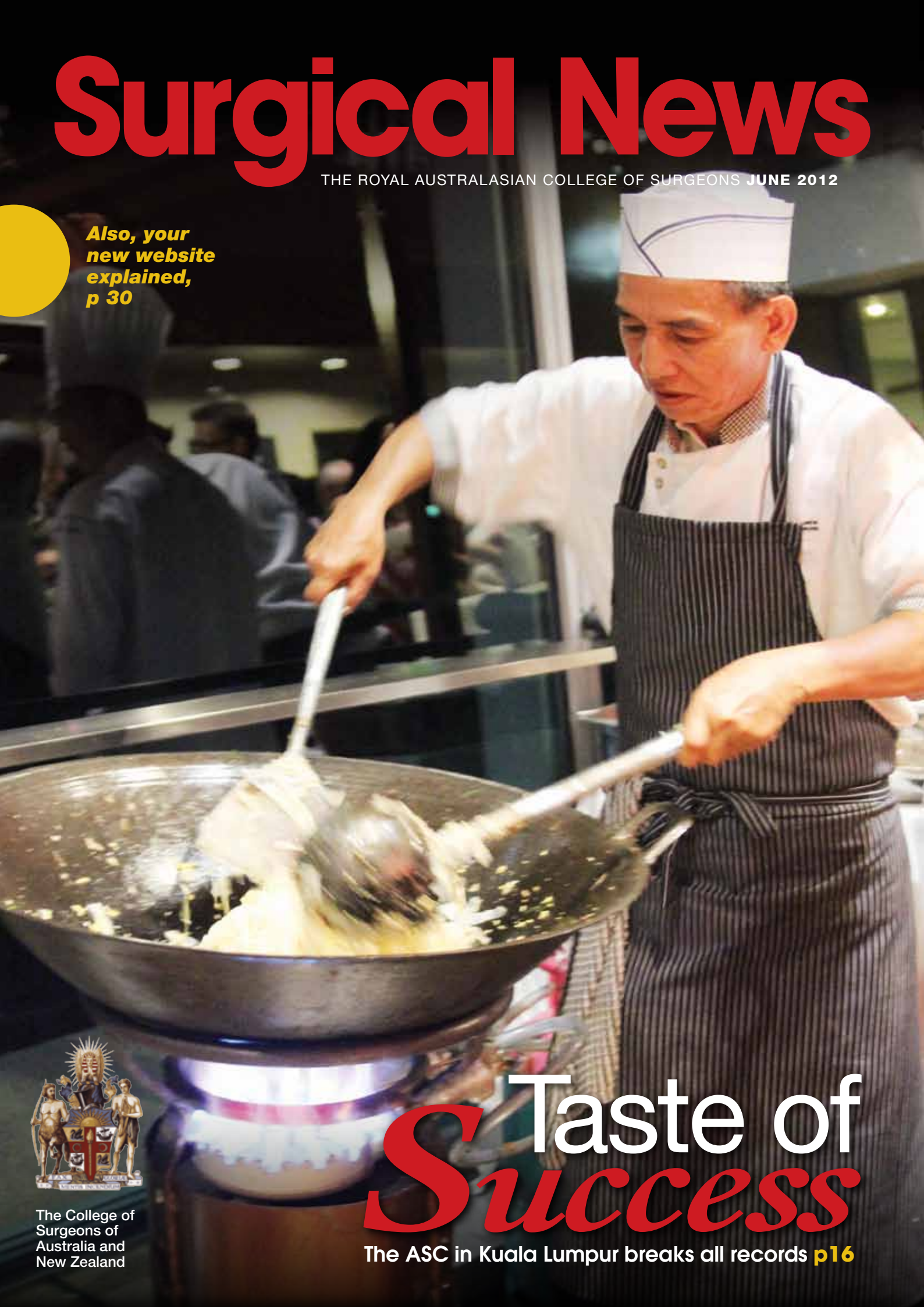
Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **JUNE 2012**

Also, your new website explained, p 30

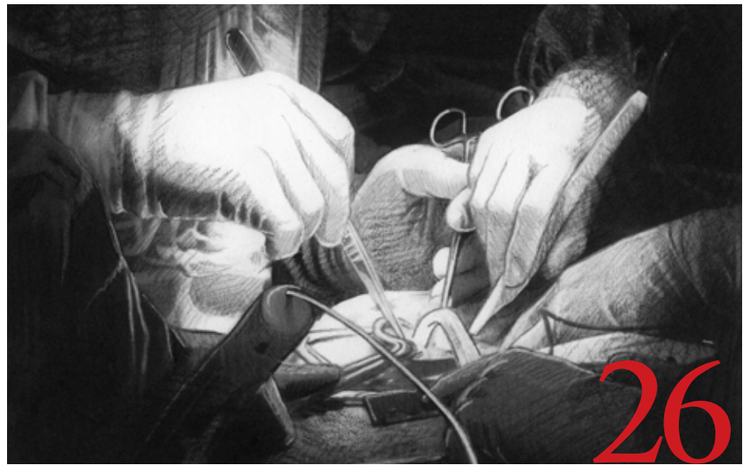


Taste of *Success*

The ASC in Kuala Lumpur breaks all records p16

The College of Surgeons of Australia and New Zealand

contents



Certified System
Quality ISO 9001
SAI GLOBAL

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org
Letters to the Editor should be sent to: letters.editor@surgeons.org
Or The Editor, Surgical News, Royal Australasian College of Surgeons,
College of Surgeons Gardens. 250-290 Spring Street, East Melbourne, Victoria 3002
T: +61 3 9249 1200 **F:** +61 9249 1219 **W:** www.surgeons.org
ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis /

Published for the Royal Australasian College of Surgeons by RL Media Pty Ltd. ACN 081 735 891, ABN 44081 735 891of 129 Bouverie St, Carlton. Vic 3053.

ON THE COVER:
Local chefs cook up a storm at the Cultural Night of the ASC

President's Perspective

Annual Scientific Congress *success!*

The Annual Scientific Congress in Kuala Lumpur was an outstanding success. Well over 2300 delegates made it the most popular Congress ever and the challenges of our multi program event were admirably accommodated within the Kuala Lumpur Conference Centre. Phil Truskett, Raffi Qasabian and all the Program Convenors put together a diverse program. Thank you. I would also like to make a particular note of the wonderful job done by Campbell Miles, Lindy Moffat and the staff in the Conferences and Events Department at the College and to welcome Roger Wale. As many of you know Campbell is retiring from his role this year. He has revolutionised the ASC.

I sometimes hear surgeons say, 'but there will be nothing at the ASC for me'. Packed attendances at plenary sessions dealing with issues of Communication, Collaboration, Professionalism and Making the Team work spoke to the contrary view. It highlights not only the importance of these issues and some outstanding professional development opportunities, but the recognition by surgeons of all specialties of how important these skills really are.

International visitors like Professor Rhona Flin (pictured) from Aberdeen and Simon Paterson-Brown from Edinburgh were able to describe the background, development and implementation of courses such as the NOTSS Course (Non-technical skills for surgeons). This course has now been replicated for Anaesthetists and for Operating Theatre nurses providing a common approach in the operating theatre and hopefully providing skills that improve outcomes for patients.

Professor Marcus Stoodley who received the John Mitchell Crouch Fellowship described the excitement of his research in developing molecular treatments for brain arteriovenous malformations.

In contrast to the purer science, the President's lecture was delivered by Professor Chandra Muzaffar from Malaysia. This was a humbling experience as he described so eloquently the challenge of unity in today's multi-cultural societies.

And then to the future, with Dr Mukesh Haikerwal providing the detail of how the e-health initiatives will unfold over the next 12 months. Mr Graham Mercer, President of the

Australian Orthopaedic Association, then explained the use of digital images within the e-health environment.

The Masterclass Program was initially envisaged as targeting Trainees and Younger Fellows, but its popularity has gone beyond those initial targets and it now attracts an eclectic surgical audience.

The International Forum is an increasingly popular day interesting to surgeons of all disciplines. This year there were speakers from 12 countries and from five continents. The inaugural Rowan Nicks Lecture, "Strengthening care for the injured in the Asia-Pacific and globally", was delivered by Professor Charles Mock from the University of Washington.

Increasingly there are a number of satellite meetings and courses around the core of the ASC. I was a guest of the Younger Fellows at their Forum at the Golden Palm Resort in Selangor. Seema Bagia and her Committee organised an excellent program exploring the "public/private" balance in a surgeon's life. A joint faculty from Australia, New Zealand and the UK helped promulgate the CCRiSP Course to Malaysia. The EMST Chair met with other ATLS Chairs, Coordinators and Educators at the 5th Annual Region 16 ATLS Meeting and Russell Gruen from the Alfred Hospital in Melbourne ran a Trauma Quality Improvement Course to name just a few.

I challenge anybody to question the variety offered by the ASC. This is a small sample of the breadth of the program. To those who say that 'there is nothing there for me', let me respond by stating that surgery is not just making a diagnosis and performing an operation. There are nine competencies which together make a surgeon. All were highlighted at some point in an excellent program. We are in a complex world with substantial expectations and requiring a diverse skillset. The ASC is now deliberately designed to ensure that all these expectations can be met.

Relationship between the College and Specialty Societies

Most readers of *Surgical News* would be aware of the ongoing work being undertaken to enhance the relationships between the College and the Specialty Societies. There has been much progress and some success with many initiatives underway and others to be more evident in the coming months. Presidents of the 13 societies have been meeting with the President and Vice President of the College, working parties have been meeting and consultancies have been undertaken in order to review governance and board activities, the standards and compliance that underpin our educational programs as well as ensuring the subscriptions and fees paid by all Fellows and Trainees are used effectively.

Thus far Council has identified a number of matters which might be termed "low hanging fruit" and these have already been progressed. More complex issues will require further discussion with the Specialist Societies and within Council. Where appropriate, external consultancies have been sought, but only where particular expertise is needed to answer a specific question. This approach to the use of external consultants will reduce unnecessary cost.

While in general College structures work well, all organisations need to reflect on their management systems and governance structure periodically. The Council is taking the present situation as an opportunity to do so. In essence, while I am sure there is room for improvement, I am against "change for change's sake".

It is my ambition, in the early months of my Presidency, to consult widely and to ensure those issues that have been highlighted are properly addressed. This will include appropriate consultation with individual Fellows, the Specialist Societies and debate in Council.

I would like to thank those members of Council who have retired from Council following the May AGM. Ian Civil, Keith Mutimer and Mark Edwards served on Council's Executive, Rob Black, Hugh Martin, Sam Baker, Vince Cousins and Greg O'Grady all filled various roles on Council, and on a personal level all provided friendship and wisdom.

As President, I am honoured by the trust shown in me by Fellows and Council. I follow in some giant footsteps and now have a greater understanding of the commitment and dedication that this position requires. I again would like to acknowledge the outstanding work of my predecessors, particularly Mr Ian Civil, who gave so tirelessly for the College and for the Fellowship.

Mike Hollands
President

Delivering life-changing skills

Our role in the development of new techniques is growing

Visitors to the Skills Laboratory at the College may not be aware that just metres away from the building is an area known locally as the East Melbourne Hearing Precinct. Bisected by Bionic Ear Lane, the area is historically significant as the location of the pioneering research and development of the multiple-channel cochlear implant led by Professor Graeme Clark FRACS. It remains the centre of ongoing collaborative research and development, implant surgery and associated activities at the University of Melbourne's Department of Otolaryngology, the Royal Victorian Eye and Ear Hospital Cochlear Implant Clinic, the Bionics Institute, the HEARing Co-operative Research Centre, and the Melbourne office of Cochlear Limited.

The cochlear implant – popularly known as the Bionic Ear – is a device that helps deaf people 'hear' by coding speech, music and environmental sounds into electrical signals and then transmitting the signals across the damaged part of the cochlea (inner ear) directly to the auditory nerves allowing the brain to perceive sounds. The device comes in two parts; an electrode array which is surgically implanted in the cochlea, and a receiver-stimulator which is worn externally. Manufactured by Australian company Cochlear Limited, the device has brought hearing to more than 200,000 severe to profoundly deaf children and adults.

College Fellows have been central to this amazing Australian success story for over four decades and continue to play a central role. Fellows were instrumental in realising the implant and ensuring the safety and efficacy of the surgical approach. Professor Clark, as leader of the research and development team, has been the recipient of many international awards over the years in recognition of this achievement.

A vast range of design and safety factors had to be assessed prior to implantation in a patient. Clark and OHN surgeon Brian Pyman mastered the surgical technique by practising on about 50 human temporal bones before carrying out the first surgery on a patient and, after more than a year of searching for a suitable patient, Clark and Pyman performed the first cochlear implant operation at the Royal Victorian Eye & Ear Hospital on 1 August, 1978.

By 1985, the Australian multichannel cochlear implant became the first to be approved by the Food and Drug Administration in the US for use in adults, and in 1990 for children. The 2000th cochlear implantation surgery in Melbourne was performed recently at the Eye & Ear Hospital's Cochlear Implant Clinic.

The College's Victorian Skills Laboratory is proud to play an ongoing role in this life-changing work. It hosts temporal bone workshops for Trainees in Otolaryngology Head & Neck Surgery and also regular cochlear implantation courses in conjunction with the HEARing CRC. OHNS surgeons from around the Asia Pacific and beyond have passed through the Skills Laboratory, coming from not only Australia and New Zealand, but also China, India, Indonesia, Korea, Malaysia, Mongolia, Pakistan, Philippines, Saudi Arabia, Singapore, Sri Lanka, Taiwan and Thailand.

The workshops include a hands-on temporal bone workshop and tutorials on surgical technique and medical management issues with experienced surgeons. The Skills Lab has the capability to accommodate 12 work stations outfitted with an operating microscope, surgical motor, suction, irrigation and a full array of instruments.

"College Fellows have been central to this amazing Australian success story for over four decades and continue to play a central role"

The hands-on sessions, directed by Associate Professor Robert Briggs FRACS, Head of Otology and Medical Director of the Cochlear Implant Clinic at the Royal Victorian Eye and Ear Hospital, guides the participants through dissection of the mastoid process of the temporal bone, carefully navigating important structures such as the facial nerve, followed by the creation of a window in the cochlea through which a cochlear implant electrode array is then inserted.

And the research continues. Among many Fellows contributing to the ongoing research to improve the effectiveness of cochlear implants, a number have a close relationship with the College through the Skills Laboratory workshops. Professor Stephen O'Leary, Graeme Clark's successor as William Gibson Chair in Otolaryngology at the University of Melbourne, is directing research on methods of delivering protective drugs to the inner ear to reduce the risk of hearing loss during surgery.

One of the College's more recent Fellows, Dr Benjamin Wei produced some important findings during his PhD studies on the effects of inner ear trauma on the risk of pneumococcal meningitis, resulting in recommendations for cochlear implant design, insertion technique, and clinical practice. Ben was awarded the Premier's Award for Health and Medical Research for his achievements.

It is appropriate that the College's Victorian Skills Laboratory, standing as it does so near the East Melbourne Hearing Precinct, continues to play an important role in work that is transforming the lives of thousands of people and will do so for generations to come.

