SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VOL 15 NO 2 / MARCH 2014

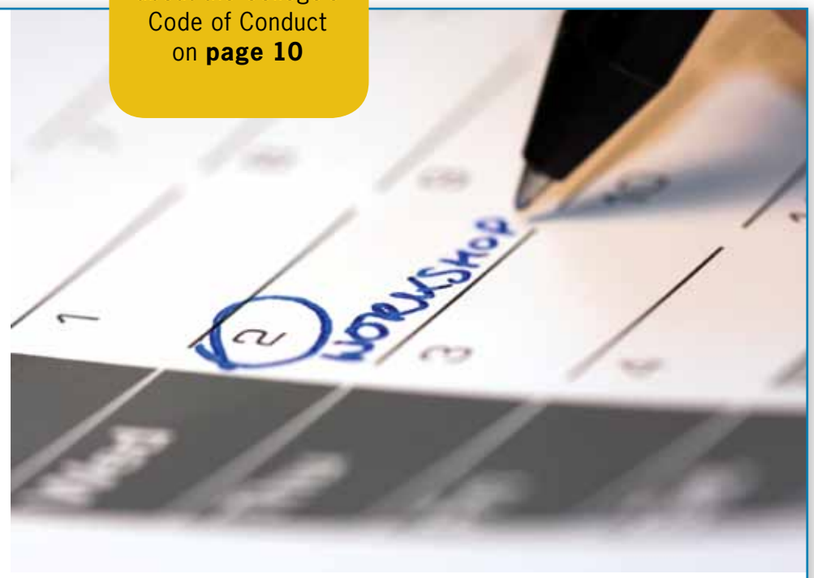
Scalpel Battles

Students show their surgical edge

The College of Surgeons of Australia and New Zealand

2014 WORKSHOPS & ACTIVITIES

Read all about the College's Code of Conduct on **page 10**



Supervisors and Trainers for SET (SAT SET)

29 April, Melbourne

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

Keeping Trainees on Track

26 March, Gold Coast; 8 April, Sydney

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

Communication Skills for Cancer Clinicians

29 March, Melbourne

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

Non-Technical Skills for Surgeons (NOTSS)

18 March, Adelaide; 15 April, Melbourne

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

Finance for Surgeons

31 March, Adelaide

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

Polishing Presentation Skills

9 April, Brisbane

The full-day curriculum demonstrates a step-by-step approach to planning a presentation and tips for delivering your message effectively in a range of settings, from information and teaching sessions in hospitals, to conferences and meetings.

Surgical Teachers Course

3 - 5 April, Gold Coast

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

Writing Medicolegal Reports

24 July, Brisbane

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

Strategy and Risk Management for Surgeons

7 August, Brisbane

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

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

AMA Impairment Guidelines 5th Edition: Difficult Cases

13 August, Sydney

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

Process Communication (PCM) – Part 2

5 – 7 September, Sydney

The advanced three day program allows you to build on and deepen your knowledge while practicing the skills you learned during PCM Part I. You will learn more about understanding your own reactions under distress, recognising distress in others, understanding your own behaviour and making communication happen. Advanced PCM concentrates more strongly on the failure mechanisms of distress, making it easier to apply PCM in order to resolve conflict and motivate others.

Building Towards Retirement

15 November, Sydney – Video link to Perth

Surgeons from all specialties who are considering retirement from operative or other types of surgical practice will benefit from attending this day long workshop. Fellows from a variety of disciplines and their partners join with colleagues and corporate speakers in an interactive discussion format that focuses on three sessions on preparing for retirement, options after retirement and resources to realise options.

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

WORKSHOPS

March-May 2014

NSW

8 April, Sydney
Keeping Trainees on Track (KTOT)

QLD

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

3-5 April, Gold Coast
Surgical Teachers Course

9 April, Brisbane
Polishing Presentation Skills

SA

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

31 March, Adelaide
Finance for Surgeons

VIC

11 March, Melbourne
Academy Educator Studio Session

14 March, Melbourne
Conjoint Medical Education Seminar

15 March, Melbourne
Academy Educator Studio Session

29 March, Melbourne
Communication Skills for Cancer Clinicians

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

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

ASC

5 May, Singapore
KTOT

5 May, Singapore
NOTSS

5 May, Singapore
SAT SET Course

Registrations are taken via Conference and Events for ASC events.

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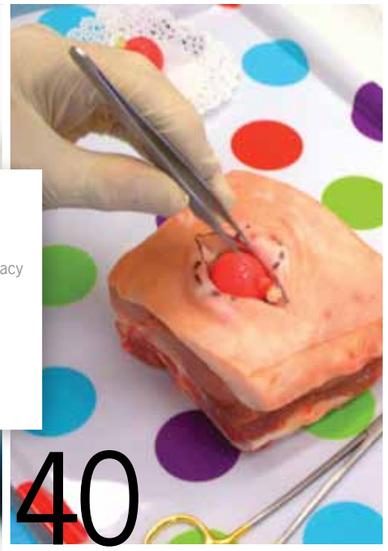

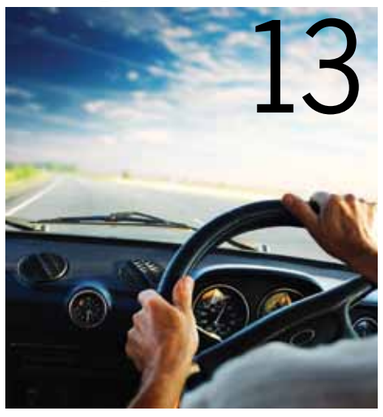

REGULAR PAGES

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ON THE COVER:
Scalpel battles. A Queensland initiative to enhance engagement with undergraduate medical students

WORLD WAR ONE - A CENTURY LATER

MIKE HOLLANDS
PRESIDENT

I have just returned from visiting the Colleges of Surgeons in Ireland, Scotland and England. It is 100 years since the first 'global' war with World War One having commenced in July 1914.

