjoying the lifestyle, but having the opportunity to join a private practice," he said.

"Elliot and I go out on the boat quite often to explore the river and the channel and while we make a half-hearted attempt at fishing we don't catch much – though there are flathead to be found if you're lucky."

The following are Mr Gall's top tips to make the most of Hobart's southern hospitality.

With Karen Murphy

THE DELIGHTFUL DERWENT

If you have a mind to take your time, there's no better way to see Hobart and explore her secrets than by boat. The city has a number of ferry services, shuttle craft and water taxies including services travelling upriver to MONA and downriver to Peppermint Bay. Yet a special treat for boat enthusiasts or history buffs is to be found by stepping back in time by stepping aboard the Steam Yacht Preana. Built in 1896 for a wealthy Tasmanian flour mill owner, Preana's fall from grace, though slow, was inexorable.

From the 1930s, she was used as a fishing vessel, then a private motor launch, then left idle and engineless until she finally sank in 1992 before being rescued by the Preana Trust and returned to her Edwardian glory. Mr Gall said: "It's lovely out on the waters of Hobart and a particularly fun day trip is to jump on a boat at Constitution Dock and head downriver to Peppermint Bay for lunch. There are some great restaurants there and it's fun and it's easy."

FINDING A FINE DROP

Hobart's hospitality hub is to be found in the historic precinct of Battery Point and Salamanca Place, connected by the picturesque Kelly's Steps built in 1839. Lined with a charming array of tall sandstone buildings once used as warehouses for the busy port, most of the buildings in Salamanca Place have been refurbished, restored and reused as restaurants, art galleries, bars and theatres.

Mr Gall said his favourites of these were the Grape Wine Bar, which offers an excellent wine selection and tapas, and the West End Pump House, located at 105 Murray Street. "Tasmania produces some truly fine wine, but both of these bars have extensive, diverse wine lists so even though we may be tucked away down South we can still savour the best wines from the great wine regions of the world."

FORGET HOSPITAL – THINK HOSPITALITY

Describing Hobart's food scene as becoming increasingly interesting, dynamic and sophisticated, Mr Gall listed his preferred casual restaurant as Smolt (pictured), in Salamanca Place, his favourite fine-dining destination as the Cantonese restaurant Me Wah in Sandy Bay and the crème-de-la-crème as The Source at MONA.

"There are a large number of eateries to choose between, but these are my current favourites," he said. "The menu at Smolt is interesting and the atmosphere is relaxed while the maitre'd at Me Wah, Stephen Tso, is wonderfully engaging and extremely knowledgeable about wines, particularly Burgundy. The Source at MONA is probably the best restaurant in town and if you plan to go, it is advisable to book well in advance. It has a progressive French menu, a great wine list with an emphasis on French wines, and a spectacular view over the water."

Pic: Andrew Wilson

MONA

Officially opened in January 2011, the Museum of Old and New Art houses more than 400 art works from the private collection of millionaire Mr David Walsh. The driving force behind the cultural renaissance and revitalisation of Hobart, MONA also hosts the annual MOFO and Dark MOFO festivals which are rapidly gaining popularity with visitors from around the world.

Although the building appears dominated by its surroundings at street level, the interior is centred upon a seemingly endlessly-descending spiral staircase that leads down to three ominous, dramatic labyrinthine galleries built into the cliffs of the Berriedale Peninsula. Mr Gall said: "It's quite hard to describe how spectacular MONA is, but the fact that it has changed our city in just a few short years probably says it all."

A SOPHISTICATED PLACE TO STAY

Located on Hobart's scenic waterfront, the Henry Jones Art Hotel is an Australian first. Once a colonial-era jam factory, the 1804 building was transformed by architects Morris-Nunn and Associates and is now furnished with more than 300 artworks to allow guests to experience art in a new, dynamic environment.

The hotel comprises 56 individually designed rooms, decorated with historical artefacts and images along with contemporary art acting as the centrepiece to each room and all public spaces. "The Henry Jones is an example of an outstanding conversion of a dilapidated old space into a wonderful, inspired modern building," Mr Gall said.

Dr Robert Costa observes to guide and teach Indian specialists.

INDIAN HORIZONS

Seeing the benefits of work in the Pacific has led Mr Robert Costa to stretch his helping hand further

For some years, Sydney Cardiothoracic Surgeon Mr Robert Costa gave his time and skills to help the people of the Pacific region through Operation Open Heart, an outreach program run by the Sydney Adventist Hospital. More recently, however, he has joined forces with his Cardiothoracic colleague at Westmead Hospital, Mr Himanshu Desai, to travel further afield to India to help build the skills and confidence of local surgeons.

Heading teams that have included surgeons, anaesthetists, perfusionists, intensivists and senior nurse educators, Mr Costa has now travelled to India three times in the past five years. The immediate past-chairman of the NSW Regional Committee talks to Surgical News about the work conducted by the travelling teams and his plans for the future.

How did you come to be involved in this project?
I first became involved in outreach work through the influence and encouragement of my friend and colleague Mr Ian Nicholson, who was this year recognised for his contribution to outreach programs with an Order of Australia. I'd done overseas work around the South Pacific for a number of years, but my colleague Mr Desai, who had accompanied me to the South Pacific, had the idea of doing the same thing in India. Five years ago we took a team over to see what we could accomplish.

Where have you worked in India?
Our first trip was to a hospital in Jalgaon, in the state of Maharashtra and the second visit was to the city of Mr Desai's birth, Ahmedabad in the state of Gujarat. On our most recent trip we again visited the hospital in Ahmedabad and also worked for a week at a charitable hospital run by Sri Sathya Sai in Puttaparthy near Bangalore.

This is a sophisticated facility, called the Sathya Sai Institute of Higher Medical Sciences, which was established specifically to treat the poor of India as a practical aspect of the spiritual teachings of the movement's founder and swami, Sathya Sai Baba. All patients are treated without charge. The hospital has no billing department!

Dr Costa with his visiting team.

What problems have you encountered during the three visits you have taken so far?
On our first trip, we thought we could make the best contribution by visiting a hospital and offering to operate on people who would not otherwise be able to afford or access cardiac surgery. We took a full complement of staff and equipment, including a by-pass machine. We did a few operations in Jalgaon, but because of power outages and issues with the hospital's infrastructure, we elected to suspend operating as we had concerns about patient safety.

The aim of any outreach program is to help the local community access services or skills that would normally be outside of their reach. Cardiac surgery requires a relatively high level of support and it was the lack of this support that caused us concern. The lack of a guaranteed power supply, the availability of blood bank supplies and other services such as sterilisation of instruments is a constant concern.

These concerns caused us to rethink our strategy and Mr Desai and I decided we could perhaps achieve more by visiting a hospital that routinely conducts cardiac surgery and to focus our efforts on working with the local staff rather than operating ourselves.

Our second trip was to the UN Mehta Institute of Cardiology and Research in Ahmedabad. We took a select team of surgeons, anaesthetists, medical and clinical perfusionists, and nurse educators. This trip was very successful as we were able to demonstrate not only technical skills, but the importance of the many non-technical skills of surgery.

When did you last visit India and how is the new approach to training being received?
Our most recent trip was in January this year where we spent one week in Ahmedabad and one week in Puttaparthi. On our recent visit to UN Mehta, we were pleased to see that the hospital had taken up the majority of our suggestions and were implementing others as soon as their infrastructure changes would allow.