Michael Grigg
Vice President

Destination surgery

Some Australians are taking up cheaper surgery in foreign countries, frustrated by waiting times and cost of surgery. After looking at the options, Yasin Odeh took up the chance to have his shortness of breath cured with 'sunken chest' surgery in India. Chairman of Professional Standards at the Royal Australasian College of Surgeons, Graeme Campbell said that stories such as these highlight deficiencies in the system. "(But) ultimately, you've got to work out; is it worth the risk?" Mr Campbell said.
***The Age,* May 6.**

Record transplant feat

Surgeons at the Austin Hospital have worked around the clock to complete eight liver transplants in just 10 days.
The total number of hours in operation was 88, with some complex operations lasting up to 15 hours. Around 50 transplants are performed per year by the Austin team though never as many in such a short time. College Fellow and Unit Director, Professor Bob Jones said, "We were just flat out, but when we were finally able to stop and reflect, it was fantastic to think of all those patients who were transplanted."
***Herald Sun,* 28 May**

Hand hygiene part of training

Trainee surgeons will now need to demonstrate a commitment to hand hygiene if they are to become Fellows of the College. In conjunction with Hand Hygiene Australia, an online test has been developed for applicants to the 2013 SET intake.
Dean of Education Bruce Barraclough said the test reflects the College's ongoing emphasis on the fundamental importance of hand washing. "Surgeons are very focused on clean hands, to the extent that they scrub up before surgery, wear gloves and even double glove … and we want that focus to (remain) strong (throughout their day)".
***Australian Doctor,* May1.**

Hypnotise the pain away

Patients could be hypnotised instead of using anaesthetics for certain types of surgery, a New Zealand pain specialist has said.
Bob Large told the Australian and New Zealand College of Anaesthetists at their conference last month that around 10 to 15 per cent of people could be hypnotised for surgery such as gall bladder or thyroid removal.
He also said that much of the population could benefit from using hypnosis for pain control.
"Most of us can get some sort of pain control by just being engaged in a good clinician interaction with a good hypnotic technique."
***Sunday Times,* May 13.**

Some churlish *thinking*

Curmudgeon
(noun): A crusty, ill-tempered old man;

Curmudgeonly
(adjective)
(Websters' dictionary).

Being a curmudgeon is a fine profession. It is not one that you can train for or one that you can apply for. You are born into the role. A young person cannot be a curmudgeon.

I know some fine curmudgeons – my old mate, Rob Atkinson, is a fine curmudgeon. He and I had discussed forming an International Society of Curmudgeons and writing articles for Surgical News from the view point of curmudgeons. By writing this article before him I will have annoyed him considerably. That is great – he will be able to exhibit typical curmudgeonly behaviour by being ill-tempered and crusty. Tough, Rob, get over it. As you know we don't care about these niceties.

We curmudgeons can get cranky about things for no apparent reason and at a whim. We are stubborn – don't try to persuade us as we are immutable after we have taken a position. Don't try logic on us as we are illogical. We don't care if you do not agree with us and also don't care for praise if our view is also your view. Our tools of office are offence and bloody-mindedness.

Each month I am going to have a good moan about things. Some articles will be medical and some not. I think that I will start each article by: "There is one thing that really annoys me and it is..." So here goes a trial run.

There is one thing that really annoys me and it is women who think that they can be curmudgeons. It is a male calling, a bit like being a Catholic priest (but different). So I am sorry ladies you can't. You can be grumpy old women, ill-tempered and crusty, but you can't be a curmudgeon (see Mr Webster above). If you don't like this, that is tough – get over it!

Battling health bureaucrats

The article by Greg Harvey (Surgical News, Vol 13, No 3, April, Regional News, page 22) concerning the difficulties of combining private practice, College activities, family life and an increasingly uncooperative public hospital commitment as exemplified by a recent advertisement for the position as "Head" of Surgery at the Royal Hobart Hospital is thoughtful and appropriate, and highlights a situation which is not unique.

The decline of the ability of surgeons to influence the practice of surgery in the public hospitals has been insidious and progressive, with a near terminal situation now existing where the theatre time is severely reduced, beds are closed, clinics are manipulated to reduce the number of patients on waiting lists, with a focus on the needs of the bureaucrats and the politicians to preserve their power structures with little attention to the needs of the individual patient.

While it is appreciated that funds are tight for reasons that may be debatable, a system that can allow a patient to be admitted to hospital after making personal arrangements which may involve considerable disruption to family life and possibly significant costs, only to have the operation cancelled due to lack of theatre availability, ICU or ward beds, is nothing short of cruel and has obviously failed.

Having initially been appointed to the Royal Hobart Hospital as an Honorary Surgeon in 1965 and spent some 10 years as the Medical Staff Representative on the Board of Management, which included University representatives, I am appalled at how we have allowed the focus on patient care to deteriorate to this point by the insidious intrusion of health bureaucrats.

The rot began with the abolition of the Boards of Management of the individual hospitals in favour of a centralised bureaucracy, so that the open information on costs and patient care in regular monthly Board meetings became hidden in the bowels of the bureaucracy within the Department of Health.

It is my hope that the introduction of Clinical Directors with responsibilities for individual disciplines would stem the tide, and this desire led to me becoming the initial Director of Surgery, which involved a simple once a week joint meeting with the other Directors and the CEO at which problems were resolved and resources allocated, together with an open door and free availability to colleagues policy. This was, however, a forlorn hope, as with each succeeding change of Director the power has been whittled away, until we see the disgraceful current situation outlined by Greg Harvey, whereby it is proposed that the head of surgery will no longer in effect be a surgeon.

It is a simple matter for bureaucrats to take over power by increasing meetings and scheduling them for times which are not possible for a practicing surgeon to attend.

What can be done? Surgeons will not remain in or be willing to serve in the public hospitals unless they can be assured that they can utilise their hard won skills in reasonable circumstances, allowing respect and care for their patients without interference from a bureaucracy focused on finance and political power. The bludgeon of "You are exceeding your budget" is frequently used although it is often impossible to find out what the budget is, certainly not early enough in the financial year to modify it. There is a huge need for the financial experts to catch up with the realities of patient care.

Some years ago the College set-up training in "Leadership, Management and the Law" as a contribution to management skills in hospitals, and many surgeons have undertaken this training, but the willingness of people holding power to allow surgeons to be involved in a realistic way has been very limited, although involvement varies from place to place.

My experience as Chairman of the Clinical Advisory Committee of the Department of Health in Tasmania, designed to integrate clinical services in the public hospitals and advise on the facilities available, led me to the conclusion that while clinicians were willing to be involved and put forward many intelligent and constructive ideas, implementation of change was very limited indeed, so that in my view an advisory role is not sufficient to produce outcomes.

Recently there have been reports of the establishment of individual Surgical Hospitals with seemingly excellent results, both in services and costs.

It seems that a possible way forward to allow surgeons to practice their craft and care for their patients appropriately while teaching a younger generation, is to somehow separate the practice of surgery in public hospitals from the other functions of the hospital, administratively and practically.

To try to reform the whole system of finance, management and resources in the public hospitals would be an impossible task, but perhaps if the College could agree on the circumstances under which surgery should be practiced in public hospitals and define some principles, then the considerable clout of the College built upon its standards, teaching, audits and professional development may be sufficient to effect some change.

Should it be within the remit of the College to move into defining the milieu in which public hospital surgery is practiced, and if so, how do we do it?

***J. McL. Hunn**, AM, MBBS (Melb), DCH (Glas), FRCS (Edin), FRACS*
Emeritus Professor of Surgery,
University of Tasmania


Regional News

How do we continue our role in the public system?

I am coming to the end of my term as State Chair of the Tasmanian branch of RACS with mixed feelings. I was surprised to find that I had been on the committee for nine years (I only qualified 10 years ago). I have enjoyed the experience, but my role on the committee has been tempered by a shortage of that precious commodity called time.

As in all states, Tasmania's public health system is in crisis, but it may arguably be in the worst condition. I understand our bed numbers have been halved! So I will take this last opportunity to provide a personal take on a system in crisis. What follows is only my opinion, written to provoke thought and discussion in our surgical community.

I recently saw an advertisement for "Head" of the Department of Surgery at the Royal, brought about by the pending resignation of Bob Linacre. You should talk to Bob some time about his experience in this job and why he has resigned. Part of me looks at that role and thinks it would be a great challenge. But how to juggle a family life, five children all of whom do sport and other activities, a private surgical practice, pro bono work like College roles, and working at a public hospital?

I forgot one other thing – self or own time – that gets swamped so easily. What has to give?

At the moment self time, family time and College time is lost first. Which means my work for the College is not as thorough as I would like it to be. The volume of emailed material to be read for regional committee meetings is such that I am guilty of not reading it all in the detail I should.

Strength in numbers

Indigenous ENT clinics

I would like to thoroughly support the discussions regarding Indigenous clinics and engaging the community service clinics to achieve this. The article by Dr K Kong (*Surgical News* Vol 13, No 4, May 2012) refers to public initiatives, but I feel it worthy to highlight the initiative we have, using a private service. Currently I offer free clinics to indigenous children, with Federal funding to support these clinics. As there is no ready access to public operating services, it was important to make sure that a timely process of seeing children AND fixing them was achievable.

A collaborative approach between myself, anaesthetists, Ramsay Private Hospital services, Attune Audiology, and the local Indigenous Health clinic means that we are able to access a private hospital facility, at no cost to the patients or their family. The success of this model means that children seen are having an operation within four weeks of their consultation.

Such innovative approaches are far more efficient than any public service we could otherwise nominate and significantly contribute to "closing the gap". Everything is done as a team effort with a single focus of seeing and fixing kids quickly, close to home, and in a culturally appropriate manner.

This initiative would not be anywhere near possible without the assistance of the local Indigenous Health clinic, which sends a representative to our rooms to help parents during the nominated clinic we run for these children. Not only do they help co-ordinate appointments, but provide transport where necessary and help with completion of necessary paperwork.

On the day of surgery, there is also someone present as moral support for the parents. A significant revelation for us with this clinic arrangement is the high rate of poor literacy amongst parents, so having someone familiar to the families present makes a big difference to the experience.

We are hoping that we can secure even more funding to expand this service, and any suggestions other Fellows have on such experiences would be warmly received.

Dr David McIntosh
ENT Specialists
www.entspecialists.com.au

A collaborative approach between myself, anaesthetists, Ramsay Private Hospital services, Attune Audiology, and the local Indigenous Health clinic means that we are able to access a private hospital facility, at no cost to the patients or their family.

Foundation for Surgery

Turning up the volume for Indigenous health

The Foundation for Surgery has funded research into Evidence Based Action Plans to address Indigenous health

Cover Story

The Foundation for Surgery is committed to addressing the health challenges and inequities in Australia's Indigenous communities. As part of this commitment, and through generous donations from Fellows, the Foundation funded research into the development of Indigenous health Evidence Based Action Plans (EBAPs)

The College's Indigenous Health Position Statement recognises that significant and urgent improvements need to be, and can be, made to Indigenous health and the provision of health care, and that improvements in Indigenous health in Australia and New Zealand will require collaborative, cross-disciplinary efforts.

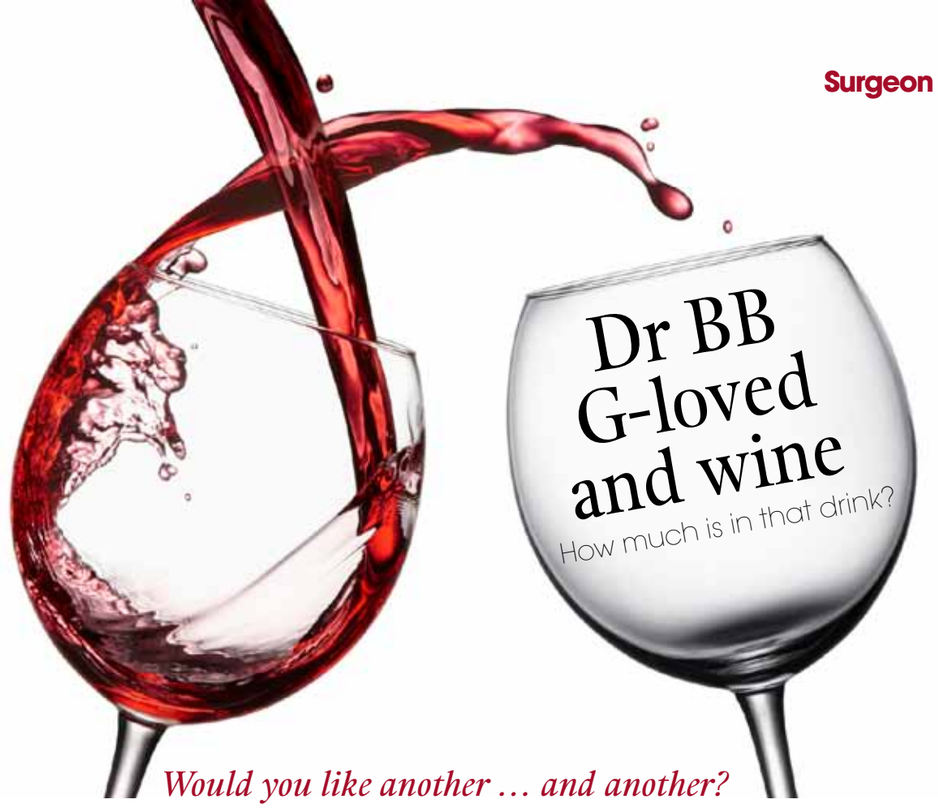
The EBAPs identify how improvements in the delivery of surgical services to Aboriginal and Torres Strait Islander peoples can contribute to better health outcomes in their communities. The EBAPs are action-orientated overviews developed to help solve identified problems and involve a review of existing research evidence in consultation with stakeholders. The research was led by Professor Russell Gruen at Monash University and Alfred Health and Associate Professor Kelvin Kong, Chair of the College Indigenous Health Committee, in collaboration with relevant research, clinical and policy experts around Australia.

Otitis Media among Aboriginal and Torres Strait Islander peoples is the subject of the first of a series of four articles on the EBAPs to be published in Surgical News. It focuses on the chronic level of ear disease in children, which may, if not treated, lead to loss of hearing, which will have profoundly adverse effects on social development, schooling, speech development and subsequent long-term employment prospects. If not addressed, ear disease is a debilitating burden for the patient, the health care provider and the wider community.

The topics of the three subsequent Evidence Based Action plans to be published in Surgical News are: renal transplantation, eye diseases and trauma.

Surgical News

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



Would you like another … and another?

The other day I was out at a University function for the Medical School. I had the opportunity to catch up with some of the surgeons over drinks and canapés. It proved a very pleasant evening. I had no idea of course that one of our company would be consulting me a few days later.

I make an effort when seeing colleagues to assess their good health (or lack of it) in the same way as I would for any patient. So when the surgeon appeared in the consultation room, I included the usual questions about lifestyle and habits.

"How much do you drink in a week", I asked softly. "Oh, about 3 units per week, I think," came the reply. This is always a good answer for applying for life insurance. It admits to drinking alcohol, but nothing excessive. I started to write this down verbatim when my mind flipped to our faculty gathering and I remembered the speed and the quantity of the alcohol consumption. The individual hadn't seemed to bat an eyelid. "How often would you have five or six drinks in an evening", I asked, as innocently as I could. "Perhaps once or twice a month," came a rather seemingly offhand, but maybe slightly nervous reply.