Although many items were discussed, a substantial focus was to highlight one of Australia and New Zealand's more significant battles in World War One which was the Gallipoli campaign that started in April 1915 and finished in January1916. Whilst not a military success, it is regarded as the campaign that fashioned the tradition of the ANZAC.

At the ASC in Perth in 2015, there will be a significant number of presentations about the role of surgeons in military campaigns and the Gallipoli campaign in particular. Whilst in the United Kingdom and Ireland I encouraged the Royal Colleges to join us in 2015.

Indeed I co-hosted a cocktail evening at the Edinburgh College to promote the Edinburgh College's participation in the Perth meeting. David Watters gave an excellent presentation on Gallipoli and two of the Edinburgh surgeons gave excellent presentations on WWI and carried the theme through to Britain's recent engagement in Afghanistan.

Whilst in Ireland I was invited to give a keynote address on professionalism at the RCSI annual Charter Day Meeting. I stressed the role of Colleges and their importance in maintaining professional standards. It is fair to say that all Colleges are dealing with the aftermath of Bristol Hospital, Shipman, Bundaberg Hospital, King Edward Memorial Hospital, Mid Staffordshire and other inquiries. The list is long and more than depressing.

This is where health systems have not performed with a focus on patient care. At times it is the overall standard of care and in others it is perceived as an errant practitioner who has not been constrained by the systems in place. Patients have suffered as a result.

Although as individuals we aspire to provide high quality care, it is not perceived as enough by the policy makers and regulators who remain highly concerned that 'bad apples' exist or that hospitals abandon the focus on quality clinical care in a pursuit of balanced budgets.

I feel sure that much of the legislation around national registration and its subsequent increased regulation and oversight of the profession is a result of governments being doubtful that the profession is able to regulate itself.

Demand for accountability

In the UK, the Government and the revamped medical regulators are demanding substantial accountability within its revalidation and recertification approaches. There is much greater acceptance of reporting of clinical outcomes. The work of Sir Bruce Keogh who is a Cardiac Surgeon and also the National Medical Director in NHS England from 2013 is well known to many.

Institutional and at times individual surgeon outcomes are now readily accepted across many specialties. In many ways, one has the feeling that the various medical colleges have been left defending the small pockets of poor performance rather than championing the progression of standards and patient safety for the benefit of the community.

Let me emphasise this – the College must champion delivery of 'gold standard' patient care.

The message that I am bringing back to Australia and New Zealand as the President of the College and also in my role as Chair of the Committee of Presidents of Medical Colleges (CPMC), is we need to grasp the role of ensuring standards. We have done the difficult yards of establishing well-regarded programs of Continuing Professional Development (CPD), have peer-reviewed mortality audits and also the mechanisms for all-of-practice morbidity audits.

The Medical Board of Australia is now demanding compulsory CPD. It is important that highlighting the standards that are required, and working effectively with our colleagues who do not achieve them, is now critical.

The College, as a membership-based organisation must balance the expectations of Fellows with those of the community. Unless we deliver on these expectations, then regulators worldwide will intervene with increasingly restrictive legislation as we have seen in the United Kingdom over the last two decades.

I look forward to seeing many of you at the Annual Scientific Congress in Singapore in May. Run in parallel with the meeting of the College of Anesthetists, it promises to be a great event.

WORKFORCE OF THE FUTURE

Planning a future surgical workforce is not an easy matter

MICHAEL GRIGG
VICE PRESIDENT

It is no simple matter to ensure, many years in advance, that sufficient surgeons with the right skills will be trained and available to be employed in the right place at the right time.

Yet it is an important matter for the College in view of the unique position we enjoy of being the sole provider of surgical training in Australia and New Zealand. This is a position we have fought hard to maintain in recent years. A position driven by the deep-seated belief that the people best-placed to train surgeons are surgeons; that this will ensure the highest quality of surgeons into the future.

As such we expose ourselves to accusations of monopolistic behaviour and of running a 'closed shop'. Society seems well-aware of the risks associated with an undersupply of surgeons, but sometimes it seems to me that only surgeons are aware of the risks associated with an oversupply, particularly in terms of dilution of skill levels and even the reduction of the threshold for intervention.

Workforce planning is therefore important, but it is a process fraught with difficulties. Long-term projections always require a degree of crystal ball gazing. We know that research and growth in knowledge may result in treatment that avoids the need for surgical intervention; or, conversely, may expand our ability to intervene surgically where previously this was not possible.

However, if the communities across New Zealand and Australia are to be well-served we must not fail to grapple with these issues. We need to plan the future workforce to the best of our ability utilising the best knowledge at hand. Both countries must seek to reduce their reliance on overseas trained doctors, not least because some 'donor' countries need their own graduates more than we do! For the New Zealand and Australian Governments this means doctors working in their countries need to be trained internally – not imported.