The staff were eager to point out that their surgical results had improved with our suggestions. The emphasis on preoperative assessment and optimisation and data collection and audit had contributed greatly.

This year Mr Desai decided that the team should focus solely on teaching so both of us scrubbed in as assistants and offered suggestions to the very competent surgeons. One of the biggest issues we saw was in nursing education and training, particularly in Intensive Care.

This year we took a small team of people which included senior nurse educators to help train both ward nurses and Intensive Care staff. The anaesthetists and Intensivists worked very closely with their Indian counterparts to pass on their expertise. This was an extremely successful visit. The Indian doctors and nurses are highly committed professionals who are keen to learn new skills and approaches.

What are the main types of procedures you have conducted there and for what types of patients?
The majority of the procedures we assisted with were coronary by-pass grafting, valvular heart and open aortic surgery. Rheumatic Fever is still a scourge in the developing world so many of the patients being treated were quite young, most aged under 40, who had suffered heart damage from contracting the disease

as children. The quality of the surgery being done, particularly in Puttaparthy, was very good and many of the patients they treat, being poor and unable to pay for such surgery, would certainly die without it. This was exemplified by a patient who had suffered an acute aortic dissection two weeks earlier. After being diagnosed, the family spent the next two weeks saving enough money for travel costs for the 600 km trip to Puttapathy. The fee quoted at the original hospital was totally out of their reach.

Who funds the visits?
All members of the visiting teams pay their own travel costs with the hospitals organising accommodation. In Puttaparthy we lived in the ashram run by the Sathya Sai Organisation. This was a fascinating and unique experience. We chose to live and abide with the customs of the ashram.

We wore white clothes, men and women were segregated at meal times and we slept on hard metal beds. We also attended some of the religious rites of the ashram during our down time and it was pleasing to have access to this aspect of Hindu spirituality. In the Sai Hospital, most of the staff work there because of their spiritual commitment to the Sai Baba and his philosophy. The majority forsake the opportunity of greater financial or advancement opportunity in the government or private sector.

How have you enjoyed your time in India?
Being in India is a humbling and gratifying experience. As anyone who has been there knows, India is truly a land of enormous contrasts, particularly between those with astounding wealth and the desperately poor who often live side-by-side. It can be confronting to witness. One can walk by a mansion with luxury cars in the driveway and then stumble over a family living under a plastic sheet just next door. I can say my taste in Indian cuisine has expanded enormously.

Why have you taken this on and what do you enjoy about it?
To travel to various parts of the world and even across our region is to understand how truly fortunate we are in Australia. This work gives me a great sense of satisfaction in knowing that we are truly helping people obtain the best care by training the care givers.

Where next?
Now that we had been there a few times, I would like to establish a broader program to include more surgeons from other specialties and also including the medical field. I would like to see a rotating roster of Intensive Care doctors spending a week at a time in some of these hospitals so that a trained intensivist could be there for a few months a year. I finished as Chairman of the NSW Regional Committee in May so hopefully I will then have the time to work with Mr Desai to develop a proposal to put to the RACS and other Colleges.

With Karen Murphy

Long Tan Memorial plaque

REMNANTS OF WAR

Like the mythological Phoenix, Vietnam has risen from the ashes


Long Tan Memorial: L to R: Bruce Waxman, Brian Morgan, Carmen Sharp, Gwen Pearson, Pauline Atkinson, Rob Atkinson and Choung Nguyen (Guide)

BRUCE P. WAXMAN
CONVENOR, SENIOR SURGEONS' SECTION
ASC SINGAPORE 2014

Any visit to Vietnam, especially Hanoi, would not be complete without experiencing the "water puppets" theatre, either in Hanoi city or where the tradition commenced, a local village. We had the privilege of doing both. At such events the mythological Phoenix is a major attraction, with the male and female mating underwater, producing one or two eggs and subsequent offspring.

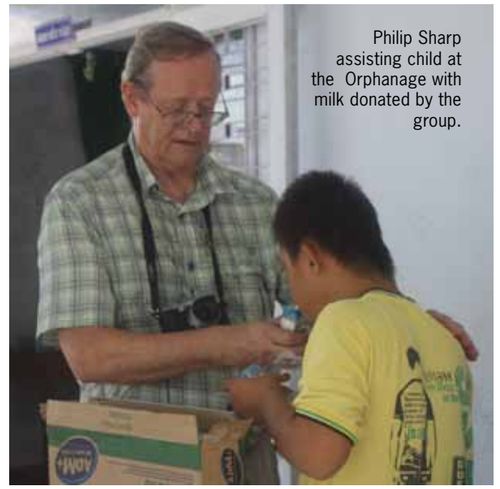
Along with the other mythical animals: the dragon, the unicorn, and turtle, the Phoenix holds a special place in Vietnamese culture, being symbolic of peace, prosperity and happiness. (David Nguyen: www.voices.yahoo.com/the-secrets-phoenix-8978587.html)

These attributes could not be a better description of how we found Vietnam in our 12 day post-ASC visit, in May 2014, with the theme of military history, but combined with a guided tour of this country we came to love.

Our party of four surgeons, three with partners, and with the knowledgeable mentoring of our guide, Choung, helped by his partner, Minh, for the Vung Tau section, travelled from south to north with major stops at Ho Chi Minh City, Vung Tau, Hoi An, Hue, Hanoi, and for three of us, Halong Bay.

One of our objectives was to retrace some of the steps the Australian military had taken in the Phuoc Tuy province, particularly around Vung Tau, where one of us, Rob Atkinson, had served during the American war (that's what the Vietnamese call it), having just graduated from medicine.

The most moving episode was a visit to Nui Dat, the site of the major Australian base, seeing SAS Hill, the old bitumen airstrip used by the Hercules transports, and particularly retracing D company's patrol from Nui Dat to Long Tan, where a commemorative service including the last post was conducted in memory of the 18 Australian diggers who were killed in action in the battle for Long Tan on August 18, 1966.


Philip Sharp assisting child at the Orphanage with milk donated by the group.

We also had the opportunity of visiting what Australian Vietnam veterans have contributed to the plight of Vietnamese children. The Thi An Orphanage in Ba Ria, and the Nui Dat Kindergarten, the latter, overlooking what is now a soccer field but was once the helicopter pad adjacent to the main street, probably the widest of any village in Vietnam, remnants of the bitumen airstrip, mentioned above.

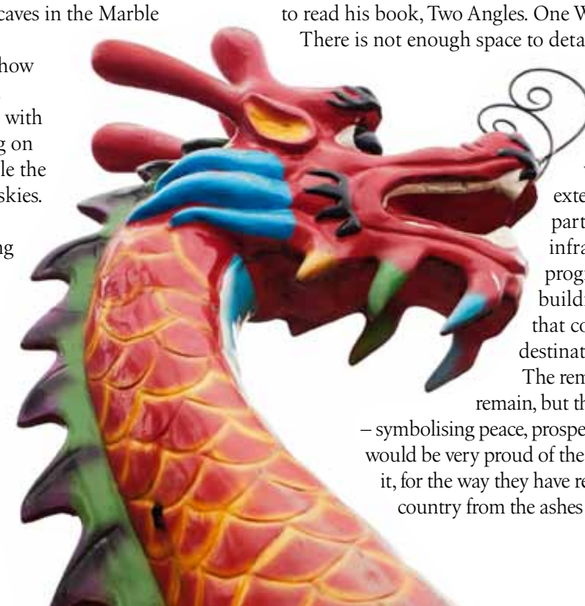
Exploring the Viet Cong guerrilla tunnels in Cu Chi, near Ho Chi Minh City, and those at Minh Dam, near Vung Tau, as well as the caves at Nui Thi Vai, and particularly the huge caves in the Marble Mountains, near Danang, gave us some insight into how the North Vietnamese and Viet Cong surgeons coped with these conditions, operating on patients underground while the Americans controlled the skies.