Now what do we doctors do when a normal patient gives us their alcohol history? Of course we either double or treble what they tell us. For a start no one ever pours themselves a unit, but always a drink that might be one and a half or two units. So I calculated about 7-10 units per week and added drinking 5 or 6 drinks once or twice a week. Am I unreasonable? I don't know, it's just my experience, but maybe only my experience of myself.

This was a male surgeon so 12 units plus another 7-10 made about 21 – almost within the safe 14-21 units per week. If these estimations are correct he is unlikely to become an alcoholic.

In Australia and New Zealand a standard drink is 10g or 12.7 ml alcohol. This equates to 30ml of spirits, a 330ml can of beer or 100ml glass of table wine. Now I don't know about your house, but in mine when a glass of wine is poured from the usual 700ml bottle we get about 4-5 glasses, so each of our drinks must be between 125 - 150mls or so [volume (litres) x % alcohol by volume (mL/100mL) x 0.789 = number of standard drinks].

But what about the surgeon and their spouse who share a bottle of wine every evening? They settle down in front of television with a nicely matured red, and 2-3 glasses each later they are off to bed. That's a good 4 units each per day, probably too much for the woman of the household were they to share equally. If they consume a bottle each at the weekend, there's another 8 units per bottle.

Alcohol is probably beneficial in small amounts following a J shaped curve of benefit and harm. The evidence is better for red wine than white, but I've always wondered if this is because some of the evidence is grown in France. Let's accept that it improves the circulation and enhances well-being in individuals not suffering from pancreatic or liver disease.

So how did I prod my surgeon patient to review and reflect on his alcohol consumption? Well, I checked his LFTs when I last did their annual review and the gamma GT was then just a little raised. I reminded him of this. I checked waistline, height and weight. He had gained a couple of kilos…

I discussed with him the calorific value of alcohol. He was a red wine drinker so that was about 100-150 kcals per glass. I put it to him that 300 kcals per day is 50 minutes cycling, 35 minutes jogging or swimming laps.

I reckon he's just safe, and probably pretty typical of many surgeons. But if two drinks become 3 or 4 they may not be metabolised when called in unexpectedly in the middle of the night for a private patient.

Finally, I suggested he not change anything, keep an alcohol diary for a month, measure the volume of his drinks, and report back on his actual intake.

And now that I have written my column, I really must pour myself a glass of red.

Dr BB G-loved

In Memoriam

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

Graham Smart,
NZ General surgeon

David Chamberlain,
Vic Orthopaedic surgeon

Daniel Crowley,
NZ O&G surgeon

Ian Backwell,
Vic Otolaryngology surgeon

Fergus Wilson,
Qld Orthopaedic surgeon

Bryan Yeo,
NSW General surgeon

Reynold Noronha,
NZ Urologist

James D.R. Elliott,
NZ Orthopaedic surgeon

John Horton,
NZ General surgeon

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

Informing the College

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

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

Making your audit easier

Enter your data through a secure online interface

I would like to thank you for your ongoing commitment to the mortality audit process. The Australian and New Zealand Audit of Surgical Mortality (ANZASM) program has been operational for more than 10 years beginning in Western Australia. It is now operating nationally, with all States and Territories contributing since 2010.

I would like to make you aware of the 'Fellows Interface', an extension to the existing in-house Web-based Mortality Audit IT system. Currently project staff enter audit information into the system to facilitate the assessment process. However, the Fellows Interface enables Fellows with the means to enter information directly into an electronic template of the Surgical Case Form, as well as for first-line assessments. This system has been configured for both PC and Mac users. Nationally more than 30 per cent of surgeons are using this interface as a means of submitting their forms.

The web-based Audit and Fellows Interface system ensure data security. All access to the system is controlled by username and password. Each user's access to data is limited to their own operational needs. All communication is encrypted using current industry security standards (HTTPS). All you will require is an internet connection and preferably Internet Explorer 7 or above, Safari 4 or Mozilla Fire fox 3.6. Directly entering data saves time; it can be completed at different times, thus progressively completing all of the case information.

The system has been in use for two years now and the feedback I have received during this time has been encouraging. This initiative provides users with a dynamic, user-friendly tool to enter Surgical Case Forms and complete First-line Assessments online. Completing audit forms has been made more convenient. The process is more streamlined with less paperwork.

I am hoping that more users will try the Fellows Interface system and feedback comment, both positive and negative. Staff are available to assist you. Please contact your regional Audit office for a user id and password.

Guy Maddern
Chair, ANZASM
Steering Committee

Poison'd Chalice

"My masters, are you mad?'

All my life, my name has been a source of amusement to others. You can imagine the sort of thing – "you have got to be kidding Kidding! Of course you are Kidding!" How very droll! And sometimes it remains unspoken but I can see it on their faces.

Take the other night for instance. It was just past midnight. My registrar and I had just completed our "date" with a trauma patient – a shattered body that needed to be resuscitated, brought together and repaired. "Did you know that Shakespeare wrote Twelfth Night (also called 'What you will') in 1601? – 410 years ago" I asked her. She looked up at me; the look on her face was pure "you have got to be kidding!" perhaps realising that though the operation was over, a night with little sleep lay ahead. She mumbled something along the lines of "how very interesting" clearly too tired to feign even a modicum of interest.

As I looked at her, I realised that my registrar had not regarded the past few hours as an educational opportunity or a learning experience but merely as an exercise in service provision. It was a look that was becoming all too common on the faces of surgeons throughout the hospital. Surgeons – are we becoming mere service providers, is the relentless weight of economic reality in our hospitals dampening the dynamics of education? Have we forgotten that hospitals not only care for the sick but are significant educational facilities for all.

I decided to try another tack.

Did you know that in Act II, Scene III, Malvolio makes some wonderful statements? "Have you no wit, manners, nor honesty?" And then he follows with that classic phrase of "Is there no respect of place, persons, nor time, in you?" I was becoming aware that my registrar had not been fully trained in the area of the classics. It was a shame. But then again, I form a minority of one as far as I can see in wanting this established as a criteria for selection into surgical training. They do not need to love the classics like I do, nor quote from them quite as liberally but sometimes there needs to be a moment to reflect on meaning, thoughts, aspirations above and beyond the immediate imperatives. Of course being able to recite all those cranial nerves that are listed in Last's Anatomy is helpful as well.

I took my leave of the night "warriors" in the operating theatre and began my drive home. Malvolio's statement about respect of place, persons and time reminded me of the Fellowship Pledge that moved me when I heard the new Fellows recite it at the Convocation. "I pledge to always act in the best interest of my patients, respecting their autonomy and rights." Maybe there is a touch of Shakespeare within the College.

As I climbed into bed I was greeted with a sleepy "Is that you?" I refrained from stating the obvious, wondering who else it might be climbing into her bed but remembering that I was fortunate to be sharing this time with a very much more attractive person than myself.

"The operation went well" I said. "That's nice" came the disorientated reply signalling the end of the conversation. As I closed my eyes waiting for the comforting blanket of sleep to engulf me, I reflected as to how I might use parts of the College pledge to prompt case study discussion within the Unit meeting tomorrow morning. The revolution.

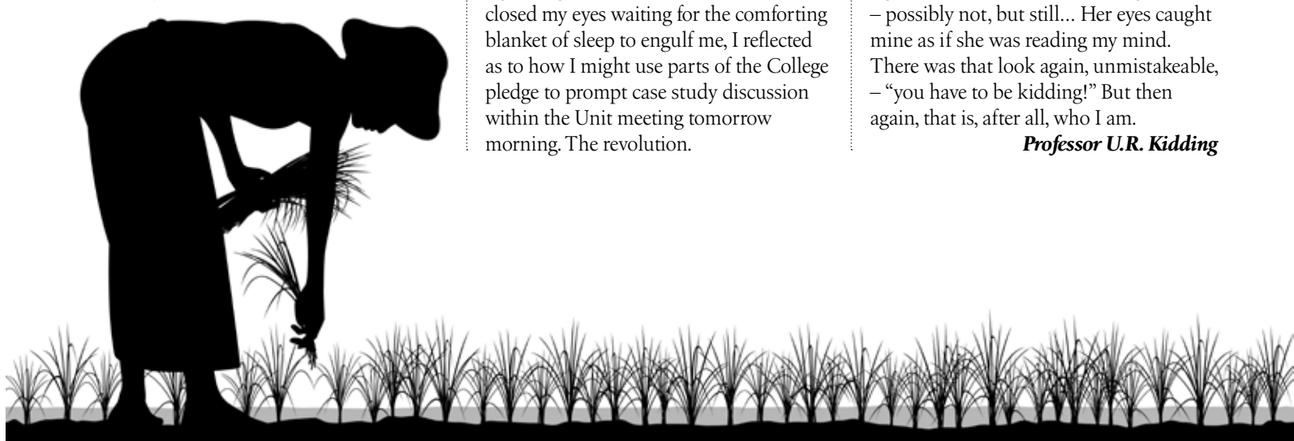
Morning arrived in a flash, but I felt strangely refreshed. In no time, I was back in the hospital, at the Unit M + M meeting. The case being discussed had been involved but it had ended badly. Refugee from a remote provincial town in a south east Asian country, dialect not well understood by our terribly understaffed interpreter department. Had been in the country only for a short period of time, an episode of hematemesis and melena. We had established positive serology that determined an isolation status, very few red blood cells that required active transfusion, bulging oesophageal varices that required active treatment. It had all happened so fast. Twelve hours ago he basically walked into the Emergency department. Family nowhere to be found, communication overwhelmed with issues of translation and his memories of a green rice paddy and picturesque mountains now replaced by last visions of the total sterility of the isolation room and his "carers" in bizarre outfits.

The registrar described it in detail and my heart rate became more than 'just a tachycardia' . She described the horror of haemorrhage unable to be stopped and varices beyond repair.

I remembered the words of the Fellowship Pledge - "accepting the responsibility and challenge of being a surgeon".

As I listened to my registrar expound on the treatment options for oesophageal varices I began to wonder about the patient – his interests, his autonomy, his rights. Could we have done things better – possibly not, but still... Her eyes caught mine as if she was reading my mind. There was that look again, unmistakeable, – "you have to be kidding!" But then again, that is, after all, who I am.

Professor U.R. Kidding



An International Success

Some highlights from an ASC enjoyed by all

This year's Annual Scientific Congress, the second to be held in Malaysia, proved a great success with approximately 2,300 delegates attending from the Asia Pacific region and the wider world not only to hear presentations on surgical and technical advances, but to contemplate this year's theme "The Making of a Surgeon."

As part of the theme, presentations were given on the impact of a surgeon's personal behaviour on team performance and surgical outcomes, how the military model of teamwork could act as a professional guide for surgeons and the growing availability of technology to allow for the telementoring of younger surgeons.

Scientific papers were also given in areas as diverse as breast reconstruction rates for mastectomy patients, the need for a public health campaign to prevent lawnmower injuries in children and developments in wrist surgery.

Professor Spencer Beasley, a paediatric surgeon at Christchurch Hospital told delegates there were four main determinants of surgical outcomes. These included clinical expertise, technical skills, non-technical competencies such as teamwork and, lastly, the effect of a surgeon's personality, mood and thoughts on their capacity to manage themselves and others.

"It is this last determinant, the intra-personal factors, which have been largely neglected and warrant further attention," Professor Beasley said.

"While training and experience are well known to affect clinical and operative decision-making, the influence of the surgeon's thoughts, mood and behaviour on the quality of clinical performance is only just being realised."

Professor Beasley's presentation considered the extent to which surgeons' own mindset affect the way they function clinically and also how their behaviour may affect those working with them while noting that it was crucial for surgeons to be able to recognise and prevent destructive behaviour in the workplace.

"A valid, evidence-based and practical model of identifying and understanding signs of distress in us and our colleagues, and of resolving conflict or poor performance, should be applied to our clinical work," he said.

Professor Jeffrey Rosenfeld, a distinguished Neurosurgeon at Melbourne's Alfred Hospital who holds the rank of Major-General in the Australian Defence Force, told the Congress that surgeons could improve their work practices by adopting some of the values of military teamwork.

He said that military surgeons must live and work as cooperative team members, rather than solely as team leaders.

"The officer commanding the surgical team may be non-medical because of their command experience and military qualifications," he said.

"It is the surgeon's responsibility to advise senior commanders and members of the immediate team when it comes to technical surgical issues. Each member of the surgical team has a defined role and range of responsibilities... and lessons learned by teams in the military setting can be applied to operating rooms and wards in civilian hospitals."

Dr Julie Miller, a Melbourne-based Endocrine Surgeon, told delegates how a new surgical technique to remove one or both adrenal glands had been safely learned and introduced through the use of telementoring.

She said that while posterior retroperitoneoscopic adrenalectomy (PRA) offered less pain and faster recovery than open or laparoscopic surgery, few centres in Australia had extensive experience of the procedure.

She said that while the ideal approach to achieving proficiency with any new surgical technique involved the on-site observation of an experienced surgeon-mentor, this was not always possible, but that advances in internet applications had now made remote telementoring a viable alternative.

Dr Miller told the Congress of how PRA was safely introduced to Melbourne via the use of a Skype video link to an overseas surgeon who had performed more than 200 PRA procedures.

"As far as we know, this is the world's first case of live telementoring of a new operation using widely available free software without expensive telecommunications equipment," she said.

"Remote telementoring is a safe and feasible way to assist surgeons in safely introducing new techniques."

Building connections

Held at the Kuala Lumpur Convention Centre in May, the 81st ASC of the College was also used to highlight the surgical links between Malaysia and Australasia.

Professor David David, a distinguished Adelaide-based Plastic and Reconstructive Surgeon, said in his presentation that the last time the College held its ASC in Kuala Lumpur in 1978, plans were made to support Malaysia's efforts to help the severely facially deformed.

He said those plans evolved into the establishment of the Australian Craniofacial Unit (ACFU), a co-operative venture between the Malaysian Ministry of Health and the Department of Health in South Australia, which provides Australian surgeons to teach in Malaysia as well as training opportunities in Australia.

Since then, six full-time Plastic and Reconstructive Surgeons had been trained in Australia while more than 277 complex patients have been managed by the ACFU with approximately 5000 patients treated in 10 Malaysian centres.

In New Zealand, however, a substantial proportion of the population was at risk of increasingly inadequate access to specialist plastic surgery services, according to Professor Swee Tan, a plastic surgeon from Hutt Hospital in Wellington.

Professor Tan presented research which concluded that the current New Zealand workforce of 53 plastic surgeons was both inadequate and mal-distributed.

"Proper workforce planning, as well as a new model for service delivery, is required to provide equitable access to sustainable and efficient services of quality," he told the ASC.

"Transition from a centralised hub, networked and integrated with new services closer to populations requires strong clinical leadership and political support and facilitation."

Dr April Wong, a Breast Fellow from Sydney, presented research showing that while breast reconstruction had been shown to be safe with a high patient satisfaction rate, fewer than 10 per cent of Australian women opt for reconstruction after a mastectomy.

Dr Wong based her findings on a review of the rate of reconstructive surgery done by Associate Professor Andrew Spillane and Dr Kylie Snook and concluded that the age of the patient and tumour size were the main factors affecting decisions on reconstruction.

"The two common reasons for no reconstruction were patient choice and the perception of a high risk tumour likely to require adjuvant therapy, which is often considered in combination with other patient factors," she said.