The complexity of the issue is increased because it is not just about numbers, but also about distribution. There is very little evidence to support the proposition that oversupply will result in resolution of the problems of maldistribution. Australia has had an increased output from its medical schools for several years now and New Zealand's first year of increased graduate numbers have just begun; PGY1.

Both countries have given priority to their own citizens and permanent residents in making intern appointments. Our communities have invested considerably in their medical education and it is entirely appropriate that this is protected through securing employment and further education for our own. Those trained locally already have an understanding of the subtleties of the culture of the country and of its health system and this helps to ensure the provision of appropriate medical advice and care.

In New Zealand this has been taken a step further into the vocational training sphere. Health Workforce New Zealand (HWNZ) allocates government funds to District Health Boards (DHBs) to assist with the costs of PGY1, PGY2 and specialty training. HWNZ has announced that it will now only provide that assistance when a specialty Trainee is a New Zealand citizen or New Zealand permanent resident.

This does not prevent DHBs from employing Trainees who are citizens of other countries and are not NZ permanent residents; but if they do so they now have to fund all costs associated with that Trainee from their own operating budgets.

Once again, the reason for this decision is to ensure appropriate return for tax-payer dollars by encouraging the progress of the increased output from New Zealand medical schools into specialty training programmes and the College is supportive of this initiative.

The dilemma for the College occurs with respect to Trainees in the smaller surgical specialties, where all of their training cannot be completed in New Zealand due to the size and distribution of the population. Currently for those specialties, Australian citizens/permanent residents may be allocated to a New Zealand training post while New Zealanders are in Australian posts.

Although Australia does not have an equivalent of the HWNZ funding, it is the Australian taxpayer who then supports the training of those New Zealanders. This matter has been raised with HWNZ by the New Zealand National Board and discussions on 'reciprocity' of funding are ongoing.

If the community is to obtain the maximal return from tax-payers' dollars, our newest Fellows need to have long-term employment prospects. Many new Fellows seek post-fellowship training opportunities for one to two years before taking up a permanent consultant post.

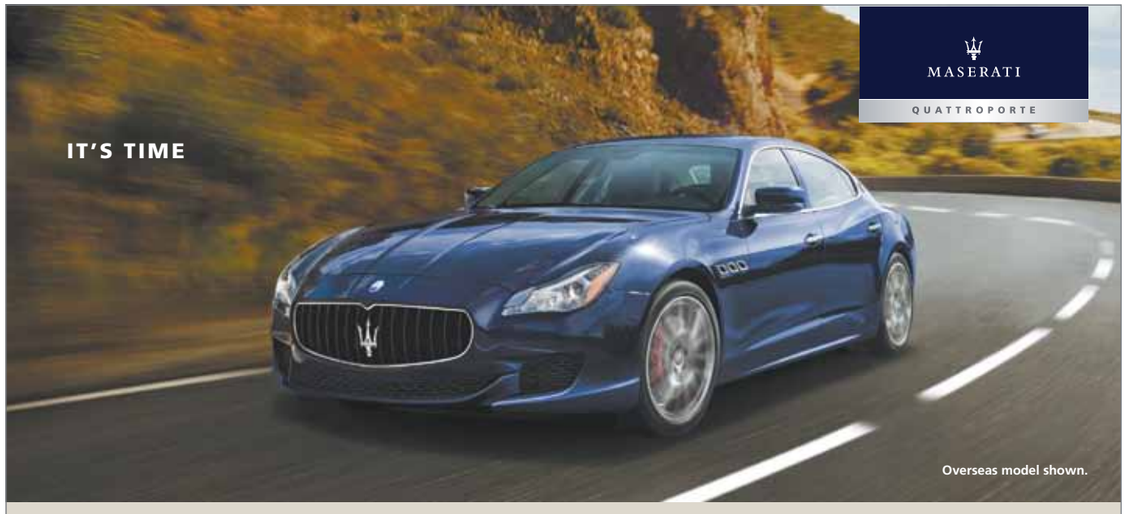
For many New Zealand Fellows in particular these opportunities are only available overseas, but suitable posts are becoming scarce as overseas jurisdictions also struggle with employing their own graduates. There is a financial cost involved for new Fellows seeking the best training that they can obtain overseas, and uncertainty.

HWNZ has a scheme for financial support for post-Fellowship training, but access to that is contingent upon a DHB confirming the intention to provide employment when the new Fellow returns – and the majority of DHBs are not prepared to make those future commitments.

Thus the College has many challenges to confront – encouraging employers to look into the future is one of these. But the training of sufficient surgeons for each country reflects just a segment of workforce planning - the distribution of that trained workforce is equally crucial.

The College must continue to be involved in the distribution issue and promulgate that considerable work opportunities exist in regional centres. We must promote a willingness of surgeons to seriously consider consultant careers outside metropolitan centres, we must promote the rewards and celebrate their professionalism.

> *"Surgical workforce of the future must be planned today"*



INTRODUCING THE ALL-NEW QUATTROPORTE.

After ample anticipation, the new Quattroporte is here. A harmonious blend of seductive design and innovation. The new Quattroporte GTS boasts a 3.8 litre V8 engine delivering 530hp at 710Nm of torque for blistering performance. Distinctly Italian and iconically Maserati, this sports saloon is now even more responsive offering luxurious comfort and intuitive control. The powerful new Quattroporte S with 410hp at 550Nm of torque, is also available for order. So, if you've ever dreamed about owning a Maserati Quattroporte, it's now time.