What made this all the more poignant was meeting and talking with two such veterans of war, Dr Nguyen Luong Son and Dr Pham Gai Txi, whom we spoke with in Hanoi, who had been there and done that! No blood for transfusions, no helicopters and a medical supply chain dependent on the tunnels provided significant challenges. I suspect (and we did not ask) the postoperative mortality may not have been significantly different from that of the Americans.

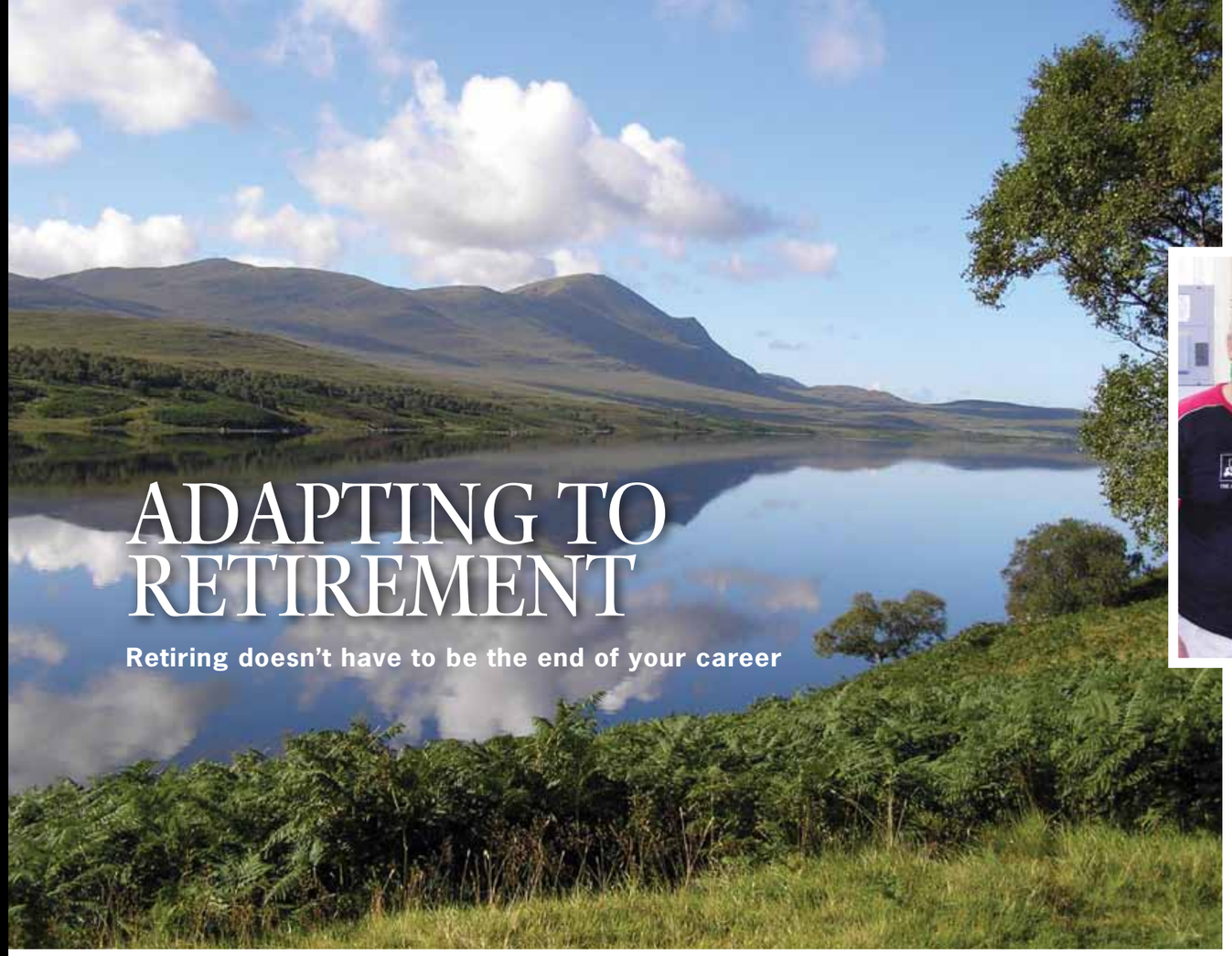
'Images of War' was another significant memory of our tour. This included the Remnants of War Museum in Ho Chi Minh City, which had many photos on display depicting the horrors of war, but the Requiem section dedicated to the photo-journalists killed in action really got to me.

The same evening that we visited the museum we were hosted by Hoang Van Cuong, in his tiny dining room on the third floor of his very narrow dwelling on the top of a modern all-night deli. He was a Vietnamese war photographer and his family provided us with a delicious Vietnamese meal, while we purveyed his collection of wartime photographs and an opportunity to read his book, Two Angles. One War!

There is not enough space to detail all the majestic places we visited, some of the special moments, the lovely people we met, and the extensive development, particularly of infrastructure in progress with bridge building and freeways that connect the many destinations in Vietnam.



The remnants of war remain, but the mythical Phoenix – symbolising peace, prosperity and happiness – would be very proud of the people that worship it, for the way they have rekindled their country from the ashes of war.



ADAPTING TO RETIREMENT

Retiring doesn't have to be the end of your career

JARVIS HAYMAN
VISITING FELLOW
SCHOOL OF ARCHAEOLOGY AND ANTHROPOLOGY
AUSTRALIAN NATIONAL UNIVERSITY, CANBERRA ACT

It was suggested by a friend and former colleague who is a senior Fellow of the College that I write of my retirement experiences after a life as a surgeon. I dismissed the suggestion as being rather self-aggrandising. After all, retirements come to all surgeons sooner or later, unless they die in harness, as unfortunately so many do.

However, finally putting pen to paper was prompted by the article in the recent edition of the College journal[1], in which it was suggested that a discussion on the issue of ageing as it relates to surgeons be promoted. Perhaps my experiences may provide some food for thought for surgeons at any stage of their career.

I had been a general surgeon in a large provincial town for 18 years, sharing the surgical roster with two other colleagues. The practice was a busy one, operations being performed at the local hospital with no surgical registrars, only interns to assist. At the time I was at the apex of my career, 52-years-old, took regular exercise, playing squash, going bush-walking and jogging. I had a loving wife, a marriage of 27 years and three well-adjusted daughters.

One Sunday afternoon while jogging my usual laps round the local football oval, I felt discomfort in the chest and epigastrium which I put down to 'indigestion'. However, omeprazole failed to relieve the discomfort and after increasing breathlessness climbing the hospital stairs, I consulted a medical colleague who immediately sent me to see a cardiologist.

The coronary angiogram was carried out on a Friday afternoon and a 90 per cent block of the origin of the left anterior descending coronary artery diagnosed, much to my own and the cardiologist's surprise as I had no risk factors for coronary artery disease. This was the only lesion; an uneventful LIMA bypass graft was carried out on the Monday and I made an uneventful recovery.