Dr Wong said clinicians should strive to offer women the option of reconstruction, discussing it with nearly all women undergoing mastectomy.

Melbourne-based hand surgeon Associate Professor Felix Behan presented a paper describing a new surgical procedure which can relieve arthritic pain in the carpometacarpal (CMC) joints.

He said a simple cartilage graft from the conchal fossa with overlying subcutaneous fat from the ear, a readily available harvest site, had been found to be suitable in overcoming such a difficult reconstructive problem.

"An analysis of a series of 20 cases – with arthritic changes of the CMC, confirmed by X-rays to support the clinical state – demonstrates the usefulness of this simple insertion cartilage graft as a 'washer' between the arthritic joint surfaces to relieve pain and optimise function," he said.

"It is simple to perform, results in an almost instantaneous pain-free state and significantly enhances quality of life."

In line with the College's long and proud tradition of public health advocacy, delegates this year were told that efforts to prevent lawnmower related injuries (LRI) in children should be redoubled.

Dr David Sharp, a Brisbane-based Surgical Trainee, recently conducted a study into the incidence and treatment of LRI based on a retrospective review of all LRI treated at the Mater Children's Hospital between 2006 and 2011.

He found that such injuries more commonly occurred in spring or summer and more severe injuries were seen in children from non-metropolitan areas with ride-on mowers.

"LRI in children can lead to significant physical and psychological morbidity," Dr Sharp said.

"Prevention is better than treatment, so there is a need for awareness of risk factors associated with LRI and there should be renewed emphasis on injury prevention campaigns."

With Karen Murphy


01


02


03


04

Day One


05


06


07


08


09

10

01: Bruce Barraclough and Leigh Delbridge **02:** Wendy Graham and John Crozier **03:** Mark Rice and Paul Myers
04: Marcus Stoodley and Marianne Vonau **05:** Syme Orator Datuk Paul Low Seng Kuan **06:** Richard Lander, Elizabeth Lander, Richard Perry and Julia Perry **07:** Ian Civil, Datuk Paul Low Seng Kuan, Denise Civil and Cheng Har Yip **08:** Warren Kuo, Ming Ng and baby Arabella **09:** John Quinn, Deborah Quinn, Thea Davies, Michael Grigg and Geoffrey Davies
10: Patricia Numann, Joseph Duignan, Eilis McGovern and Mark Edwards


01


02

Day Two


03

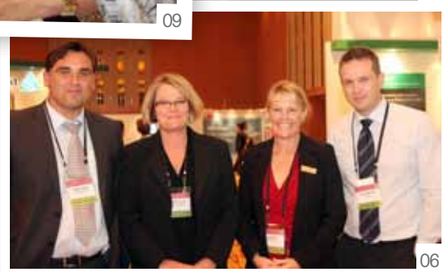

09


04


05

CULTURAL NIGHT

08


06


07

01: Susan Hansford Nigel Steven and Janet Hill **02:** Johnson and Johnson team **03:** Nihal D'Cruz and Cassandra Scrader
04: Rhona Flin **05:** Spencer Beasley **06:** Peter Van As, Tracy Ellis and Sue Booth and Aleks Mraovic
07: Henna art was available at the Cultural Night **08:** The view from the Convention Centre walkway
09: Forming pewter bowls courtesy of Royal Selangor's School of Hard Knocks

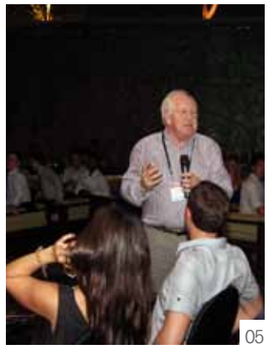
Day Three


01

02


03

04


05


06

01: Jeffrey Rosenfeld and Ian Civil
02: Mukesh Haikerwal **03:** Graham Mercer
04: John Windsor
05: Younger Fellows Dinner guest speaker Cliff Hughes
06: Younger Fellows Dinner Sally Ng and Seema Bagia

Day Four

01


02


03


04

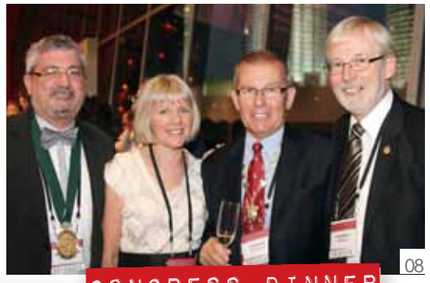
CONGRESS DINNER


05


06

01: Mike Hollands **02:** Phil Truskett **03:** Traditional dancers entertained at the dinner
04: Ian Gough, Ian Civil, Moira Truskett and Denise Civil **05:** David Hillis **06:** President's Lecture, Professor Chandra Muzaffar


07


08


09

CONGRESS DINNER


10


11

Day Four


12


13


14


15

07: Julie Miller, Bob Thomas, Gerard Doherty and Stephen Farrell **08:** Graham Mercer, Anthea Mercer, John Getty and John North **09:** Changeover of President's wife brooch, Denise Civil and Jane Young **10:** Deborah Quinn and Helen O'Connell **11:** Congress Dinner in full swing **12:** Changeover of President's badges **13:** Presentation of new President Ian Civil, Jane Hollands and Mike Hollands **14:** John North, Harriet North, Neil Wetzig and Gwen Wetzig **15:** Michael Cox, Murray Pfiefer and Cliff Pollard

01

02


03

PLENARY


06


04


05

01: Final Plenary panel, Thursday, Simon Paterson-Brown, Jeffrey Rosenfeld, Michael Grigg and Phil Truskett **02:** Mike Hollands chairing the final Plenary **03:** Question time at the Plenary **04:** Michael Grigg **05:** Phil Truskett **06:** Mike Hollands with Joseph W Y Lau

THANK-YOU TO ALL WHO ATTENDED THE 2012 ANNUAL SCIENTIFIC CONFERENCE IN MALAYSIA …
'TIL NEXT YEAR!

Research three ways

Dr Chiang has received a boost with the help of the College

Vascular surgery trainee Dr Nathaniel Chiang has spent the past four years investigating methods to improve wound healing through increasing the tissue oxygenation of surrounding tissue in vascular patients.

With support from both the College and New Zealand's Health Research Council, Dr Chiang has conducted his research through the University of Auckland and the Waikato Hospital.

He said his research had focused on peripheral vascular disease, particularly post-operative wounds and slow-healing ulcers and wounds in the lower limbs.

"The specific problem with ulcers and wounds that won't heal particularly in the feet is that blood and oxygen is not getting to where it is needed," he said.

"One of the ways to revascularise the limb is to conduct by-pass surgery, but up to 40 per cent of such patients can go on to develop further wound complications which in some cases can lead to amputation.

"I wanted to investigate different methods vascular surgeons could use to avoid that outcome wherever possible."

Dr Chiang received the College's Eric Bishop Scholarship in 2011 to allow him to complete a PhD involving three distinct research streams.

The first looked at the wound healing of patients given extra oxygen during bypass surgery, or extra extended warming before and after surgery via the use of the BairHugger® blanket, or with a prostaglandin drug, named iloprost®, which induces peripheral vasodilation, to determine if such methods could amplify the wound healing cascade.

As part of the randomised control study, Dr Chiang used hyperspectral technology to measure oxygen in the wound tissue with a machine called OxyVu®.

"It was a great privilege to be able to use this technology because the machine funded by the University of Auckland is the only one outside the US," he said.

"I also measured hydroxyproline, which is a biochemical surrogate marker to collagen production and therefore wound healing from 100 patients and am in the process of analysing that data.

"I also wanted to look at wound healing in foot wounds, for example after amputation of a digit or a forefoot to determine if topical negative pressure dressings such as VAC® made a significant impact on healing in comparison with sophisticated pharmacy dressings.

"To do this, I measured wound volume using both devices named FastScan® which is a laser that maps accurately the contour of wounds and the SilhouetteMobile®, which is a PDF hand-held device that also deduces wound dimensions. Both devices are manufactured in Christchurch by ARANZ®.

"As part of this research stream, I also collected the wound dressings to look at the composition of the fluid to measure the balance of cytokines and growth factor present. Some animal studies suggested that VAC® dressings alter this balance in such a way that favours wound healing. Saying that, my particular study found there was little difference between the two dressing treatments.

The third component of Dr Chiang's research involved analysing the effectiveness and accuracy of the various innovative devices used mentioned above.

Dr Chiang conducted his research under the supervision of Professor Jamie Sleigh, a Professor of Anaesthesia at the University of Auckland while his co-supervisors were Associate Professor Lindsay Plank at University of Auckland and Mr Thodur Vasudevan, a vascular surgeon at Waikato Hospital, senior lecturer of surgery at the University of Auckland and a board member in RACS Vascular surgery.

Now back in training at Middlemore Hospital in Auckland and continuing his PhD part time, he hopes to have his thesis completed by early next year.

Born in Hong Kong, Dr Chiang moved to the UK as a child, completed his medical degree at the University of Edinburgh and began his training in Leeds before moving to New Zealand six years ago.

Now married and expecting his second child, Dr Chiang said the support he had received from both the College and New Zealand's Health Research Council had been greatly appreciated.

"I could never have done this without such financial support," he said.

"I think it's of great importance to try and find new techniques that allow us as surgeons to limit the pain and suffering of patients.

With Karen Murphy

profile

RESEARCH HIGHLIGHTS

Scholarship: RACS Eric Bishop Scholarship 2011 – March, 2011

Fellowship: HRC Clinical Research Training Fellowship 2009 – November, 2008

Grant: PBRF Fund, School of Medicine, University of Auckland ($7,000), June, 2009

Grant: Waikato Medical Research Foundation Funds ($10,000), May, 2009

Grant: Faculty Research Grant by University of Auckland ($45,000), August, 2008

Best Presentation NZVS: New Plymouth, New Zealand. February, 2010

Best Poster NZAGS: Bay of Islands, New Zealand. April, 2008

Report from the ASC

Look forward to hearing more from the Women In Surgery section with a new strategic plan

The revitalised Section of Women In Surgery (WIS) is less than a year old, so it was with excitement that surgeons from multiple specialties met at the WIS Breakfast in Kuala Lumpur on Wednesday, May 9, to discuss Section directions and attend the excellent WIS program.

At the WIS Section business meeting, members discussed and approved the proposed five year WIS Strategic Plan. This document outlines the Section's vision for 2013-17. It encompasses the WIS Section Terms of Reference[1] and has six key focus areas of Leadership, Mentoring, Flexible Training, Recruitment, Retention and Advancement. It identifies specific target achievements in leadership, mentoring and flexible training for 2013-17.

The Section examined a comprehensive Discussion Paper on flexible training demographics, challenges and models. Members noted that while College policy supports flexible training, there are significant and multifactorial barriers to its practical implementation, which may explain why very few surgical Trainees undertake part time training despite a 2010 RACS Trainees Association (RACSTA) survey indicating that 33.8 per cent of Trainees are interested in undertaking a period of flexible training.[2]

The interest of multiple groups within the College in flexible training was acknowledged, including RACSTA and Academic Surgery, and synergistic relationships will be strengthened. The complex relationship of RACS as a provider of training, not employment, was also discussed as was the necessity for partnership with Trainees, supervising departments, hospital administrators, and jurisdictions to occur to develop flexible training positions.

The Discussion Paper was endorsed for publication to stimulate further discussion, with a view to the future formulation of strategic recommendations in this area.

We were honoured to be joined at the breakfast meeting by both Professor Cheng Har Yip, (President, College of Surgeons of Malaysia) and Professor Patricia Numann (President, American College of Surgeons) who both addressed the meeting.

Professor Yip spoke about the rise of the female surgeon in Malaysia and her experiences in surgery, commenting that when she commenced training her colleagues were unsure how to relate to her. She noted that child-raising is easier for Malaysian surgical Trainees who have an extended family network, and that working in public practice is less difficult than running a private practice when you are raising children.

Professor Numann (pictured above left), who established the Association of Women Surgeons in 1981, spoke about her personal and professional experiences as a woman in surgery. She noted that a few decades ago physical abuse was commonplace for women in surgery and advised us on the importance of examining hard data when assessing if surgical gender gaps were narrowing.

The diverse WIS conference program chaired by Dr Kylie Snook included presentations on the sustainable practice model of the Acute Surgical Unit (Dr Jodie Ellis-Clark), challenges facing women in surgery in the United States (Associate Professor Melina Kibbe, pictured above right), personal perspectives on choosing a surgical career (Dr Neil Berry), discrimination and bullying in surgery (Dr John Quinn) and a survey on workplace bullying in surgery (Mary Ling).

On behalf of the WIS Section I would like to thank Dr Cindy Mak for convening a superb program at the 2012 ASC and invite you to join us in Auckland at the 2013 ASC, where Mrs Eva Juhasz will be our WIS convener.

The WIS Section brings together surgeons from all disciplines and its current focus is on improving opportunities for leadership, mentoring and flexible training. The Executive Committee meets via teleconference four times a year in addition to activities at the ASC. If you would like to join or engage with the Section please contact the Executive Committee, the WIS Secretariat Monique Whear, or email sections@surgeons.org.

Jill Tomlinson,
Deputy Chair WIS Section Executive Committee

WIS Section Executive Committee (2011-14)

> Amal Abou-Hamden (SA)
> Ruth Bollard (VIC)
> Deborah Colville (VIC)
> Kate Drummond (Chair, VIC)
> Eva Juhasz (NZ, co-opted member, ASC 2013 convener)
> Cindy Mak (NSW, co-opted member, ASC 2012 convener)
> Christobel Saunders (WA)
> Simone Smith (NSW)
> Jill Tomlinson (Deputy Chair, VIC)

References
1. http://www.surgeons.org/media/381913/pol_2011-06-23_women_in_surgery_section_terms_of_reference_v3.pdf
2. McClelland B. Report Card on Surgical Education. Surgical News July 2010 Vol 11 No. 6 p.8.

On her bike

Sarah Coll talks about her passion for surgery and cycling, and making it work for her family

Orthopaedic surgeon Dr Sarah Coll crossed the continent from her home in Perth after completing her medical degree to do her specialist training in Queensland and found her perfect professional and personal locale in the beautiful tropical city of Cairns. She has since established a private practice called Advanced Injury Recovery (AIR) Medicine. Dr Coll now treats patients from across Far North Queensland, specialising in arthroscopic and minimally-invasive surgery to allow for rapid recovery. Last year she gave up her public work and now consults at the Cairns Private Hospital and Cairns Day Surgery and combines all this with the raising of two toddlers and a passion for cycling. Dr Coll talks to *Surgical News* about the pleasures and pressures of motherhood, her love of orthopaedic surgery and getting out on the bike.

Why did you choose orthopaedic surgery? I wanted to fix people and return them to their role in society whatever that role may be. I didn't enjoy being a doctor until I was an orthopaedic registrar.

Did you wait to start a family until you had received your Fellowship or did you combine motherhood with training? I did not meet a suitable life partner until I graduated from orthopaedic training. I couldn't find anyone who could keep up! I can't imagine combining training with child rearing and I don't know how other mothers do it. I found the constant waking of my second child incompatible with being on call. I did not feel safe making decisions during the night when I was so tired. I was able to function during the day and continued working part-time, but I was very drowsy at night.