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OFFICIAL MASERATI DEALER OF VICTORIA

Fellow heads Medical Council of New Zealand

Surgeon takes on key health role

The Royal Australasian College of Surgeons congratulates Auckland surgeon and Fellow Andrew Connolly (pictured) on his appointment as the new chair of the Medical Council of New Zealand.

Mr Connolly is a general and colorectal surgeon, employed fulltime at Counties Manukau District Health Board.

Appointed to the Council in November 2009, Mr Connolly was elected deputy chair of Council in February 2012.

Trained in Auckland, Mr Connolly undertook a formal 18-month period of surgical research under Professor G L Hill before completing post-Fellowship colorectal training in the United Kingdom. He returned to Middlemore Hospital as a consultant surgeon in late 1997.

He has a strong interest in governance and clinical leadership and has been the Head of Department of General and Vascular Surgery since 2003. He has served on the ministerial advisory group that was responsible for the 'In Good Hands' document.

Mr Connolly has served on various national committees, including the National Guidelines Group for the screening of patients with an increased risk of colorectal cancer.

He has previously held the role of Presiding Member of the Lotteries Health Research Distribution Committee, and recently chaired a Ministerial review of the impact of the elective waiting times policy and was a member of the review panel of the New Zealand Cancer Registry.

He has a strong interest in surgical education and training and acute surgical care, as well as taking an active role with surgical research into enhanced recovery and has a passion for military history, particularly World War 1.

Mr Connolly paid tribute to outgoing chair of the Council Dr John Adams, saying his contribution to the New Zealand Curriculum framework would be his ongoing legacy both to the Council and medical education.

Surgical News Extra Audio Program

Now Online!

In keeping with the new and different ways in which you like to receive College news and other important information for your practice, the Surgical News Extra audio program will now be provided solely online. This will be for a trial period as we continue to explore your preferred methods of communication.

Surgical News Extra Audio Program features extended interviews on articles in the current issue, plus practical advice that surgeons can implement in their practices, including insights on financial management and wealth creation, legal and tax advice and economic forecasts.

Featured this month:

- Coinciding with his visit to Australia this month, Professor Sir Peter Rubin, Chair of the UK's General Medical Council, discusses the reasons for, and ramifications of, the introduction of 'revalidation' in that country.
- College Censor-in-Chief Simon Williams explains the importance of adhering to set deadlines and the process for extension requests.
- Dr David Read, Northern Territory representative on the Royal Australasian College of Surgeons' Trauma Committee, talks about the College's position on the 'open speed' trial currently being conducted on a 200km-stretch of road north of Alice Springs.
- Michael Gorton, College Solicitor, looks at aspects of the peer review process, what legal implications there might be and the benefits of indemnity.
- The Bongiorno Group's Tony Bongiorno and Michael Waycott consider the keys to wealth creation for health professionals.

The March *Surgical News* Extra interviews, along with all previous editions of Surgical News Extra, are available on the College website (www.surgeons.org.au). Click 'The College' on the home page and look under the 'Policies and Publications' section where you'll find 'Surgical News Extra'.

“This commitment is evident not only as active learners, but also by facilitating and teaching on courses”

CPD AND THE CODE OF CONDUCT

The Code of Conduct is just one of the College’s initiatives to support Fellows in maintaining the highest standards of surgical care

GRAEME CAMPBELL
CHAIR PROFESSIONAL STANDARDS

A key function of the College is to support its Fellows in maintaining the highest standards of surgical care in the community. In achieving this, the College undertakes a number of initiatives including professional development workshops, a surgical competence and performance framework and the Code of Conduct.

The Continuing Professional Development (CPD) program is also integral to maintaining professional standards and reinforces not only our commitment to our patients, but also defines Fellowship of the Royal Australasian College Surgeons as representative of excellence in surgical care. Through active participation in CPD, the community can be reassured that the surgical profession in Australia and New Zealand is both willing and able to self-regulate.

Why CPD Matters?

The transition to an annual cycle for CPD has been designed to deliver a program that is both efficient for Fellows and sufficiently rigorous to meet the requirements of the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand (MCNZ).

Australian and New Zealand surgeons are in the unique position of being largely self-regulated, a privilege afforded in recognition of their position of trust within the community. The vast majority of our Fellows show a strong commitment to CPD and engage in life-long learning through participation in a variety of professional development activities.

This commitment is evident not only as active learners, but also by facilitating and teaching on courses in Australia, New Zealand and overseas. The growth of the Academy of Surgical Educators is just one example of our commitment to improving standards of education and support for our teaching colleagues.

While self-regulation avoids the imposition of a model overseen by external agencies who may have limited understanding of the working life of a surgeon, it also comes with the responsibility of setting and maintaining the highest standards of surgical care and professionalism.

Regulatory authorities in Australia and New Zealand are increasing their scrutiny of practitioners’ participation in CPD and the consequences for failing to comply are significant. Non-compliance with the Medical Board of Australia’s CPD standard may constitute a breach of the legal requirement for registration and result in action being taken under the Health Practitioner Regulation National Law. ▶

> *The College's Code of Conduct defines professional behaviour of surgeons and reflects the values espoused in the College pledge*

In New Zealand 10 per cent of medical practitioners are audited each year. Those who fail to comply with the MCNZ requirements may find conditions placed on their scope of practice or suspension of registration.