The episode was a salutary experience but after a three month break, work continued as hard as ever. Three years later one of my surgical colleagues died of gastric cancer very rapidly after a short illness, at the age of 71, having worked very hard in the same town

The team of Masters students who helped me at the Texas body ranch, myself at the far left.

for years on his own before being joined by another colleague and then myself. He had had no time for retirement and his only pleasure was working on his small property in his spare time. This concentrated my thoughts on retirement and four years later, at the age of 59 and with operating becoming increasingly difficult because of arthritis progressing in both hands, I decided to retire.

Fortunately, on the advice of a surgical colleague, I had joined a fellow surgeon in a medico-legal practice in Sydney doing part-time work and I continued to do this for a year. Changes to the state laws, however, caused a marked reduction in the number of compensation cases. I began to question the ethics of this type of practice, not from the medical aspect, but from the legal aspect; there was often pressure from law firms to continue assessing cases beyond the medical necessity to do so.

It was then that I decided to pursue my lifelong passion for history and archaeology and study for a degree. I approached a well-known Professor at the Australian National University who suggested I would have to start at the bottom, which I was happy to do, and study for a Graduate Diploma in Arts (Archaeology).

After 18 months and gaining distinctions in all subjects, I was permitted to research a thesis for a Master's degree. I pursued another interest I had had since a boyhood spent walking the hills and mountains of Scotland; researching the remains of Highland Clearance villages in the far north of Scotland, which resulted in a thesis on the Archaeology of the Scottish Highland Clearances[2].

By this time I was well immersed in academia and the research environment and approached a bio anthropologist about the possibility of researching for a PhD thesis in a subject that would be useful, but at the same time employ the medical knowledge that I had gleaned throughout my career. He suggested that research into finding a method of estimating the time since death in human bodies found decomposed would be practically useful. I will be eternally grateful for him taking a person of advanced years under his guidance (by then I was 65) as it has led me on a fascinating journey.

With the aid of an Endeavour Research Fellowship provided by the Australian Government, I was able to spend four months at the Grady Early Forensic Anthropology Research Laboratory (a 'body farm') of Texas State University in San Marcos monitoring two decomposing bodies, with some interesting new findings resulting from the research.

Now, having completed a doctoral thesis in forensic archaeology and developed models to estimate the time since death in human bodies found decomposed in Australian conditions up to 14 days, I am writing papers on the research for publication, still physically and mentally active at the age of 72. The journey during this second career has indeed been pleasurable and hopefully will continue.

What are the lessons I have learned as I near the end of this journey? During a surgical career, I strived to make people healthier and prevent many from dying prematurely. In retirement I have studied and researched archaeology and human decomposition. It seems clear that there is only one life for all of us, there is no resurrection, make the most of the only life you will ever have.

Surgeons have many talents which can be useful in retirement, it is only a matter of realising them, giving full rein to them, and if possible, also using the skills learned during a surgical career. Cherish your family; they are your rock and support in stormy times. ▶

Perhaps my experiences may provide some food for thought for surgeons at any stage of their career

Preparing a decomposed body for autopsy.

Start financial planning for retirement as soon as possible after becoming established in surgical practice. Many surgeons are financially illiterate, having devoted most of their energies to their career. It is important therefore to seek out the most appropriate financial advice at an early stage.

As surgeons, it is all too easy to fall into the trap of thinking we are indispensable, as our patients boost our egos, put us on a pedestal and give some of us a 'God complex'. Be humble, reflective and admit that we are all fallible to some extent and can make mistakes. Keep physically and mentally fit and have regular physical and mental check-ups by an independent doctor; discuss with colleagues any doubts about our failing abilities and heed any warnings given to us.

So often throughout my career have I seen older colleagues having to be metaphorically tapped on the shoulder and told it was time they hang up the scalpel, or what is even worse, have some surgical disaster befall them at the end of their career which blights an otherwise unblemished record.

Join in community activities outside the closed medical community; it maintains a balanced lifestyle. This is easier to do in a rural situation where our patients are our friends, but equally important in a large city where so often medical people become isolated and their only friends are other medical personnel.

Develop interests outside surgery, both mental and physical, that you may not be able to pursue fully while carrying out surgery, but which will be able to be followed in retirement and do not be hesitant in following them. So often I have seen colleagues with no plan in mind and having no interests outside medicine, become bored, depressed, and ill and die shortly after retirement.

My retirement was prompted by health and the thought that there could be an enjoyable life after surgery. It was not until I finally gave up surgery that I realised I was 'burned out'.

It took a year before I stopped taking note of emergency sirens resounding around the town and the thought that I might at any time be called to the emergency department at the hospital. In the absence of a mandatory retirement age for surgeons, it behoves all of us to commence planning at the stage where it can be a profitable and enjoyable experience.

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2. Hayman J. Conflict in the Highlands: the archaeology of the Scottish Highland Clearances. '*Archaeological Review from Cambridge*'. 2010; 25(1): 65-79.

MICHAEL GORTON
COLLEGE SOLICITOR

A recent paper by Associate Professor Ian Scott (Director of Internal Medicine and Clinical Epidemiology at Princess Alexandra Hospital in Queensland) has significant legal, social and policy implications. Given Australia's ageing population, and the expected increase in the demand for care for chronic and aged patients, there will be significant pressure on the resources available to the health sector. The recent Federal Budget has withdrawn expected future funding for the hospital sector in particular.

Government and policy makers will, therefore, need to review a range of options and strategies to maximise resource useage and minimise cost.

Associate Professor Scott concludes: "In the US, approximately 30 per cent of health care expenditure is wasted on activities that add no value to care; the corresponding figure for Australia is unknown, but is likely to be significant."

Despite significant increases in health budgets over the past decade, with health care expenditure in Australia growing from 8.2 per cent of GDP 10 years ago to 9.3 per cent of GDP now, gains in life expectancy and reduction in disability burden since 2000 have "flattened out considerably".

The 10 strategies identified in the paper include:

Minimise errors in diagnosis

The cost of delayed, missed and incorrect diagnosis is substantial and could be minimised. The costs of over-diagnosis, over-servicing and unnecessary intervention could be improved.

This obviously has implications for clinicians, as well as for the health system as a whole.

Minimise practices that provide little benefit or cause harm

There is a role for clinicians and the specialty colleges to move to evidence-based approaches to clinical decision making, assessment of new drugs and treatments. Reviewing existing drugs and treatments, policies and guidelines issued by specialty colleges, health departments and others involved in the health sector, could assist. Unproven interventions, without clinical evidence, should be deferred or avoided.

Select care options on the basis of comparative cost effectiveness

This may be somewhat controversial, which requires an assessment of cost effectiveness, rather than simple clinical decision making on the benefit to a patient. Nonetheless, clinicians and specialty colleges have a responsibility to consider resource allocation within the health sector, and, where clinically appropriate, could take into account comparative cost effectiveness of particular treatments, drugs, and practices.

Target clinical interventions for the greatest benefit

This again is controversial, since it seeks to allocate health resources in a potentially discriminatory manner, but suggests that interventions be made in that part of the health population which derives the greatest benefit. This raises serious legal and ethical questions, but is a conversation that may be necessary.