How many children do you have and what are their names and ages?
I have two magnificent children: Amelie, three, and Alexander, 18 months.

What are the main challenges confronting mothers in the surgical profession? It's all about time, so getting a good nanny has been of huge importance to me. I have one who believes in my work and supports me 100 per cent in my career. I also have a second nanny who is able to come at 5.30am so I can ride my bike with my husband. He is also extremely supportive and enjoys seeing how much pleasure I get from my work.

What brought you to Cairns and what do you love about it? I came up to Far North Queensland after my intern year in search of adventure. Then I fell in love with orthopaedics and didn't get any further than Cairns. I love being in a regional area, both professionally and personally. I love the big blue sky, the beautiful mountains and love being able to practice the type of orthopaedics I most enjoy.

Is your brother also an orthopaedic surgeon and if so, who chose first?
Yes. My brother, Angus Keogh, is a hand surgeon in Perth who works at the St John of God Hospital in Subiaco. He is four years younger than me, but I'm not sure who chose first, we haven't discussed it. He was a medical student when I lived with him and I was a Trainee at that stage so he must have known about the hours I worked. I don't know if it inspired or deterred him!

What are your interests outside your professional and family life?
Bike, bike, bike. I am a fanatical cyclist and try and train five times a week. I was racing men's D Grade prior to my pregnancies, but not very successfully. I am going to ride part of the Cairns to Karumba ride in June with my family in tow. I consider my work my other favourite hobby and feel very privileged to be a surgeon. I struggle to take time off and get itchy fingers if I stop working for more than four weeks. I am also enjoying learning about running a business.

With Karen Murphy

Courtesy of Ray Sizer, Shepperton News

Illustrating a surgical journey

Bill Kelly couldn't help but record his surgical journey through the pencil

When artist Bill Kelly was convalescing after surgery in 2010 and in the quiet company of other creative friends the conversation turned, naturally enough, to the depiction of surgery in art.

Somewhat to the surprise of those talking and despite the collective knowledge represented in the discussion, only two major works could be immediately identified.

The first was the mighty Rembrandt work "The Anatomy Lesson of Dr Tulp" which, it must be said, is not exactly surgery given the state of the patient.

The second was the lesser known work called "The Gross Clinic" by 19th century American painter Thomas Eakins.

But now that dearth of surgical depictions has been rectified by Mr Kelly who has not only created a series of beautiful limited-edition prints of surgeons at work, but possibly the first and only images by an artist of their own surgery.

Mr Kelly is a highly awarded and celebrated artist with more than 20 solo shows to his name. Formerly the Dean of the School of Art at the Victorian College of the Arts, his works have been acquired by the National Gallery of Australia, the Heide Museum of Modern Art and the Tarra Warra Museum of Art.

With much of his work focused upon his passionate interest in human rights and the dignity of the human spirit, he is particularly regarded for his large-scale public drawings which have been displayed both in Australia and abroad including in New York, Guernica and Durban.

Now living in country Victoria, Mr Kelly said he began working on the surgical series after being urgently sent to the Goulburn Valley Hospital in Shepparton to receive emergency blood transfusions.

"I had an initial blood test which was the start of the journey and two days later I had a colonoscopy which showed I had bowel cancer that required immediate surgery," he said.

"When we first heard that, friends and family suggested I go to Melbourne for it, but my wife and I thought that there are good people everywhere so we made a pro-active decision in support of rural health.

"One week later I was in theatre under the care of Michael Kamenjarin and the surgery was immensely successful with pathologists later giving me the all clear and with no need for chemotherapy or radiotherapy.

"I have had more than 12 months of clear blood tests, feel immensely fortunate and now my wife Veronica jumps on and hugs Dr Kamenjarin every time she sees him."

With the series of prints titled "The Journey", Mr Kelly began sketching as soon as he entered the hospital, depicting every stage of his treatment from the cannula in his arm providing the lifesaving blood, to standing on the scales prior to surgery, to the surgeon's hands and the dimly lit faces of those working to save him in theatre.

"I draw all the time and when I admitted myself to the Emergency Department I found a pen in my pocket and started drawing during the blood transfusions with my free arm," Mr Kelly said.

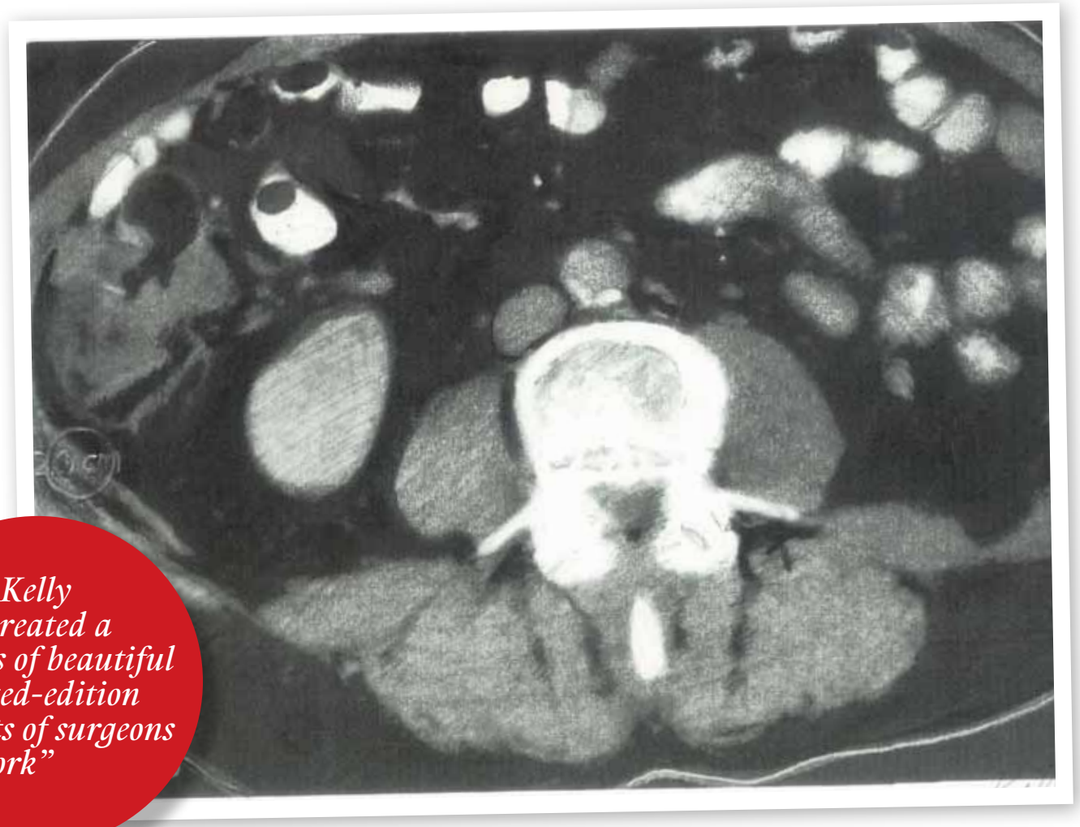
"I didn't know I had cancer then, but when they told me I just thought it provided an amazing opportunity to look at this journey – an experience that thousands of people go through every year – as an artist."

To facilitate the project, Mr Kelly approached hospital management for support who provided him with a liaison officer to guide him through privacy and freedom of information issues while co-ordinating the interaction between the artist and nurses, surgeons, pathologist and oncologists while his wife Veronica brought in his art supplies and a camera.

"The cooperation and support I was given was incredible," he said.

"The hospital personnel were so generous with their time, explaining scans to me, for example, describing to me exactly what I was looking at, while the liaison officer Jan Phillips took photos for me in theatre given I was not really in a position to do it myself!

"I wanted to show the beauty of the process, the grace and dignity of the care given and the skills and dedication of the care givers and also to ▶



"Mr Kelly has created a series of beautiful limited-edition prints of surgeons at work"

explore the journey back to health even though I didn't know whether I would get there."

During the weeks he spent in hospital, Mr Kelly compiled a thick file of drawings and sketches and more than 80 photographs of hospital staff caring for him and other patients.

When he returned home, Veronica set up his bedroom as a studio with his equipment in easy reach.

"My work was not a therapeutic response to the disease or treatment – it's what I do all the time," he said.

"I knew the experience would take me places I had never been before while giving me the chance to artistically represent the great skills and concentration of the people working to keep others alive.

"In my life as a humanist artist I have dealt with many confronting issues and places like war zones and scenes of tragedy so this wasn't confronting to me.

"The most interesting time was after the operation waiting for the pathologist's report when time seemed to stretch somewhat, but even then it was more my concern for my family, who felt so powerless, than it was for me.

"And that was another aspect of the experience that I very much wanted to capture – the kindness and compassion shown by such skilled people toward my family, keeping them informed, helping them as they were helping me.

"An experience like mine, where you're being cared for by people whose sensitivity and compassion are so great they feel they are one with you and your family, offers tremendous scope for healing and we are very lucky in Australia to have access to such amazing care."

The series of works produced by Mr Kelly from his initial diagnosis to recovery are both intimate and striking and include 20 smaller limited edition prints along with two larger pieces titled "Self-portrait: Between Darkness and Light" and "Self-portrait on a Mystical Journey".

He said that while the images are of modern surgery and depict modern technology and real people, he also called on the past for inspiration.

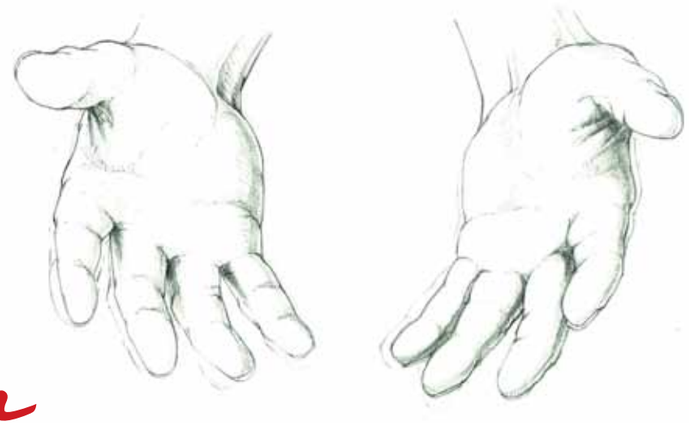
"With the large piece, the 'Self-portrait on a Mystical Journey', I was thinking of the Rembrandt painting when working on it because of the wonderful drama of the light within the darkness and the intense concentration on the faces of those depicted," he said.

Bill Kelly's works will be on display at the College in Melbourne from 12 June to 3 July. The limited edition prints are available for sale with smaller works priced at $900 and larger works at $1500.

And now that he is fully recovered, his hectic life begins again.

Later this year, another series of his works, titled "The Heart of the Matter", will go on exhibition at the MARS Gallery in Bay Street, Port Melbourne, from June 7 while later still, Mr Kelly will participate in a drawing group exhibition at the London College of the Arts followed by another group exhibition at the New York Studio School.

With Karen Murphy



From the *surgeon*

Rural Surgeon Mr Michael Kamenjarin, who operated on Mr Kelly in 2010, tells *Surgical News* of his experience of the artist project.

What did Mr Kelly's surgery involve?

Bill was investigated for anaemia and underwent colonoscopy by Dr Nana, a physician at the Goulburn Valley Hospital, in late July, 2010. Dr Nana diagnosed his caecal cancer and he was subsequently referred to me. I performed a right hemicolectomy on Bill in August, 2010. The operation took two hours and was uneventful.

How did you feel to be part of Mr Kelly's art world?

It was an interesting and different experience being involved in such an art project. During the procedure and in the post-operative phase, multiple photographs were taken by the hospital liaison officer and post-operatively by Bill himself.

In my opinion, surgery is quite a private matter between the surgical team and the patient with the surgeon carrying the primary responsibility for the patient's well being.

So whilst the process caused me some psychological discomfort, it did not compromise the technical aspects of his care. If I was asked if I would be involved in a similar future experience, my response would be that someone else should share the limelight!

Have you seen his works and if so what do you think of them?

Yes I have. Bill has captured his journey of undergoing bowel cancer surgery with amazing clarity. He is an impressive artist.

Your new College website

Personalised, accessible and networked – the new College website offers a fresh design and impressive new interactive capabilities

Since 20 February you will have noticed the College website has a fresh new look. The College consulted extensively with Fellows, Trainees and IMGs, and we understood that you wanted a website that was more personalised, accessible and networked.

A personalised website means one where information is tailored to you. This includes a revamped My Page which is tailored for each user type and presents information according to your profile. It also means that you can personalise your website experience further by accessing your settings which are explained below.

An accessible site means one where information is able to be accessed by a wide range of user types on different platforms. The new website has been optimised for iPads, so it displays well on these tablet computers. Additionally, accessibility means that you are able to access all College applications and resources from one convenient place – the My Page.

A networked site means one where you are able to contact fellow surgeons and interact with them online through discussion groups, blogs, messaging and networking. Much like LinkedIn or Facebook, you are able to set up your own Network Profile including information about your specialty and area of practice, as well as where you have worked or currently work and your list of publications. Once you've set this up, you are able to connect with surgeons and start networking immediately.

The most popular content, such as the Online Library and access to the most relevant surgical journals and e-books, remains on the site. We have also worked to deliver more functionality which takes advantage of the latest website and communications technology as requested by members. Overall, the website has a definite web 2.0 feel, meaning that you can not only receive, but engage with information received from the College, as well as access a host of applications including online learning and the CPD Online Diary.

We would like to explain the features to help you to get the most out of your new website. Before you start, please consult the Web Setup Checklist to get the basics right and make sure that you are ready to log in and get the most from your new website.

WEB SETUP CHECKLIST

Take these steps to get the most out of the new website.

- ✔ **1. Establish** your user name and password – contact the IT Help Desk on +61 9276 7417 (Help.Desk@surgeons.org) if you don't have one or have forgotten your password.
- ✔ **2. Log** in to the site from the homepage.
- ✔ **3. Once in,** spend a moment setting up your Network Profile to begin collaborating online.
- ✔ **4. Check** your Communications Preferences. You will need to set these to see something in the News Feed.
- ✔ **5. Access** Discussion Groups and Topics and start a group of interest to you.

Personalising your web experience

Settings *(situated at the very top left of the My Page)*
The website can be personalised to your needs. This means, for example, that if you are a Fellow practising Cardiothoracic Surgery and you are based in New Zealand, you are able to establish your settings so that you receive information in the News Feed relevant to Cardiothoracic Surgery and New Zealand as it becomes available. The My Network Profile is where Fellows, Trainees and IMGs are able to set up a profile which they will share and enter information such as employment and education details with which they will interact with other surgeons in the Surgeons' Network. Other settings inform what information about you is displayed in your Network Profile and published to your contacts' News Feed.

Quick Links
(last item in the left hand menu)
The Quick Links (like favourites or bookmarks in your browser) appear on the bottom left hand side of the page when you are logged in. If you find a page that you want to get to quickly from your My Page, you can add it as a Quick Link. One suggestion is to provide direct access to the library page of your specialty from the My Page by adding it as a Quick Link

Staying in touch with the College

News Feed
(centre of the My Page)
The News Feed appears in the central part of the My Page when you log in. The News Feed contains items that appear when they are published and that you have registered for according to your communications settings. Here you will also receive some important messages from the College as well as notifications about your contacts such as which events they are attending and when they post to discussion forums.