The College's Code of Conduct defines professional behaviour of surgeons and reflects the values espoused in the College pledge. The Council of the College has agreed that failure to comply with CPD requirements will constitute a breach of the Code of Conduct.

The College has a measured response to breaches of the Code, as outlined in the Code of Conduct Handling Potential Breaches policy. All Fellows should be aware that breaches of the Code of Conduct could result in the loss of Fellowship, with the College notifying the appropriate registration authority should this step be taken.

Help with CPD?

The College is committed to supporting its Fellows in completing their CPD and ensuring that they are compliant with regulatory requirements, and does not wish to see any Fellow lose their Fellowship for failure to meet their CPD responsibilities.

The College's Professional Standards Department is working hard to improve access to online facilities including the development of an integrated app and streamlining verification processes. The department is there to support all Fellows with their CPD and you should not hesitate to contact the staff if you require any assistance with meeting your requirements.

By ensuring 100 per cent compliance in CPD, the College is sending a clear message to the public of the surgical profession's commitment to ensuring excellence and the highest possible standards in healthcare.

eLearning Module

Code of Conduct

To support Fellows, International Medical Graduates and Trainees in understanding the expectations outlined in the Code of Conduct, the College has developed an eLearning module that takes participants through a series of scenarios relating to sections of the Code. On completion of the module it is expected that participants will be able to demonstrate:

- A better understanding of the College's Code of Conduct
- An increased awareness of how the Code relates to everyday situations in the workplace
- How to apply the Code to improve decision making (and how to access additional guidelines and resources) to support everyday practice

Each scenario takes approximately ten minutes and can be completed at any time by accessing the member's area of the College website – RACS Knowledge – eLearning. The eLearning module comprises five case studies that cover the following topics:

- Bullying
- Harassment
- Inappropriate advertising
- Following the rules
- Surgeon in need

Fellows who complete the eLearning module can claim CPD points for their participation. While the eLearning module is not compulsory for Fellows, it offers a valuable opportunity to refresh your knowledge of the Code and may provide some helpful tips on how to address challenging situations within the workplace.

For assistance with issues relating to the Code of Conduct, the Executive Director for Surgical Affairs (EDSA) in Australia or New Zealand can offer help, advice and support to all Fellows in a time of personal crisis, regardless of the cause and circumstances of the situation. With the understanding and experience of a practising surgeon, the EDSA can act as a sounding board, helping you to define a course of action towards recovery. All discussions and correspondence are treated as confidential. The EDSA can be contacted via email at **college.edsa@surgeons.org**

CAR-NAGE & CHOICE

It's a pleasure to try your patience

BY **PROFESSOR GRUMPY**

There is one thing that really annoys me and that is cars. I know that we need them in our society to get around, but there are so many things that really get up my nose. Firstly just buying one is a pain. We curmudgeons are not known for patience.

The salesmen (and increasingly saleswomen) are too bright and cheery. "Good morning, it is such a pleasure to help you on this lovely day ..." They clearly have a hang-over and it is raining cats and dogs.

As for their sales pitch; it is so painful. "When are we looking at buying this new car?" I wasn't aware that we were doing anything, but if you want to contribute that is fine with me.

"Have you thought of upgrading to our XXDL model?" No, I hadn't and certainly won't now that you have raised the issue. If I wanted that sleek red thing with the turbo-charged engine and all the bells and whistles, I would have asked for it.

Have you noticed that if you want something a bit more than the basic model, but not the XXDL model, it is hard to get exactly what you want? It is not unreasonable to want to have a reversing camera, but in order to get this simple safety device why do you have to buy a luxury pack for $10,000 that includes a sun-roof, a 15 speaker sound system and heated leather seats?

At last you buy the car and then you find the annoying things that were not obvious on the test drive. My new car has this thing called "i-stop". The device turns off the car's engine when you are stationary. As soon as your foot comes off the brake, the car restarts; that is fine for an 'energy saving' device, but it feels as if the car has stalled (which I suppose technically it has).

Then, when you pull into the garage at home, it sometimes will also turn itself off; but not 'fully' off as the radio is still going. If you ignore it and walk away with the 'key' in your pocket it starts wailing like an upset child (I forgot to mention that there is no real key, as we have known keys for hundreds of years, but an electronic thing). The only way to really turn the car off is to restart it and then turn it off again.

And as for the computer that runs the car, it decided after 2,000 kilometres to inform me by a red flashing message on the dashboard (which I could not turn off) to check the engine. I did and it was still there.

So back to the dealer who after an hour of diagnostics with a computer attached to my car said that "expected effluent gases from the catalytic converter were not as anticipated". I think that means that the exhaust gases smelt rotten. He said that he would override the message as the catalytic converter could not possibly be faulty as it was so new. Does the same logic apply to the car's computer?

In time one gets used to the peculiarities of the new car – the i-stop, the GPS and the bossy electronic mastermind. I must admit that now I quite like my sleek red XXDL model.

IN MEMORIAM

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

Martin Christie
NSW Fellow

Peter Woodruff
Queensland Fellow

Richard McArthur
Victorian Fellow

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

Informing the College

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

ACT: Eve.edwards@surgeons.org
NSW: Allan.Chapman@surgeons.org
NZ: Justine.peterson@surgeons.org
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VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

POISON'D CHALICE

'this above all;
to thine own self be true
(Hamlet, Act 1, Scene 3)

BY **PROFESSOR U. R. KIDDING**

"Ulysses, come home ..." I stirred in my dream, or was it my recurring nightmare? The words resurfaced, "Ulysses, come home ..."