Review end of life approaches & decision making

This is a very controversial area, but recognises that a sensible conversation will look at the effectiveness of intervention, the clear direction and directive given by the patient, the necessity of particular treatments and interventions, and the need to provide a tighter legal framework in this area. Formal advanced care directives are under discussion by government at the moment, but inevitably social policy, ethics and legal implications will arise.

Clearly the involvement of patients in shared decision making and allowing patients to have greater involvement in their case management has the potential to improve outcomes. There is sufficient research to show that the level of patient involvement in their own care does correlate with the success of care and the outcomes that can be achieved.

Minimise operational waste

An obvious strategy that seeks to make use of the limited resources that will be available and actively seeks to identify waste within a complex and cumbersome health system.

System change and integration

Health institutions need to become more evidence based, standardised and nimble enough to change in the face of new evidence and new information and research.

A coordinated system that actively operates through primary health care and acute health care, linking to the aged care sector effectively, can minimise waste, reduce error and produce a better case managed result for patients.

Achieving this outcome requires a substantial investment of resources itself, and significant changes to the way health care is delivered in Australia currently.

This summary of some of the implications of this important article provides suggestions for a way forward for an overhaul of the health system. While the social policy and legal issues need to be carefully considered, the question is whether there is a political will, within a structure that divides health between Federal and State governments, to achieve these outcomes.

Some of the benefits of these strategies are obvious, but undertaking the work to achieve them is not always possible.

Reference
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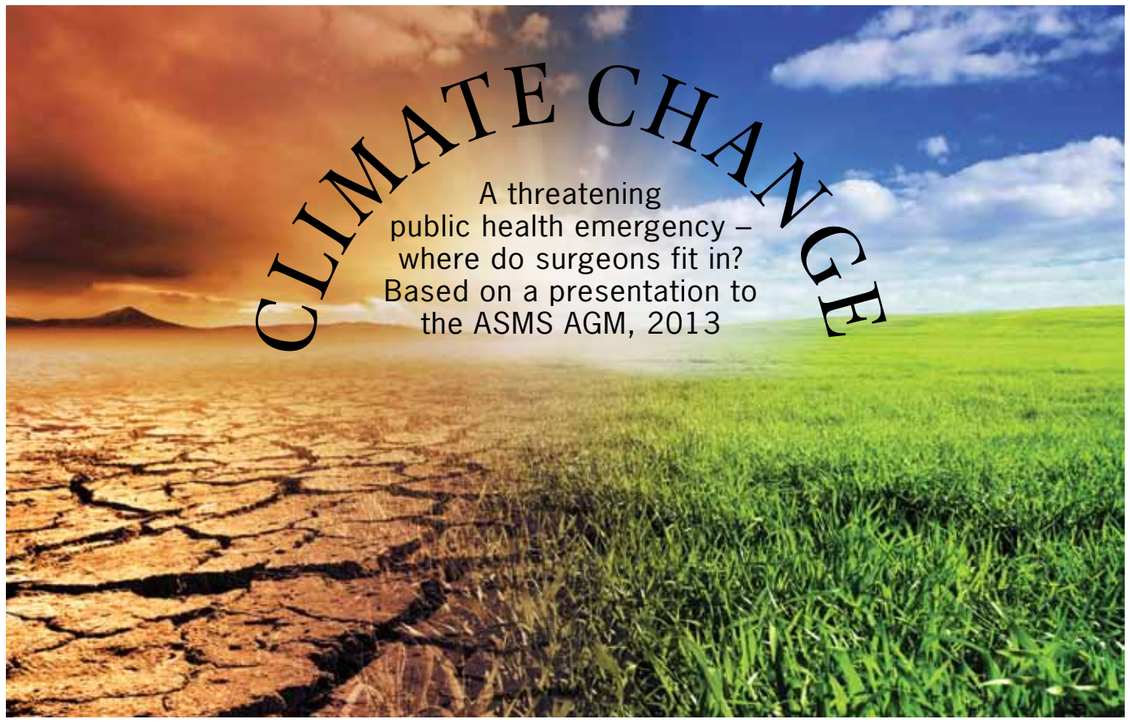

RUSSELL TREGONNING
ORTHOPAEDIC SURGEON, SENIOR CLINICAL LECTURER, SCHOOL OF MEDICINE, UNIVERSITY OF OTAGO, WELLINGTON.
EXECUTIVE MEMBER, ORATAIAO: THE NZ CLIMATE & HEALTH COUNCIL.

After decades of peer-reviewed work, the Intergovernmental Panel on Climate Change, an international scientific organisation involving thousands of climate scientists, recently concluded "... warming of the climate system is unequivocal." and "... human influence on the climate system is clear."[1]

This work, and observation of health outcomes world-wide is prompting global health authorities (WHO, WHA, BMJ etc) to promote the Lancet/UCL Commission contention that, "Climate change is the greatest threat to human health of the 21st century."[2] Dr Margaret Chan, Director-General of the WHO, states, "The verdict is in. Climate change is real. Human activities are a prime cause. Human activities can also be the solution. We must act now, together, to find ways to protect human health and the people on this planet."[3]

New Zealand is already experiencing climate change: higher mean temperatures, more hot and fewer cold extremes, and shifting rainfall patterns – and it's on track to get worse. Despite this, our media treats the issue as a debate, which confuses the public. Governments encourage fossil fuel subsidy and exploration. Climate and health are largely ignored in their policies on agriculture and transport, the two leading causes of NZ greenhouse gas emissions (Figure 1. NB 'Energy' includes transport which makes up approx. 20 per cent of the total NZ GHG emissions).

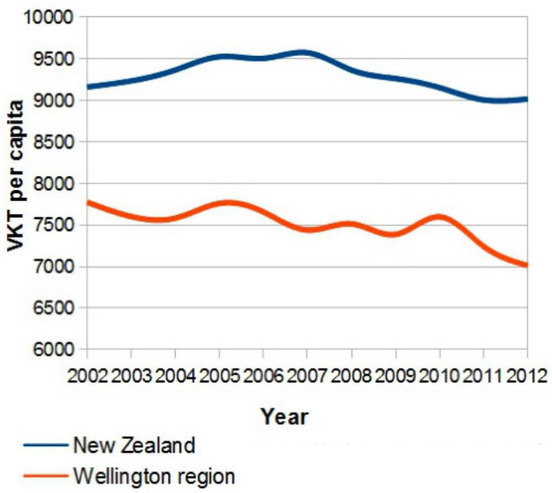

Figure 1: Vehicle-kilometres travelled per capita. Data from Ministry of Transport and Stastics New Zealand.

> "[Climate Change is] on track to get worse. Despite this, our media treats the issue as a debate, which confuses the public"

What does the reality of climate change and its agreed health implications mean for we surgeons? Our College (RACS Code of Ethics) tells me that I am charged "to advocate for improvements in individual and public health". The Medical Council of NZ tells me that I am to "protect and promote the health of patients and the public". The NZ Medical Association Code of Ethics: item 10, states that I must "accept a responsibility to assist in the protection and improvement of the health of the community". The World Medical Association Declaration of Geneva (revised 2006) states: "I solemnly pledge to consecrate my life to the service of humanity..." These are weighty responsibilities. But that is what we have signed up to.

The strength of the evidence that climate change is linked to human activity is being compared with that linking cigarette smoking to lung cancer. We might consider a patient who has come to a doctor for a routine health check. On discovering that this patient is a chain smoker, should we, as doctors warn of the danger of life-threatening lung disease? Are we negligent if we do not? Are we similarly negligent if we fail to inform the public that the changing climate threatens health?