Collaborating and networking with your peers

My Network *(left hand side)*
The My Network is a way to keep in contact with other Fellows, Trainees and IMGs of the College and has similarities to LinkedIn or Facebook. The first step is to set up your network profile so that others can access your profile. You can show some or all information about you. Once you have done this, you can then search for contacts to connect and share with.

Blogs and Discussion Groups
(within RACS Knowledge)
Access blogs and discussion groups to contribute to or set up a discussion group or topic. Discuss topics of interest – training programs, surgical resources, public health, policy, international development – it's up to you! There are currently a number of blogs, but we are looking for more – if you are interested in blogging please contact the Web Administrator at college.webadmin@surgeons.org.

WHAT YOU HAD TO SAY ABOUT THE NEW WEBSITE

"The new website is aesthetically pleasing and easy to navigate." – Fellow, NSW

"A useful feature is the "My Page", with relevant training material." – Trainee, New Zealand

"The website is more organised and it is easier to find what you are looking for." – Fellow, Victoria

"The new website is quite easy to navigate around and more personalised to the individual, which is great." – Fellow, Queensland

How to get more information

Go to the video user guides that show you how to access and make the most of the features. Most user guides are less than one minute, and there is a wide range available, including:

- The My Page
- Privacy settings & communications preferences
- Setting up your Network Profile
- Join a discussion group
- Create a discussion group & access blogs
- Change your password

Learning and researching the latest surgical knowledge

RACS Knowledge
(middle left of My Page)
RACS Knowledge brings together the world's best and most current surgical knowledge. Central to this is the library which continues to increase its holdings of online content, including a vast array of online journals from all specialties.

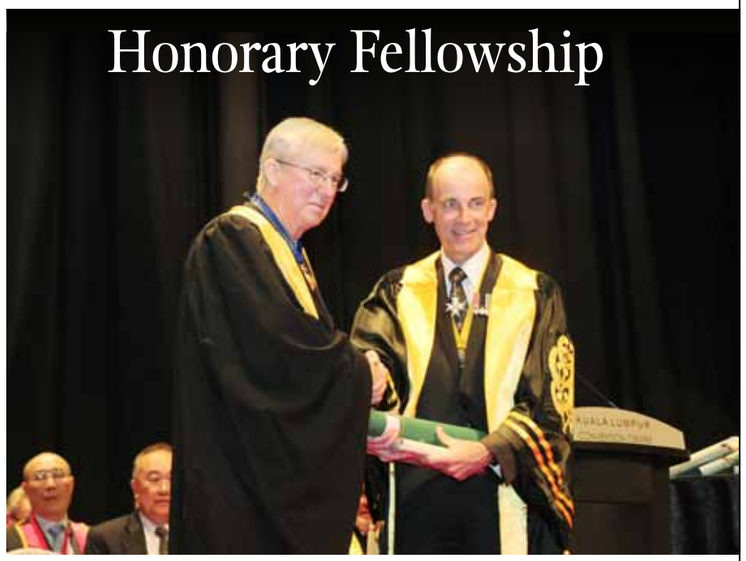
ELearning
The College has placed a major emphasis on making the latest eLearning resources available to Fellows, Trainees and IMGs. After logging in to the College website, users arrive at the My Page. Within RACS Knowledge on the left hand side, click on courses and workshops to browse the various courses and workshops offered by the College.

Contact the College

We value your feedback. If you experience any technical difficulties, please contact the IT Help Desk on +61 9276 7417 (Help.Desk@surgeons.org). If you have general comments about the website or would like further information on any of the new features mentioned in this article please contact the Website Administrator on the details below.
T: +61 3 9249 1284
E: College.webadmin@surgeons.org
W: www.surgeons.org/website

Cathy Ferguson
Chair, Fellowship Services Committee

Honorary Fellowship



The Hon Geoffrey Davies AO

The Honourable Geoffrey Davies AO was the first External Community Advisor appointed to College Council. In that position, Geoffrey not only established the role and set the standard, but gave to the College an immensely important view of itself from an external and highly knowledgeable perspective. Geoffrey's opinions have been pivotal to Council's decision-making on many occasions and the College has benefited greatly from his wisdom, and advice.

Geoffrey was born (and grew up) in Brisbane and apart from his academic success, excelled in rugby and athletics. He studied law at the University of Queensland and was admitted to the Bar in 1962. Geoffrey took silk in 1976 with areas of interest in commercial, revenue and later, constitutional law.

From 1989 he was the Solicitor-General for the State of Queensland, the first member of the private Bar to hold that position.

He was appointed to the Bench of the newly established Court of Appeal of Queensland in December 1991. At the same time he was appointed to, and then chaired, the Litigation Reform Commission. Its purpose was to reform the civil justice system and it remains an area of great interest for Geoffrey. During his tenure he spent time at the Max Planck Institute for Comparative Law where he studied, wrote and lectured on comparisons between German and common law systems, and as an Inns of Court Fellow at Lincoln's Inn where he lectured at the Institute of Advanced Legal Studies.

Geoffrey retired from the Court of Appeal in 2005 and in that year was appointed as Commissioner of the Queensland Public Hospitals Commission of Inquiry, the results of which were far reaching and relevant to the practice of medicine in Australia and NZ.

He has many interests to occupy his time and these include his family, painting, sport and an appreciation of fine wine.

Although technically retired, Geoffrey continues to serve the wider community in many ways. He serves on the Court of Appeal of Brunei Darussalam, as Adjunct Professor in the School of Law at the University of Queensland, as Chairman of Queensland Advocacy Inc and, of course, until recently on the Council of the College.

The Honourable Geoffrey Davies AO is very well qualified to join a very small cohort of non-surgical individuals who hold Honorary Fellowships of the Royal Australasian College of Surgeons.

THE GARNETT PASSE AND RODNEY WILLIAMS MEMORIAL FOUNDATION

awards commencing in 2013

PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2013.

Project Grants are for a period of up to three years and must be conducted in an Australian or New Zealand institution. Please note that a current awardee, whose fellowship, scholarship or grant is due to conclude after 30 June 2013, is ineligible.

The annual level of support will be up to AUD100,000 and, within this cap, grants must include the salary of the applicant and/or research assistant(s), on-costs, equipment, maintenance and all other costs. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 31 August 2012

GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2013.

Grants-In-Aid are for a period of up to two years and must be conducted in an Australian or New Zealand institution. Otolaryngologists or Trainees in the Specialty are eligible to apply. Please note that a current awardee, whose fellowship, scholarship or grant is due to conclude after 30 June 2013, is ineligible.

The annual level of support will be up to AUD50,000 and grants are restricted to equipment and maintenance only. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 31 August 2012

Further details concerning the above awards together with the current application forms can be obtained from:-

The Executive Officer
The Garnett Passe and Rodney Williams Memorial Foundation
PO Box 577
EAST MELBOURNE VIC 8002
P +613 9419 0280 | **F** +613 9419 0282
E gprwmf@bigpond.net.au

Thanks from Solomon Islands

A visiting surgeon from the Solomon Islands has thanked Australian surgeons and hospitals for their training assistance

With a 41 per cent increase in urology admissions to the National Referral Hospital (NRH) in Honiara since 2004 and with life expectancy now slowly rising, general surgeon Dr Dudley Ba'erodo saw the need for greater urology services in the Solomon Islands and has now attained many of the skills to meet that need.

One of only three general surgeons in the country, Dr Ba'erodo first began developing his interest in urology by working along-side visiting specialists since 2002 before being offered a Rowan Nicks Scholarship to undertake a urology attachment at Tweed Hospital in 2007.

Now in the last month of another Rowan Nicks Scholarship visit, Dr Ba'erodo has spent the past year at the Austin and Repatriation Hospitals in Melbourne learning more advanced urology surgery to enable him to treat more complex cases.

Dr Ba'erodo, the Head of Surgery at the NRH, said the greatest benefit of his latest trip to Australia had been the opportunity to learn minimally-invasive surgical techniques including the use of laser technology.

He listed his training objectives as learning the use of rigid and flexible endoscopic urology procedures, the treatment for benign prostatic hyperplasia by Transurethral Resection of Prostate (TURP), mastering the endoscopic treatment for bladder tumours and establishing a network of professional colleagues.

Dr Dudley Ba'erodo and Dr Alex Cato

All, he said, had now been met.

"The urology department at the Austin Hospital is one of the biggest in Australia in terms of the service provided while the Repatriation Hospital does all the endoscopic day surgery procedures so it has been a great privilege to be able to work and learn here," he said.

"At home we are more used to open surgery so I have greatly enjoyed the opportunity to broaden my skills in this area.

"While I learnt how to use a pneumatic lithoclast to break up ureteric stones in Tweed Heads, at the Repat Hospital I learned how to use the Homium laser to treat stones.

"Yet the most exciting procedure I have learnt was the use of Greenlight Laser to vaporise the prostate which is a skill that I now have in addition to the traditional TURP.

"Also on a few occasions I attended the Austin Hospital to watch laparoscopic nephrectomy and radical prostatectomy."

Upon his imminent return to the Solomon Islands, Dr Ba'erodo said he planned to establish a dedicated urology service in Honiara to provide minimally-invasive surgery, reconstructive surgery and cancer screening and management services.

He said the major obstacle remained the provision of equipment and consumables and the skills within the hospital to maintain the technology.

"After a long campaign I have convinced the government to buy some equipment to allow us to undertake more minimally-invasive surgery because it lessens the burden on the health budget by allowing for faster healing," he said.

"I have ordered a resectoscope and both a rigid and flexible cystoscope while a colonoscope has recently been donated to the NRH by a US non-profit organisation and my colleagues and I are now also in the process of pushing the Government to buy laparoscopic equipment."

Dr Ba'erodo said that despite such continuing challenges facing surgery in the Solomon Islands, progress was being made in both the number of surgeons working in the country and the range of skills available.

He said that two general surgeons were expected to finish their training at the University of Papua New Guinea later this year before returning home, another doctor was now completing a Masters of Surgery in ENT who will become the country's first ENT specialist.

They will then add to the local surgical workforce which now comprises the three general surgeons, one orthopaedic surgeon, one ophthalmologist and three obstetricians/gynaecologists.

Dr Ba'erodo said an active campaign was also now underway to encourage more young doctors to complete a Masters of Medicine in Surgery at the University of Papua New Guinea or the National Fiji University.

He said that despite such additions to the workforce, however, specialist team visits from Australasian surgeons would still be required.

"We still don't have the capacity to cover all the specialties in the Solomon Islands and I can't really see us being in such a position for ten years," he said.

"But simply covering the workload is not the only advantage of such team visits for they also mean that we can select the most complex cases for treatment by surgeons from Australia and New Zealand and learn and improve our skills by assisting."

Dr Ba'erodo gave a presentation during the conclave at the recent ASC held in Kuala Lumpur, Malaysia, and used the occasion to thank the late Mr Rowan Nicks for his legacy and generosity in providing the means to allow surgeons to acquire the skills needed to develop their own surgical services.

"This indeed is a very noble act from a very noble man," he said.

He also thanked his mentors Associate Professor Hamish Ewing, Mr Alex Cato and Professor Don Moss along with College staff for their help in organising his visit and establishing his temporary domestic life in Melbourne.

"I would also like to sincerely thank my supervisor Associate Professor Damien Bolton and the Urology Department at the Austin and Repat Hospital," he said.

"In particular, I would like to thank the following Urologists: Dr Greg Jack, Mr Steven Clarke, Associate Professor Nathan Lawrentschuk, Mr Peter Liodakis and Dr David Sillar, my supervisor at the Tweed Hospital.

"They have been patient with me and took on the task of teaching and training me the procedures I needed to learn for which I am most grateful."

With Karen Murphy

Case Note Review

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

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

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

I trust you find this case note review booklet an educational opportunity and welcome any constructive feedback.

Clinical deterioration post-colectomy idicates intra-abdominal sepsis until proven otherwise

Case summary:

An elderly patient presented with a six-month history of pneumaturia and recurrent urinary tract infections. A CT scan had shown a diverticular phlegmon with gas in the bladder, suggestive of a colovesical fistula. A laparoscopically-assisted resection of the colovesical fistula was performed. Intraoperatively it was not possible to dissect the inflammatory mass from the bladder and, quite appropriately, the procedure was converted via a Pfannensteil incision to an open procedure. An anterior resection was performed with a stapled colorectal anastomosis. Both an air and Betadine leak test were performed and were negative.

The initial postoperative course was unremarkable. Several days later, the patient began to deteriorate with increasing respiratory distress, falling saturations and increasing oxygen requirements and by the fourth postoperative day it was clear that there was a serious problem. The patient was tachycardic and hypotensive with a distended abdomen. The patient's white cell count at that stage was around 3.96. The surgical note indicates that a CT pulmonary angiogram and CT abdomen were requested to "rule out PE or anastomotic leak", but despite a note from the ICU resident that a radiographer was to be called in for this, the CT scan was still not performed. Thereafter the patient's condition deteriorated over the course of the day. The patient exhibited increasing inotrope and oxygen requirements and required intubation. It was agreed that the patient should be returned to theatre, but before this could occur, the patient arrested and succumbed.

Assessor's comments:

It seems quite clear that there was a major intra-abdominal catastrophe developing over the 24 hours or so prior to the patient's demise. It is likely that this represents an anastomotic leak, although this cannot be stated with absolute certainty without knowing the results of the Coroner's autopsy. However, the rapidity of clinical deterioration would support this assessment.

I think there are several specific questions that merit addressing:

1. Was an anastomotic leak preventable? Review of the operation notes suggests that the splenic flexure was mobilised and that appropriate air tests were performed. All reasonable steps seem to have been taken to ensure an appropriately constructed anastomosis.
2. Where there any perioperative factors which may have contributed to an anastomotic leak? The short answer is 'no'. The patient's fluid balance seemed appropriate and there was no intra-operative hypotension. The patient was on suitable antibiotics.
3. Was there timely intervention? I think the crux of the issue lies here. It is well recognised that intra-abdominal sepsis may initially present with respiratory distress, and whilst the surgical team raised the possibility that this was the case, and although it did not appear to be have been either appropriate or urgent, review of the patient and clinical situation only occurred after the morning ward round on the day of death. I note that the responsible surgeon comments in the surgical case form that the Registrars were dealing with other emergencies, but the severity of deterioration both overnight and later in the day should have led to greater priority being placed on more timely management.

I would agree with the treating surgeon's comments that this patient's deterioration was rapid and that the only window for intervention was on the morning of death. It is likely that patient was entering a downward spiral thereafter and that intervention was unlikely to be successful unless it was undertaken in a more timely fashion.

Clinical Director's comments:

The Coroner's Office was extremely helpful to the project office and supplied critical information in cases such as this one. An autopsy was performed and showed that there was not an anastomotic leak, but there was an area of ruptured diverticulitis above the anastomosis with faecal peritonitis. The assessor was right in the diagnosis of peritonitis from a leaking colon, but for the wrong reason!