Somewhere in the distance I could hear the voice. It was my curse. Perhaps my parents gave it to me unintentionally when they christened me Ulysses Reginald Kidding.

Yes, Ulysses, the legendary king of Ithaca and the hero of Homer's epic poem, 'the Odyssey'. In the classics, Ulysses was known for his brilliance, guile and versatility. I had always been a bit cautious of the guile, but did believe I had been endowed with the other attributes.

Of course it was also Mentor who had been my great friend in the classic who was left in charge of Telemachus at the time of the Trojan War. The importance of mentoring had been born.

But back to my dreams or were they nightmares? It was like a fog and I was wandering disorientated within it. Was it symbolic of my role being a Surgical Director within a major hospital? Although I would usually quote the Bard, is a quote from Dr Seuss be more apt? "Be who you are and say what you feel, because those who mind don't matter and those who matter don't mind."

Of course in the politics of modern day hospitals, sometimes it is very hard to pick those who matter, from those who don't. Had I stated my views too strongly at that last Board meeting? I woke with a jolt, staring into the darkness, words from 'The Tempest', Act 4 now pounding in my mind, "We are such stuff as dreams are made on; and our little life is rounded with a sleep." Is my life going to take a different turn? Was this ominous?

My career had, I like to think, been devoted to promulgating the nobleness of the profession of surgery. Those who had gone before me had established the stage upon which I perform and those that will come after me provide the vigour, the requirement to make that performance count. That is not to diminish the importance of the patient in the overall equation – they who are prepared to place their very lives in my hands. I never cease to marvel at the trust displayed.

The awareness of my responsibility to consistently and repeatedly do the very best that I can in every situation is something only other surgeons can truly comprehend.

What is it that drives me? It is not financial gain, not fear of litigation nor accolades or prestige that are as fleeting as a feather in a windswept field. Was it a desire to be able to sleep at night? Only I wasn't sleeping so well tonight. The characteristics of professionalism cascaded through my mind: integrity, compassion, respect, altruism, trustworthiness, responsibility, ability.

Was it time to 'uncloak' myself, ensure that others knew exactly what I stood for, not to hide behind the uncertainties of senior hospital management jargon? Was it now all becoming too much?

Indeed I had outlasted numerous CEOs and Medical Directors within the hospital, but maybe it was really time to go? Or at least be true to myself ...

My better-half stirred; unsettled by my restless sleep. She would never be accustomed to these wretched nights. It was worse than being on call. At least with the urgent theatre case, there was a sense of purpose, of contributing to the saving of a human life. Not just the strutting and fretting this hour upon the stage ... (apologies to Macbeth).

"Ulysses, come home ..."

Maybe it was a necessity. I could not pretend to be the Surgical Director, the esteemed and senior surgeon and the person of Shake-spearean wit. As stated in 'Hamlet', Act 1 Scene 3, "this above all; to thine own self be true, and it must follow as the night the day, Thoust cannot then be false to any man."

I quivered, I shook. I tried to sleep, but maybe my odyssey was coming to an end. Images of surgery, hospitals and the majesty of the Greek Isles swept through my troubled sleep.

Dear reader, as you might have surmised from this most recent contribution, after a journey of five years or more, this is my penultimate instalment. Over the years many have written to me, 'Professor Kidding', enquiring as to my real identity. It has been among the most closely guarded secrets within the College. However, in the next issue of 'Surgical News', with my last missive, all will be revealed ... possibly.

CSSANZ
COLORECTAL SURGICAL SOCIETY OF AUSTRAL A AND NEW ZEALAND

TRAINING BOARD IN COLON & RECTAL SURGERY

Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery - **2015**

Applications are invited for the two year Post Fellowship Colorectal Training Program, conducted by the Training Board in Colon and Rectal Surgery (TBCRS). The TBCRS is a Conjoint Committee representing the Colon & Rectal Surgery Section, RACS, and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). The program is administered through the CSSANZ office.

For details about the Training Program, please see website **www.cssanz.org .**

Application Closing Date: Friday 16 May 2014

Applications: Please include -

1. A covering letter
2. Curriculum Vitae and
3. The contact details (including email address & contact number) for three referees.
4. Application Payment of $440.00 inc GST. Methods for payment (EFT or credit card) can be found at http://www.cssanz.org/content/2/14

Please email your application to:
Mr Andrew Hunter
Chairman, Training Board in Colon & Rectal Surgery
Email secretariat@cssanz.org
Phone +61 3 9853 8013

EXERCISE WHILE YOU CAN

Will Glucosamine spare wear and tear?

BY **DR BB G-LOVED**

Exercise is good for your health. Most surgeons are squeezed for time so opt to run, cycle or swim whenever they can. You should partake of these activities whilst you are able. It may not – indeed it does not – last.

As the slim trim years of surgical training roll out through an expanding surgical practice into the midriff of middle age, the wear and tear provoked by use, overuse, injuries and degeneration, serve up increasing complaints from deep inside large weight-bearing joints. The joints not only squeal from receding articular cartilage, but also from the dual pressures of increasing waist lines and lax ligaments.