We know what the changing climate means for health. Extreme weather events and climate-sensitive diseases cause millions of deaths globally, right now. Insecurity of food and fresh water, economic collapse and human conflict over diminishing resources are likely. Margaret Chan again: "All populations are vulnerable, but the poor are the first and hardest hit. Climate change threatens to reverse our progress in fighting diseases of poverty, and to widen the gaps in health outcomes between the richest and the poorest. This is unfair – and it is unacceptable."[3]

But fortunately there is good news: climate change action benefits health. More active forms of transport and the consumption of less red meat will cut cardiovascular disease, obesity, diabetes and cancer. Warmer houses reduce asthma and other pulmonary disease; less air pollution reduces these as well as cancer and heart disease.

Spending on roads nationwide is markedly increasing. The NZ Land Transport program (2012-2015) predicts a total spend of approximately $12 billion. Most of this is for Roads of National Significance (RoNS). Cycling, however, will be allocated less than one per cent of the total spend. RoNS by induction will therefore encourage private vehicle transport over walking, biking and public transport, thus discouraging healthy physical exercise; and all this at a time when the young are decreasingly seeking their driving licenses and the vehicle kilometres travelled per person is staying static or reducing (Figure 2).

The NZ Transport Agency policy of its "vehicle first" approach makes current transport policy a threat to international efforts to tackle global environmental problems, including air pollution and climate change; its transport benefit/cost ratios (BCRs) often fail to quantify the health and equity costs.[4]

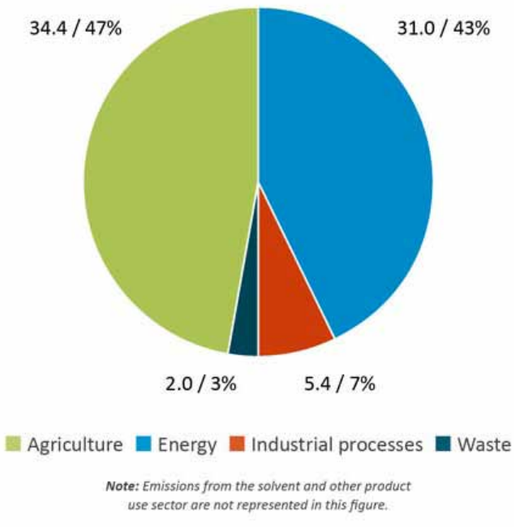

Figure 2: Ministry of the Environment Greenhouse Gas inventory-2011 (NB: Transport is included in "Energy" and comprises about 20 per cent total of GHGs).

So what can surgeons do? People respect and listen to us. We are ideally placed to interpret the science, as we are in the unique position of bridging the theory of science and the pragmatism of care and treatment. We have the greatest responsibility to act, and our professional organisations require it of us.

We should reduce the high carbon footprint of health delivery – there is huge waste of disposables in our theatres. We must also push our organisations to divest from fossil fuel industries. We need to ask our politicians for Health Impact Assessments (HIAs) before the formulation of their policies.

We have to speak out clearly to the public, the media, government; in so doing we need to provide a strong and unified message – that climate change is real and is a result of human activity; that it is already affecting people globally and is the greatest current threat to human health; and that there are many positive and practical things we can do to avert its worst health effects.

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2. http://www.ucl.ac.uk/global-health/outcomes/reports/publications-docs/lancet-commission
3. http://www.who.int/world-health-day/dg_message/en/
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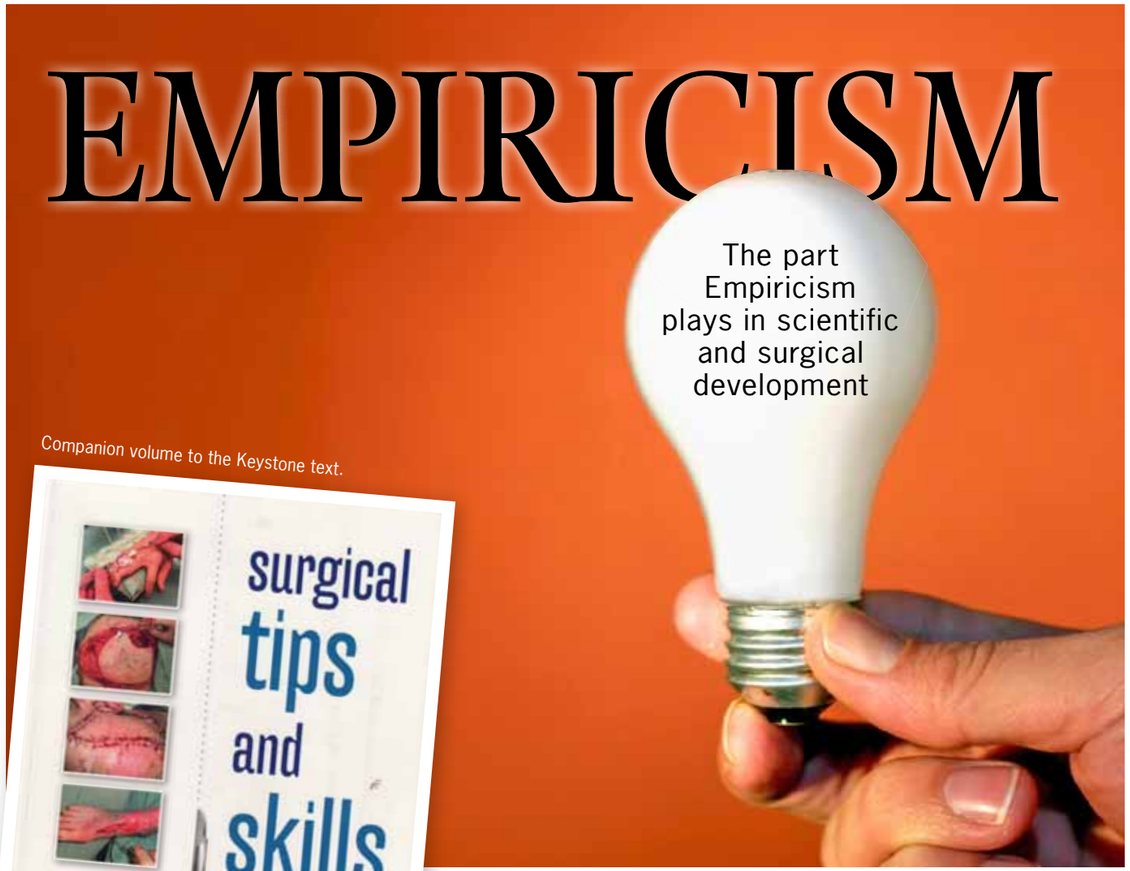


It was in early April 2014 when flicking through the obituaries in 'The Age' that I saw the anniversary notice of Francis Bacon's death in 1626 describing the English lawyer, who became Lord Chancellor of England, as a philosopher and scientist, a man for all seasons and the father of Empiricism. Tragically he died of pneumonia in the English countryside while experimenting with the use of ice for the preservation of meat, working on an eviscerated chicken.