Guy Maddern
Chair, ANZASM


R. Gruen and C. Baggoley at TQI workshop

"More than 60 people registered for the dynamic hands-on workshop with most trauma centres being represented from around Australia and New Zealand"


N.Farrow at TQI 2011 workshop


Meng Tuck Mok at TQI workshop

Partners in Trauma

The Trauma Committee and the Australian Trauma Quality Improvement Program delivered an informative workshop in November 2011

The College Trauma Committee hosted the 2011 November Trauma Week workshop on Trauma Quality Improvement partnering with the Australian Trauma Quality Improvement Program (AusTQIP). This provided a unique opportunity to collaborate nationally, share expertise, combine data and work together to improve the care of the injured and the performance of trauma systems.

We thank Professor Russell Gruen, Chair, Trauma Quality Improvement Sub-Committee, for his leadership and superb organisation as convener of the workshop. He was ably aided by Nathan Farrow, AusTQIP Manager and Meng Tuck Mok, Australian Trauma Registry Manager. The workshop was a dynamic hands-on practical workshop exploring and comparing registries from around Australia and New Zealand.

More than 60 people registered for the dynamic hands-on workshop with most trauma centres being represented from around Australia and New Zealand.

Highlights of the workshop included:

- An opening keynote address by Prof Chris Baggoley, Chief Medical Officer, Australian Government Department of Health and Ageing, on the importance of quality improvement in health care and the value of effective measurement in the Australian context.
- Presentation on quality indicators by Dr Tom Stelfox, an international expert from Calgary, Canada
- A presentation on the American Trauma Quality Improvement Program by Ms Melanie Neal, Manager of the American College of Surgeon's National Trauma Data Bank
- A road map of current trauma quality systems and data capabilities in Australia by Mr Nathan Farrow, the AusTQIP Program Manager and Dr Meng Tuck Mok, the Australian Trauma Registry Manager.
- A discussion forum that identified the top 10 trauma quality issues in Australia. 'RACS TQI Workshop Discussion Forum 1 – Identifying priorities for trauma quality improvement efforts in Australia' web link: http://www.ntri.org.au/images/stories/austqip/RACS-TQI-Workshop-Discussion-forum-1-outcomes.pdf
- A second discussion forum that asked participants to propose the top five trauma clinical indicators. 'RACS TQI Workshop Discussion Forum 2 – Measuring trauma care saves lives too – trauma clinical indicators and comparing trauma data in Australia' web link: http://www.ntri.org.au/images/stories/austqip/RACS-TQI-Workshop-Discussion-forum-2-outcomes.pdf

The AUSTQIP goal to give every injured patient in Australia the best chance of survival, good recovery and quality of life is being actively pursued. The workshop was a great way to see collaboration of stakeholders. Other goals include achieving world's best practice and harnessing the knowledge and expertise of the many dedicated clinicians, managers, policy makers and researchers who contribute so much to trauma care in Australia every day. We are hoping that this successful TQI workshop can be held on a regular, even annual, basis as we all, in our professional lives, strive to achieve continuous improvement.

Daryl Wall
Chair, Trauma Committee

Telemedicine – Legal issues

Know the issues surrounding treating patients from telemedicine

Absent are the days where a doctor needs to be in the same room as the patient to provide a medical consultation. Telemedicine, or technology-based patient consultations, utilises the advancements in videoconferencing and the Internet to aid in the delivery of medical services, when the doctor is not able to be in the same room as the patient.

One of the main benefits from telemedicine is the greater access to healthcare outcomes and consultations for those who are unable to physically see their doctor or those in remote communities. Further benefits include ease of access to subspecialty advice and second opinions, and to provide locum services.

Although the benefits of telemedicine can be seen by all, doctors need to be aware of potential legal issues that may apply with such consultations, and make any appropriate changes to their practice to effectively provide safe, legal consultations.

Duty of care, and inherent medical negligence issues, are present in everyday practice and this does not change if the consultation is via telemedicine or face to face. One use of telemedicine is for a general practitioner (GP) to undertake specialist procedures at the direction of a specialist via a telemedicine consultation.

It is arguable that, at law and under some legislative obligations, the GP may be judged by a similar standard of care to that of the supervising specialist.1 It is likely that in any telemedicine consultation, both the local GP (with the patient) and remote practitioner (such as a specialist) may be liable, as they both owe a duty of care to the patient. It is important in this regard that both the GP and the specialist inform the patient of all the risks associated with the procedure and who will be performing the actual procedure.

Telemedicine won't just change the relationship between health practitioners and their patients; it will also change the relationships between those practitioners providing the consultation. It is important that participating practitioners communicate with each other and consider the various issues surrounding responsibility and liability for the patient. If there are any reservations about treatment, both practitioners need to be upfront with each other.

Location no longer

With national registration of medical practitioners, the location of the treatments and possible insurance issues should not be as much of a concern as previously. Health practitioners are still advised to check with their insurer as to potential liabilities for telemedicine consultations and the best ways to safeguard their practice.

The Medical Board of Australia has recently released "Good Medical Practice"2 guidelines surrounding telemedicine consultations. Such guidelines highlight the importance of practitioners to have an open communication line with their patients, and to make judgment calls if telemedicine is suitable for this patient.

As with any procedure, responsibility continues for verbal discharge and after-care arrangements. Patients should be informed of these issues whether treatment is via telemedicine or otherwise. After-care may be more difficult, and therefore the responsibility of the doctor greater, for a remote patient.

Some telemedicine involves review of records, scans, xrays and reports via technology – without access to the original record. This has some risk if the technology does not reproduce the records to an acceptable level of quality. This should be considered.

Some patients will not be appropriate for diagnosis and treatment by "telemedicine". It will be a judgment call for the doctor. In those cases, the doctor will need to make it clear that the patient will need to actually see the doctor "physically" – and if necessary, with urgency.

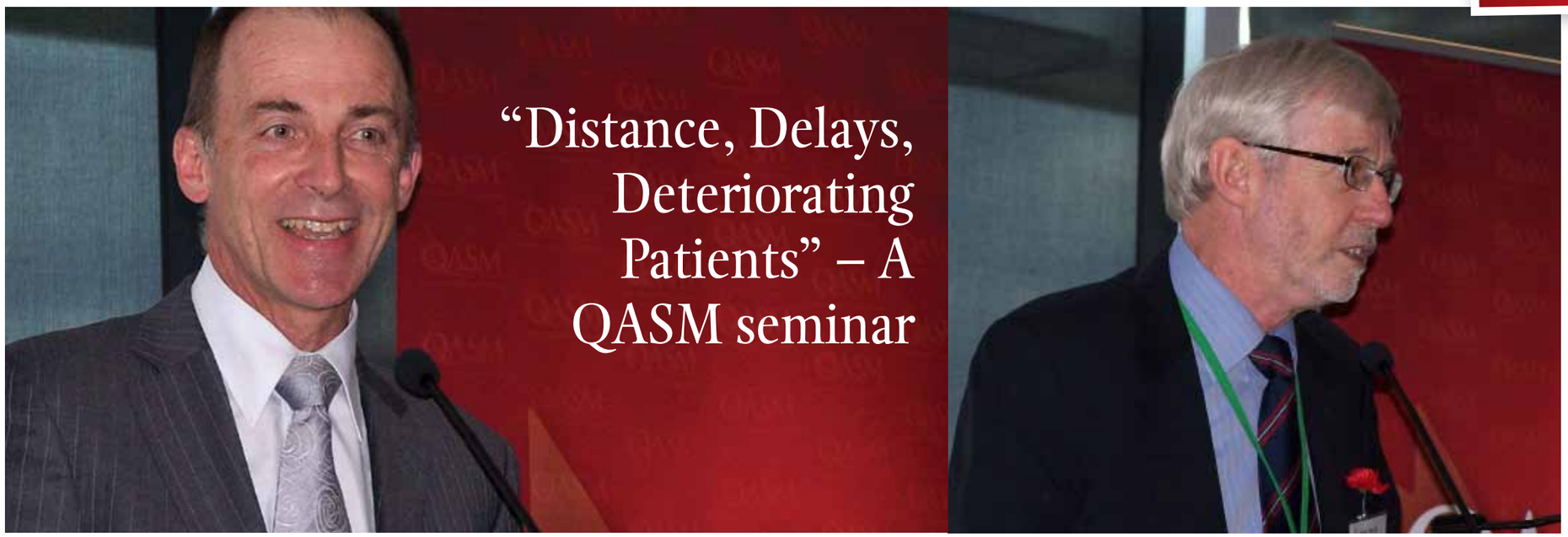
With an increase in telecommunication infrastructure to regional areas, telemedicine can provide a great opportunity for specialists to provide consultations to those who may be unable to attend a specialist in person, or when time is of the essence. But doctors also need to be aware of the increased risks involved.

With Richard Laufer

References

1. See s 59 Wrongs Act 1958 (Vic) relating to standard of care for professionals
2. http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

Michael Gorton,
College Solicitor



A successful seminar gave raise to interesting discussion

The Queensland Audit of Surgical Mortality (QASM) held its inaugural seminar for surgeons in November 2011. The seminar theme of 'Distance, Delays, Deteriorating Patients' emanated from data analysis of previous QASM annual reports. These topics were considered to be of significant interest to both metropolitan and regional Queensland surgeons. Evaluation of the seminar and feedback from surgeons has resulted in a similar seminar being planned for November 2012.

Fifty-six surgeons attended this inaugural seminar and all surgical specialties were represented. Seventeen surgeons volunteered to present on a range of issues including:

- communication networks for retrieval;
- delay and transfer challenges in key regional areas;
- the role of the tertiary hospital;
- management of paediatric cases;
- financial implications of distance and delay;
- understanding early warning tools;
- models for safety and quality improvements;
- pathophysiology of deterioration; and
- perspectives from different surgical specialties.

The College President, Mr Ian Civil, presented on the ALERT* system and participated in concluding panel discussions. The final seminar session involved a panel of experts who reviewed relevant case studies by giving their opinions and comments. Lively and constructive debate resulted from audience participation and interaction with the panel.

All seminar attendees completed evaluation forms which provided QASM with important feedback. One surgeon commented that the value of the seminar "was in the variety of perspectives and the breadth of coverage". While another surgeon acknowledged that "collegiate support is vital" when dealing with the complex nature of distance, delays, and deteriorating patients. Another surgeon wrote of the need "to empower 'clinical' staff to escalate the care of patients" and of the need "to focus on decision making in seminars of this nature".

Thank you to all those surgeons who attended the QASM seminar and evaluated its content and process. Our QASM Project Manager, Therese Rey-Conde, and I were able to review this feedback and compile lists of themes and ideas for future seminars. What was gleaned from the seminar and surgeon feedback is outlined below.

Ownership:

Consultant surgeons need to embrace 'ownership' of patients – this key factor is essential if patients are to have comprehensive and professional treatment throughout their surgical experience. Absence of consultant ownership means that decision-making can be inadequate and many times delegated to junior staff. Their reduced experience and expertise does not allow them to make complex decisions relating to difficult and deteriorating patients.

Leadership:

The surgeon with the major responsibility, should be 'in charge' of and 'responsible for' the overall care facilitation, while delegating to the other specialities their own decisions and responsibilities. Patients who have more than one consultant in their treatment process require consultant leadership.

Presence:

When the consultant surgeon is 'on call', they must be responsible for all patients admitted under their name. Every surgeon should be available at all times for simple consultation via telephone, either for complex decision-making at the bedside or in the Emergency Department. This means that each consultant surgeon should always be within a 'reasonable distance' of their 'on call' hospital. Consultant willingness to attend for both consultation and/or activity in the operating theatre is therefore essential, as is support for both the Trainee and/or the Fellow.

Training:

It is the consultant's responsibility, when 'on call' and in other less urgent circumstances, to be a trainer of all Trainees and Fellows. The on-call consultant must instil in Trainees and Fellows a culture of discussion and collaboration that seeks the best for every individual patient. Junior members of the team must always consult the consultant under whose name the patient has been or will be admitted. Consultant-led training is essential for all admissions. If you are the on-call consultant, please be available. This is an opportunity to train and mentor Trainees, service registrars and Fellows.

Communication:

Rural and remote medical officer requests for transfer to tertiary hospitals must be handled by the on-call consultant. It is not appropriate for a rural consultant to be speaking to the most junior service registrar in the tertiary hospital in these circumstances. Consultant-to-consultant communication is the key for receiving the best advice and the most prudent transfer arrangements for complex patients from rural and remote circumstances.

Facilitation:

The consultant surgeon must manage (at all levels) issues that arise in patient care whether they are through emergency admission or elective surgical planning. Numerous issues are arising every day in the public health system. Most require consultant-led input to facilitate best patient care. The consultant referring the patient for transfer would be wise to say, "I need you to take this patient". If a consultant surgeon receives such a request for admission of the patient, then the receiving consultant should simply accept. That request for help should always be heeded unless there are circumstances that could not facilitate that patient's best care at the receiving hospital. Advice should be heeded by the receiving consultant to make sure the best institution, and premium patient care for each individual, is available.

Collaboration:

Futility in the surgical process means saying 'no' to a transfer. This should be done in collaboration between consultants and not between junior staff and consultants (especially when patients are from rural and remote areas). Surgeons need wisdom to know when to say no. Futile situations in modern surgery still arise regularly and need to be considered carefully and, in the interests of fairness and justice, plurality of decision makers is extremely wise.

Advocacy:

The consultant surgeon is an advocate for each patient. If best-care processes are to be carried out, all patients need the full attention of their consultant regardless of how they come to see that consultant (whether through an elective corridor or in an emergency situation). Junior medical officers cannot be the best advocate for a patient. Advocacy by each and every consultant surgeon is a mandatory patient care role.

John North
QASM Clinical Director

(*Note: ALERT = Acute Life-threatening Events – Recognition and Treatment. For more information http://www.alert-course.com/)

Graduate Programs in Surgical Education

Build your skills in teaching others

Graduate Certificate, Graduate Diploma and Masters level programs in surgical education are offered in partnership with the University of Melbourne and the Royal Australasian College of Surgeons.

The programs are designed to support surgeons in gaining formal skills in teaching and educational scholarship. There are core and optional subjects with flexible delivery modes. The content reflects critical issues in the broader education community together with specific challenges for surgical education – the role of regulatory bodies, balancing clinical service with training, ethical imperatives for simulation based education, safer working conditions including safe hours and more.

Education specialists have worked closely with medical and surgical professionals to design these high quality programs.

The broad aims of the programs are:

- To provide a theoretical background in the principles of education
- To explore the contexts in which medical education is delivered
- To develop teaching skills to support learning in clinical and other professional settings
- To develop skills to create robust educational programs
- To introduce educational research methods
- To develop educational scholarship
- To apply all of the above to surgical education

The programs are open to anyone holding an MBBS (or equivalent) and a practicing or trainee surgeon.

Course Dates and Fees for Intake 2, 2012

Semester 2: 30 July 2012 – 4 December 2012

Semester 1: 11 February 2013 – 28 June 2013

Further information about the content of the program can be obtained at ***www.mccp.unimelb.edu.au/surgical-ed***

MIGA Doctors in Training Grants Program

The DIT Grants Program provides funding to assist doctors in training whilst pursuing specialist training opportunities in Australia and abroad. Funds are provided to assist doctors meet the expenses associated with this additional training. The DIT Grants consist of four individual DIT Grants of $5,000 per recipient, to assist in funding their training opportunity which can include travel, accommodation, program fees, etc.
More information is available at **http://www.miga.com.au/content.aspx?p=116**

Workshops & Activities

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

AMA Impairment Guidelines 5th Edition: Difficult Cases

4 July, 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 full-day seminar compliments the accredited AMA Guideline training courses. The program uses presentations, case studies and panel discussions to provide surgeons involved in the management of medico-legal cases with a forum to reflect upon their difficult cases, the problems they encountered, and the steps they applied to satisfactorily resolve the issues faced. Please note: Fellows will still need to attend AMA training to be accredited to use AMA guidelines.