Take Dr Kart L Aigue for example. Fit, energetic surgeon who has always exercised, now heavier, hobbling rather than running, pain evident from every stride. Our consultation the other day involved planning for an arthritic future. Though Dr Kart L Aigue is far too young for a joint replacement, that's likely what's in store a decade or more in the future.

For now we went through the usual common sense options – substitute bike riding for running, keep surrounding muscles well toned and strong [involves commitment], swim more often, lose some weight [even more commitment]. Then Dr Kart L Aigue asked me, "So what about Glucosamine?"

Dr Kart L Aigue is not an orthopod, but had heard about the wonders of glucosamine from middle-aged friends. I knew not even an orthopod with a large mortgage would recommend a knee replacement for someone with the age of Kart L Aigue. So what should I recommend?

Glucosamine is one of the most commonly used complementary medicines. A study of over 260,000 Australians aged above 45 revealed that more than 58,000 (22 per cent) had used glucosamine in the preceding four weeks.

Unless you are a paediatric or ENT surgeon, this is a significant number with potential implications for your surgical practice. Do you routinely ask your patients about whether they take glucosamine or other complementary medicines?

Glucosamine use is higher in females, the well-educated and better-off, as well as holders of private health insurance. Fortunately adverse effects are uncommon and minor other than shell-fish allergy or potential interaction with warfarin. But back to the question posed by Dr Kart L Aigue.

Glucosamine is an amino sugar required in the synthesis of glycosylated proteins and lipids, a constituent of extracellular matrix molecules such as glycosaminoglycans, glycolipids and glycoproteins. It is present in articular cartilage, intravertebral discs and synovial fluid.

> *"Glucosamine is an amino sugar required in the synthesis of glycosylated proteins and lipids ... it is present in articular cartilage, intravertebral discs and synovial fluid."*

There are two salts commonly available, given in an oral dose of 1500mg per day – glucosamine sulphate and glucosamine hydrochloride. Chondroitin sulphate is often given in combination. Glucosamine is extracted from the chitosan and chitin exoskeleton of crustaceans, hence the risk of shell fish allergy.

Glucosamine sulphate has been approved for the treatment of osteoarthritis (OA) in Europe (European League against Rheumatism - EULAR). The Osteoarthritis Research Society International (OARSI) recommends it may have symptomatic benefit, but to discontinue after six months if there is no response. It is available over the counter in the US, Australia and NZ. The UK National Institute for Health and Clinical Excellence (NICE) does not recommend glucosamine for the treatment of OA.

The evidence from meta-analyses of randomised controlled trials is better for glucosamine sulphate than glucosamine hydrochloride. The effects are small (0.3) but probably real, at least for responders. The Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) has been used to assess outcomes in relation to pain and function.

Other trials reported in leading journals also reported on joint space narrowing, again with glucosamine inclined to be better than placebo at preserving joint space. Most trials have shown a significant ratio of non-responders.

The three main tissues affected in OA are articular cartilage, subcondral bone and synovial membrane. In vitro studies suggesting benefit have been conducted using high doses, not likely to be achieved with oral dosing, to elucidate mechanisms of action. Glucosamine inhibits NF-signalling and reduces inflammation mediated by IL-1 in chondrocytes. Some in vivo models have shown the efficacy for glucosamine salts or with added chondroitin sulphate.

So Dr Kart L Aigue could give it a try. It is unlikely to do any harm. Clinical trials while less convinced by the size of its effect, and though somewhat heterogeneous in their outcomes, do show that glucosamine sulphate is at least as efficacious as analgesics and non-steroidal anti-inflammatories, but without their many side-effects [remember when we used to prescribe cox 2 inhibitors?].

Now glucosamine seems worth consideration, if only to avoid NSAID's. Will Dr Kart L Aigue respond?

I suggested a trial of six months, but no longer without benefit. Maybe that will buy some time whilst awaiting articulation on the stem cell front.

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REVALIDATION
THE UK EXPERIENCE

Why and how 'Revalidation' was introduced in the UK will help inform the discussion about what it might mean here

> *We all have strengths and weaknesses and this is a good way of identifying them*

WITH **KAREN MURPHY**

The Chair of the General Medical Council (GMC) of the UK, Professor Sir Peter Rubin, is to visit Australia in March to explain the workings of the new revalidation process now required for all medical professionals introduced in the wake of medical scandals that shocked the nation.

Professor Rubin will be a keynote speaker at the Revalidation 2014 Conjoint Medical Education Seminar to be held in Melbourne on March 14.

The seminar has been designed to attract senior clinicians, health educators, policy advisors and regulators of medical specialist education to advance discussions initiated by the Medical Board of Australia and the NZ Medical Council into possible changes to local revalidation and recertification programs.

Talking to *Surgical News* prior to his visit, Professor Rubin said the changes in Britain had, in particular, resulted from the largest ever inquiry into the National Health Service (NHS) which was sparked by the Bristol Royal Infirmary children's heart surgery scandal of the 1990s.

Working through almost 900,000 pieces of evidence spanning a ten year period, the inquiry found that between 30 and 35 babies died unnecessarily between 1990 and 1995 with another 170 babies who might have lived had they been treated in another hospital.

It found the cause of the high mortality rates to be staff shortages, a lack of leadership, poor skills in those working in the cardiac unit, an "old boy's culture" among doctors that led to secrecy about doctors' performances and inadequate regulation.