As observational empiricism is a basic tenet in any scientific process, and even Aristotle said in paraphrase 'first with the senses, then with the mind'; I thought it was worth recounting my experiences, on the development of the Keystone Flap. This word can refer to either the architectural concept of an arch or the central theme or ideation of a philosophical process. Even John F Kennedy used that word in his final speech when he described the United States as the "keystone in the development of world peace" at that last breakfast meeting in Dallas on that fateful day in November 1963. My original terminology of an "arc" flap was improved by Alan Breidahl's suggestion of the word "keystone".

While residing at the College of Surgeons in London, my Sunday evenings were sometimes spent in the local pub (dare I say decadently) the Seven Stars, where I experienced warm English ale, on those cold winter evenings, in the smoke-filled den, talking to the local legal entities. Not far away was Grays Inn, off Lincoln's Inn Fields, the legal precinct of London where QCs are born and bred and where Francis Bacon's statue still resides.

His French contemporary Descartes talked about Bacon's non-metaphysical (abstract reasoned thinking) approach to science. Voltaire introduced him as the Father of scientific method to French audiences. Thus Bacon was the inventor of the process of discovering unwritten laws from evidence of their application, combining empiricism and induction in a way that was to imprint his signature on the English scientific establishment. Bacon was the then guiding spirit of the Royal Society.

The Angiotome concept, the neurovascular basis of the keystone, had its origins in London where I was doing research at the College of Surgeons on flap vascularity. This principle was presented at the Madrid meeting of the European Society of Plastic Surgery in 1973, where the late Bill Manchester of New Zealand, Chairman of the session, suggested I get it into print as soon as possible, as he liked it.

FELIX BEHAN
VICTORIAN FELLOW

The clinical development embraced the neurovascular supply based on embryological dermatomal templates and supported by vertically oriented perforators without skeletonisation. This led to the Keystone concept, whose shape may be multivariant from an arc through to a quadrilateral to accommodate various surgical sites.

The concept of the keystone may have misled clinicians. It is not just merely multiple applications of the VY principle. It is the advancement, rotation and transposition artfully of loco-regional flaps from areas of laxity to areas of tightness for major defects. As the late Bob Marshall said, islanding at the integumentary level is similar to a local sympathectomy effect, which creates the vascular changes.

The six observed clinical features of the Keystone flap, called the hexadic response, are (1) the vascular flare, (2) the "red-dot" sign at the suture point, (3) the analgesic effect due to nociceptors – thanks to Brendan Coventry's research, (4) tensional closure with anoxic stimulation of angiogenesis, again quoting Wayne Morrison, (5) the resolution of oedema by opening lymphatics (another sympathectomy effect) and (6) finally the Quality of Life outcome using like-for-like tissue when "the next best tissue is the next best tissue", a Gillies aphorism which I obtained from Julian Peters. Investigations of all these features are in progress through various academic units in Australia.

I have used this technique repetitively over the past 20 years with case numbers dans les milliers and any presentations create interest. When I presented my clinical findings at Mike Klaassen's flap

reconstruction course in New Zealand in 2013, he adopted the concept and technique with open arms. My erstwhile colleagues at Peter Mac, Simon Donahoe and Mikki Pohl, have enjoyed this new reconstructive alternative replacing some of the standard methods available.

There is often a delay between the establishment of a concept, the enunciation of hypotheses and the verification of the scientific process. As William James from Harvard said in the 1870s "that in the pragmatic theory of truth, empirical experience leads naturally into a rationally based concept of thinking and with inductive exposure can produce a deductive outcome by way of explanation."

Edward Jenner and smallpox spring to mind. He worked at St George's Hospital, Hyde Park Corner, with John Hunter at my old tramping ground. Jenner observed that milkmaids were spared the skin disfigurement of smallpox. On 4 May 1796, he performed the first successful cowpox vaccination (etymologically the word is derived from the French for cow, vache).

The medical profession in accepting this principle was slow to change – the young ones, yes and the old ones, no – and it took decades for this concept to achieve wide general acceptance. Interestingly the Jenner cowhide was in the St George's medical school library at Hyde Park Corner. One Friday evening in 1972 in the library I had my Eddisonian moment, finding the term Angiotome in Dorland's Medical Dictionary which linked vessels and neuro-dermatomes which I incorporated into a reconstructive unit.

In 1926 Fleming observed the lytic process in staphylococcus on a Petrie dish due to spores he described as penicillin (pencil-like) and published a year later in the Journal of Forensic Pathology. The Australian Howard Florey was offered £25 by the British Government to clinically develop this antibiotic. He flew from war-torn Britain to the United States via Lisbon with the spores sewn into his clothing to arrange commercial development, which was delayed somewhat by American patent issues.

It has been calculated that up to ¼ million American soldiers benefited from antibiotic treatment following the D-day landings in Normandy. Even the British had to pay royalties for its subsequent use. The Nobel Prize for Florey, Chain and Fleming was eventually awarded in 1945. Incidentally, I submitted this revised text on 6 June, the anniversary of that war-time event.

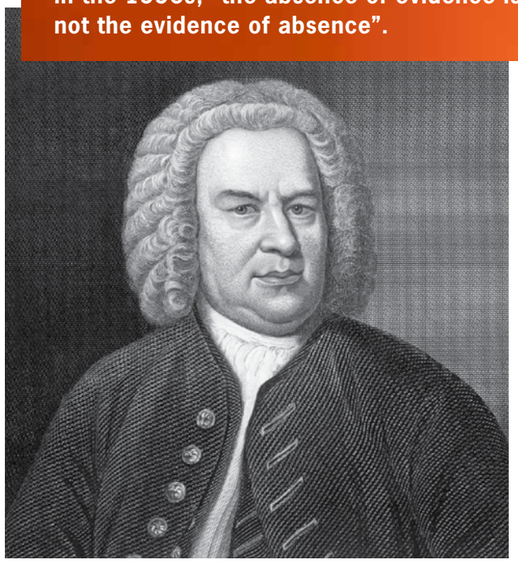
More recently, John Royle's historical article from the 'ANZ Journal of Surgery' in December 1999 discusses the history of sympathectomy. I recommend this to all, being full of scholarship and erudition as well as historical information. It was a distant relation of his, Norman Royle, who performed the first lumbar chain sympathectomy in Sydney for muscular spasms, etc, in 1923 and published in the *ANZ Journal of Surgery* in 1924.

It was shown to William Mayo of the Mayo Clinic on his visit here, who subsequently published these ideas after introducing it to the American surgical scene. It is not often that Aussie surgeons can teach the Mayo Clinic a thing or two (before the emergence of the microsurgical Mecca in Melbourne). Incidentally John himself performed the first endoscopic sympathectomy in Australia and I congratulate him for bringing this to our attention.

My clinical saga over 40 years has experienced many of these variables. My experiences have been recorded clinically accurately in a disciplined manner as the basis for ongoing teaching (a joy in itself) and as a preamble to publication locally and internationally (ethically). The edicts of evidence-based medicine (levels 4 and 5) have been observed for patient well-being and surgical advancement.

The support of my colleagues, including the redoubtable Don Marshall, has been rewarding. The willingness of the patients to accept this treatment is its own consolation and my hospital associations (Peter Mac and Western Hospitals) have always been encouraging. I could conclude by quoting Pasteur's words, "tenacity is a timely virtue", but basically I have been fortunate in this clinical non-cadaveric enterprise.

One must always be cautious to avoid hubris, as even Telemann in the 18th century, composer of more than 3000 works and godfather to some of Bach's children, said: "The great works of nature reflect the majesty of our Creator." In essence Carl Sagan the astrophysicist said in the 1990s, "the absence of evidence is not the evidence of absence".