Keeping Trainees on Track (KToT)

5 July, Launceston; 24 July, Brisbane

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.

Supervisors and Trainers for SET (SAT SET)

8 August, Sydney

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

Surgical Teachers Course

14–16 Aug, Perth & 18-20 Oct, Hobart

The two-and-a-half day intensive course enhances educational skills of surgeons who are responsible for the teaching and assessment of Trainees. Participants learn the foundation of improved educational skills, which are further developed during the course through practical application. The course is delivered through four main modules, which are integrated to achieve progressive acquisition of knowledge and skills.

Preparation for Practice

25 to 26 August Melbourne

This one-and-a-half-day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice.

Management of Acute Neurotrauma

18 Aug Townsville, 31 Oct Adelaide

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.

Non-Technical Skills for Surgeons (NOTSS)

12 October, Launceston

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

DATES
JULY-OCT 2012

NSW

4 July, Sydney
AMA Impairment Guidelines, 5th Edition: Difficult Cases

6 July, Sydney
Occupational Medicine: Getting Patients Back to Work

20 July, Sydney
Finance for Surgeons

8 August, Sydney
SAT SET

QLD

24 July, Brisbane
Keeping Trainees on Track

31 October, Townsville
Management of Acute Neurotrauma

SA

18 August, Adelaide
Management of Acute Neurotrauma

TAS

5 Jul, Launceston
Keeping Trainees on Track

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

18-20 Oct, Hobart
Surgical Teachers Course

VIC

25 to 26 August, Melbourne
Preparation for Practice

WA

14 to 16 August, Perth
Surgical Teachers Course

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

Support your section

Colon and Rectal Surgery Section member and executive Hung Nguyen interviews Dr Matt Rickard, the incoming Chair of the Colon and Rectal Surgery Section of the College.

Congratulations, Matt. Many younger fellows are not clear about the distinction between the Colon and Rectal Surgery Section (Section) of the College and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) can you tell us what are the essential differences in membership and function of the two organisations? Thanks, Hung. I think that is a really good question and I agree that a lot of the younger Fellows who have just completed their Fellowship and/or post Fellowship training aren't aware of the distinction. Colorectal Surgery in Australia and New Zealand is performed by many General Surgeons and the section supports all Fellows, Trainees and IMGs with an involvement and/or interest in colon and rectal surgery. It is the 'voice' of Colorectal Surgery within the College.

The CSSANZ represents Fellows who, by undertaking further post-fellowship training for a minimum of two years, have specialised in colorectal surgery. CSSANZ Fellows need to show evidence that the majority of their practice is Colorectal Surgery. Most practicing Colorectal Surgeons are members of both the Section and the CSSANZ. I strongly encourage all Fellows, Trainees and IMGs with an involvement and/or interest in colon and rectal surgery and all specialist colorectal surgeons to join the Section.

The Section and the CSAANZ work closely together, but are completely separate entities. Both foster excellence in the practice of Colon and Rectal Surgery in Australia and New Zealand. Both are equally involved and equally represented on the Training Board in Colon and Rectal Surgery (TBCRS). For obvious reasons, the Training Board in Colon and Rectal Surgery is one of the most important roles of both the Section and the CSSANZ. Having two separate entities to share the decision making, supervision and indemnity issues has been and continues to be one of the strengths of the Training Board in Colon and Rectal Surgery.

The Section is responsible for the Colon and Rectal Surgery program at the Annual Scientific Congress (ASC) each year and now the annual Sydney Colorectal meeting (usually in November). The Section and the CSSANZ are responsible for the annual spring CME meeting.

What do you hope to achieve for the Colon and Rectal Surgery Section during your term in the next few years? I would like to see more Fellows, Trainees and IMGs become members of the Section. I firmly believe that every surgeon in Australia and New Zealand who performs any colorectal surgery should be a member of the Section. We, the Fellows, are the College.

I've been disappointed over the past few years by the feeling of 'us' versus 'the College'. If you perform colorectal surgery and you are a Fellow of the College, you should know about the Section, join the Section, come to the Annual Business Meeting (ABM) every year and have your voice heard.

As Chair of the Colon and Rectal Surgery Section, I would automatically become a member of the Training Board in Colon and Rectal Surgery (TBCRS) (as does the President of the Society, Andrew Luck). I have already been a member of the Training Board in Colon and Rectal Surgery for three years. Training future surgeons is one of our most important jobs and is a way of caring for future patients that we will never meet personally.

What are the requirement for membership of the Colon and Rectal Surgery Section of the College? If you are a Fellow, Trainee or IMG of the College and you are up-to-date with your CPD with an involvement and/or interest in colorectal surgery you are able to become a member of the Section.

How do members of the Colon and Rectal Surgery Section have a greater say in any areas of concern regarding education and training matters? Members of the Colon and Rectal Surgery Section can contact myself directly on (mjfx@optusnet.com.au) or can attend the ABM at the ASC.

Does the Colon and Rectal Surgery Section want more members? Yes. I encourage all Fellows, Trainees and IMGs with an involvement and/or interest in Colorectal Surgery to become a member of the Section. Membership of the Section connects you with other colorectal surgeons, an exciting ASC program and helps build colorectal surgery capacity in Australasia.

Does it cost anything for a Fellow, Trainee or IMG of the RACS to join the Colon and Rectal Surgery Section? No, membership is free.

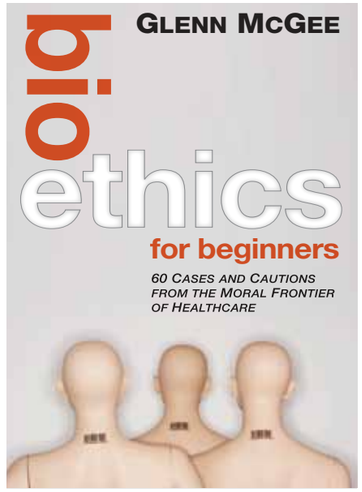
Congratulations once again Matt. I hope you continue to achieve the level of constructive cooperation with the CSSANZ that the Colon and Rectal Surgery Section has always enjoyed, as well as increasing our membership of Fellows, Trainees and IMGs.

Join the CRSS, email sections@surgeons.org

Welcome to the Surgeons' Bookclub

ALL BOOKS NOW 25% DISCOUNT

25% Discount



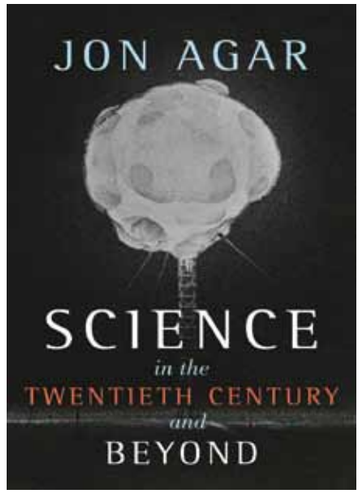
Bioethics for Beginners: 60 Cases and Cautions from the Moral Frontier of Healthcare

Glenn McGee
9780470659113 | Hbk | 192 pages
May 2012

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

How far is too far? 60 cases illustrating modern bioethical dilemmas. Bioethics for Beginners maps the giant dilemmas posed by new technologies and medical choices, using 60 cases taken from our headlines, and from the worlds of medicine and science. This eminently readable book takes it one case at a time, shedding light on the social, economic and legal side of 21st century medicine while giving the reader an informed basis on which to answer personal, practical questions. Unlocking the debate behind the headlines, this book combines clear thinking with the very latest in science and medicine, enabling readers to decide for themselves exactly what the scientific future should hold.

25% Discount



Science in the 20th Century and Beyond

Jon Agar
9780745634692 | Hbk | 256 pages
March 2012, Polity

~~AU$57.95~~ | AU$43.46
Member Price

A compelling history of science from 1900 to the present day, this is the first book to survey modern developments in science during a century of unprecedented change, conflict and uncertainty. The scope is global. Science has been at the heart of twentieth century history - from Einstein's new physics to the Manhattan Project, from eugenics to the Human Genome Project, or from the wonders of penicillin to the promises of biotechnology. For some science would only thrive if autonomous and kept separate from the political world, while for others science was the best guide to a planned and better future. Science was both a routine, if essential, part of an orderly society, and the disruptive source of bewildering transformation. Jon Agar draws on a wave of recent scholarship that explores science from interdisciplinary perspectives to offer a readable synthesis that will be ideal for anyone curious about the profound place of science in the modern world.

25% Discount

Photo Inspiration: Secrets Behind Stunning Images

1x.com
9781118290521 | Pbk | 224 pages
April 2012

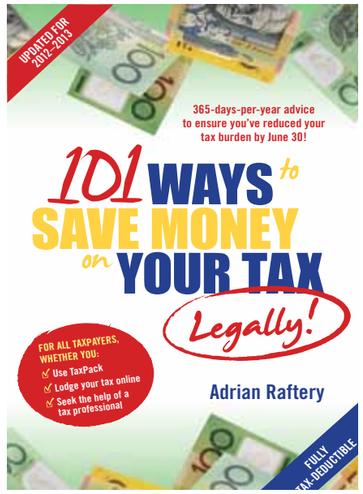
~~AU$47.95~~ | AU$35.96
Member Price

The inspiration you need to help improve your photography skills. Well-known for their stunning world-class photography, 1x.com has worked with their most talented photographers to handpick 100 awe-inspiring images and provided the back-story and photographer's secrets that helped capture them. This book presents you with inspiration as well as underlying techniques that can help improve your photography skills immediately.

- Shares behind-the-scene stories of the featured photos from the photographers themselves, from their artistic vision to the technical details that went into each shot
- Offers clear, concise, and accessible descriptions for the ideas, vision, performance, setup, location, equipment, camera settings, lighting diagrams, and image editing methods of each amazing photo

Photo Inspiration provides a unique combination of the final photograph with the tools and knowledge that made it.

25% Discount



101 Ways to Save Money on Your Tax - Legally! 2012-2013

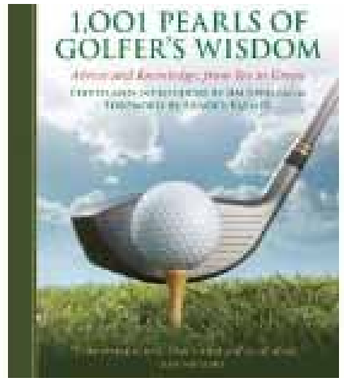
Adrian Raftery
9781118340714 | Pbk | 320 pages
May 2012

~~AU$24.95~~ | AU$18.71
Member Price

Do you ever wonder if you're getting everything you're entitled to when tax time rolls around—but perhaps you don't know where to start to find out if that's the case? With 101 Ways to Save Money on Your Tax, you can start here. Financial expert and award-winning accountant Adrian Rafferty shares proven tips and advice for minimizing your debt and maximizing your return. With this invaluable guide, you'll learn safe ways to spend your refund, what to do if you are audited, things to look for when purchasing a property, what to remember when buying shares, and how to avoid common mistakes in business.

- Reveals tax tips and bonus resources to help manage your tax affairs all year round so you can get the best possible return
- Features fully updated advice for the 2012-2013 tax year, including the latest changes from the May 2012 budget
- Delves into key areas such as handling taxes for investment properties and share portfolios

25% Discount



1001 Pearls of Golfer's Wisdom: Advice and Knowledge, From Tee to Green

Jim Apfelbaum
9781616083540 | Hbk | 400 pages
May 2012, Norton

~~AU$17.95~~ | AU$13.46
Member Price

There's an old adage about sports writing that says "the smaller the ball, the better the writing." The quotes that make up 1,001 Pearls of Golfer's Wisdom prove that to be most definitely true! Ranging from the hilarious to the thought-provoking, these quotes offer wit and wisdom on every stroke and situation. With a foreword from the Golden Bear himself, Arnold Palmer, this is certainly a book that no golfer will want to be without.

WILEY-BLACKWELL

To Order

RACS Members can now access the **25% discount*** by following the instructions:

Log on to the RACS website

Go to College Resources then Member benefits – then Wiley-Blackwell

Follow the steps on the website to ensure your **25% discount** on all Wiley-Blackwell books*

If you have previously ordered from the RACS Landing Page, then you can purchase direct from www.wiley.com by selecting the book of choice and then logging on.

Place your order – no discount code needed

Postage is charged on all orders:

AU$7.50 within Australia and AU$25.00 to New Zealand

*Excluded from discount are School (Jacaranda) titles.

To read more about these titles please go to www.wiley.com

Not all books promoted in Surgical News will appear on the RACS/ Wiley Landing Page.

You can still order these, as with any other book, by finding it within **wiley.com**, after logging in.

*Excluded from discount are School (Jacaranda) titles.

THANK-YOU
for donating to the Foundation for Surgery

NSW
Mr Peter Brown
Mr Allen-John Collins
Mr John Napper
Emeritus Professor Thomas Reeve
Mr David Youkhanis

QUEENSLAND
Mr John Lancaster
Queensland Gas Company

SOUTH AUSTRALIA
Mr John Chen

VICTORIA
Mr Stanley Chang

WESTERN AUSTRALIA
Mr William Castleden
Professor Bernard Catchpole
Mr Gerard Hardisty
Mr Theophilus Taylor

HONG KONG
Mr Kin Lee

INDIA
Mr Kottooratu Cherin

TOTAL
$56,000

Your passion.
Your skill.
Your legacy.

Your
Foundation.

Yes, I would like to donate
to our Foundation for Surgery

Foundation for Surgery
Passion. Skill. Legacy.

All donations are tax deductible

Name: .....

Address: ..... Telephone: .....

Email: ..... Speciality: .....

Enclosed is my cheque or bank draft (payable to Foundation for Surgery) for $ ☐☐☐☐.☐☐

Please debit my credit card account for $ ☐☐☐☐.☐☐

☐ Mastercard ☐ Visa ☐ AMEX ☐ Diners Club ☐ NZ Bankcard

Credit Card No: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry ☐☐/☐☐

Card Holder's Name - block letters ..... Card Holder's Signature ..... Date .....

I would like my donation to help support:

☐ General Foundation Programs ☐ International Development Programs
☐ Scholarship and Fellowship Programs ☐ Indigenous Health Programs
☐ I have a potential contribution to the Cultural Gifts Program .....
☐ I do not give permission for acknowledgement of my gift in any College publication

Please send your donation to:

AUSTRALIA & OTHER COUNTRIES
Foundation for Surgery
250 - 290 Spring Street
East Melbourne , VIC 3002
Australia

NEW ZEALAND
Foundation for Surgery
PO Box 7451
Newtown, 6242 Wellington
New Zealand

GAMMEX® Non-Latex range minimises the risks of type IV allergies and skin irritations, but some chemicals contained in GAMMEX® Non-Latex gloves may cause allergic reactions or irritations in some users.

WWW.MEDICAL.ANSELL.COM.AU

Ansell