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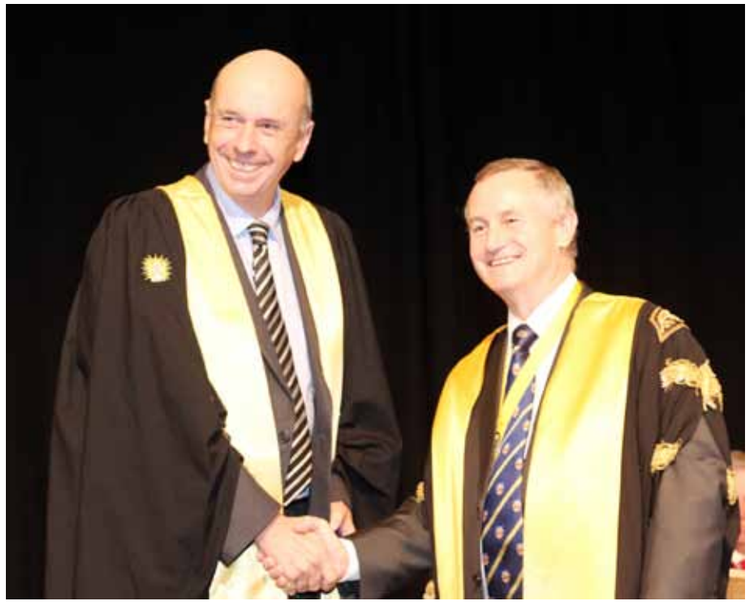


Sir Louis Barnett was responsible for the original proposals in 1920, to create a New Zealand and Australian association of surgeons which would be modelled on the American College of Surgeons and bestow a "hallmark" of surgical excellence. The Sir Louis Barnett Medal is awarded for outstanding contributions to education, training and advancement in Surgery.

PROFESSOR GUY MADDERN FRACS
Sir Louis Barnett Medal

Guy Maddern was educated in Adelaide at St Peter's College. Graduating MBBS from the University of Adelaide he commenced his medical career as an intern at Royal Adelaide Hospital in 1981. By 1982, he had enrolled for a PhD ,which he achieved in 1985. His path as an academic surgeon was thus set and from this he has never wavered. Remarkably, within eight years, at the age of 36, he was appointed as the R.P.Jepson Professor of Surgery and Director of Surgery, Queen Elizabeth Hospital – positions that he has held for more than 20 years.

His academic surgical output can best be described as prolific. He has successfully applied for more than $31 million dollars in research grants, published more than 500 papers, 22 book chapters and 6 books with the seventh in preparation. Twenty-eight young researchers have achieved higher degrees under his tutelage. He has presented his wisdom and knowledge at meetings and conferences within Australia and throughout the world on many hundreds of occasions. He has received prizes and awards too numerous to mention. He has served on many Hospital and University committees and been an adviser to Governments in a diverse range of capacities.

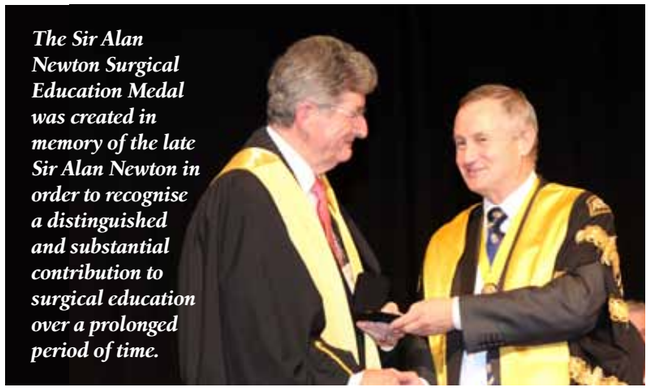
With a singular interest in evidence, Guy imagined, created and developed the Australian Safety and Efficacy Register of New Interventional Procedures (ASERNIP-s). This truly remarkable achievement has achieved international acclaim and brought great credit to our profession. In addition, he is the Director of the Basil Hetzel Institute for translational health research that has strong links with the clinical divisions of the Queen Elizabeth Hospital.

In 2002, Guy was elected to Council of the Royal Australasian College of Surgeons. He served in many roles becoming a member of the Executive of Council and Chair of the Professional Development and Standards Board from 2007 until 2011.

Guy Maddern is entertaining, engaging, enthusiastic and effective. His clarity of thought is always evident. He has a dry but infectious sense of humour. His thinly veiled barbs are highly accurate but delivered with such good grace that it is impossible to be offended. Rather the "victim" of his quick wittedness feels flattered to be worthy of such interest. He is highly intelligent, his thinking expansive, his activities inclusive.

Guy Maddern has served, and continues to serve, our surgical profession with distinction. He personifies many of the attributes to which all surgeons should aspire. He is truly the benchmark for the academic surgeon.

Citation kindly provided by Professor Michael Grigg FRACS



The Sir Alan Newton Surgical Education Medal was created in memory of the late Sir Alan Newton in order to recognise a distinguished and substantial contribution to surgical education over a prolonged period of time.

PROFESSOR JOHN COLLINS FRACS
Sir Alan Newton Medal

John Collins is an internationally-renowned surgical educator and a worthy recipient of the inaugural Sir Alan Newton medal, to be awarded for pre-eminent contributions to Surgical Education and Training. He graduated from the National University of Ireland (1964) and obtained fellowships of the Royal Colleges of Surgeons of Edinburgh and England (1972) followed by the FRACS (1974). He obtained two Masters degrees from the National University of Ireland, one on surgical nutrition (ChM 1979) and the other on "The Selection and Assessment of Medical Students" (MD (1994). His medical career has spanned a golden jubilee.

Through the last 50 years he has been a general surgeon with a special interest in breast surgery at Middlemore Hospital in Auckland (1973-2004), a leading medical educator and also a surgical historian. His residence has been shifted between Auckland, Melbourne and Oxford, though his influence and reputation have spread not only through Australasia but also throughout the world, particularly in the fields of medical and surgical education.

He was an examiner and senior examiner in general surgery for over a decade [1993-2004] before being appointed RACS Dean of Education (2004-2009). He became the champion and exponent for the introduction of the Surgical Education and Training (SET) program that replaced the two tier Basic Surgical Training (BST) and Advanced Surgical Training (AST). During this period in Melbourne he was also an Associate Professor of Medical Education with the University of Melbourne.

At the University of Oxford [2009-2014] he was a visiting Professor at the Nuffield Department of Surgical Sciences and appointed 'Independent Chair' to review the UK Foundation Programme for Medical Education England (2009-10). He has recently [2013-2014] reviewed prevocational training [PGY 1 &2] for the NSW Health Education and Technology Institute (HETI).

John has a great interest in Surgical History, recently completing a History of Medicine Diploma with the Society of the Apothecaries in London [2013]. He holds Honorary Fellowships with the Royal College of Surgeons of Ireland, the Academy of Medical Educators UK, and was previously awarded the Sir Louis Barnett medal by this College (2011). He gave a Hunterian lecture to the RCS England [June 2010], recently [April 2014] the Halsted lecture at the 4th ICOSET [International Conference on Surgical Education and Training] meeting in Harrogate, UK; and on Wednesday [May 7th 2014] he delivered the Herbert Moran Lecture at this convention.

Citation kindly provided by Professor David Watters FRACS

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