Professor Rubin said since the enquiry, the law in Britain had changed in 2012 to require all medical professionals to meet:

- Annual Continuing Professional Development (CPD) requirements
- Annual appraisal;
- A one-in-five year cycle of anonymous "360-degree feedback" from colleagues, nursing staff and patients.

He said that with 250,000 doctors now on the GMC books, the GMC had decided to introduce the new five-year feedback requirements in tranches so that by 2016 all doctors will have met revalidation requirements.

"There were so many distressing aspects to the Bristol case – even aside from the unnecessary deaths of the babies – one of which was that so many people knew what was happening and why it was happening and chose to look the other way," Professor Rubin said.

"Then, the lone doctor who did come forward was profoundly ostracised by his colleagues and other cases came to light where it was found that other doctors knew of misconduct or negligence in other facilities and also kept silent.

"These cases made it abundantly clear to the GMC that professional self-regulation was not working and must be changed."

Professor Rubin, an Internal Medical Physician and Clinical Pharmacologist specialising in the medical disorders of pregnancy and a Fellow of the Royal College of Physicians of London, said he was the first to revalidate after the changes were passed into law.

He said that while most doctors were already doing CPD and many were having annual appraisals, the "360 degree feedback" would be new to the majority of doctors and that while it took some organising it had been extensively piloted and was a very useful tool in identifying both strengths and weaknesses.

He said that in a typical 360 feedback, the doctor would choose some of the respondents while their clinical line manager would choose others. The key was to have a sufficiently large number for the feedback to be anonymous.

"Each doctor, after the feedback process, receives a general report of the views and opinions expressed, but without identification of where they have come from," Professor Rubin said.

"We all have strengths and weaknesses and this is a good way of identifying them.

"We believe that despite any discomfort such feedback might cause, it also provides an opportunity for all doctors to reflect on what they do well and those aspects of their professional life that could be improved such as communication, leadership and team skills through a non-confrontational process."

Professor Rubin said that since the revalidation process was introduced in December 2012, just over 31,000 doctors had now been revalidated with 1.5 per cent of doctors having their revalidation recommendation deferred while local investigations took place over concerns about their fitness to practice.

Professor Rubin said that the number of deferrals suggested that the new system was working and that he would be promoting it during his presentation in Melbourne.

"I am sure that most doctors in Australia and New Zealand are very good, but every country has a medical scandal at some stage and anything we can do as a profession to avoid them and protect the public should and must be done," he said.

"All of us now live in a society that is dramatically different even from that of a generation ago, a society that is very transparent, very open and the time has passed when the public will accept doctors refusing to prove that they are up-to-date and fit to practice.

"The new system in Britain is designed to pick up both ends of the spectrum, from doctors who simply do not have the skills required, to doctors who were once good but who have allowed themselves to become deskilled.

"We owe it as a profession to the public to identify such doctors and act as swiftly as possible to minimise harm."

Professor Rubin said that while there had been some hesitation and hostility towards the introduction of the new requirements by some doctors, the system was now rolling out quite smoothly across the country.

"We can be a strange group, us doctors," he laughed.

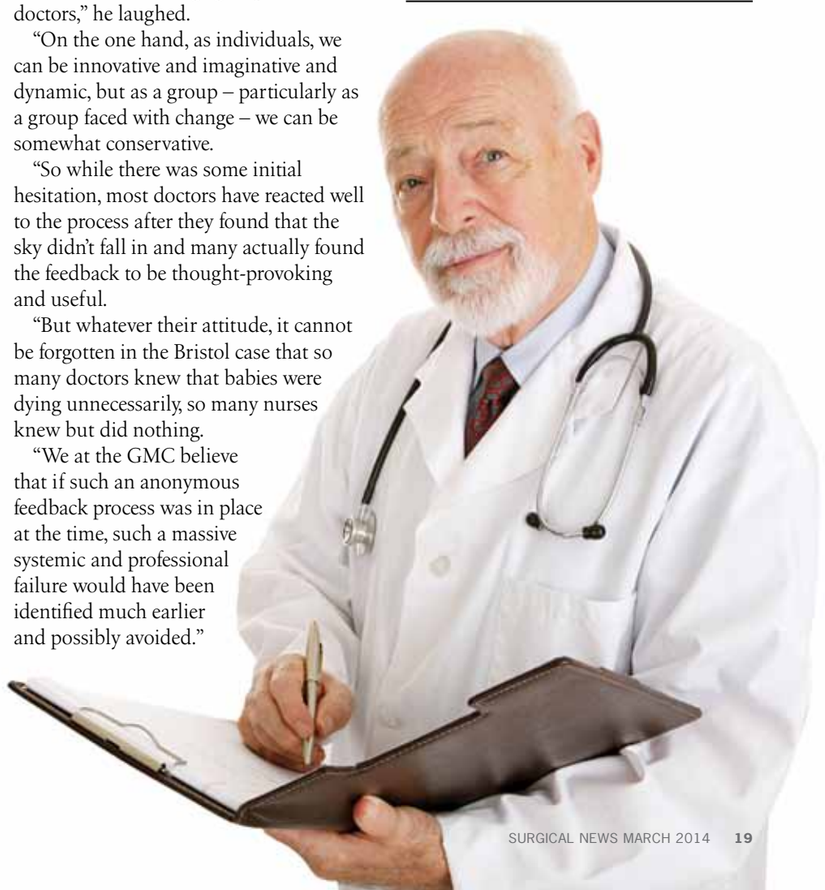
"On the one hand, as individuals, we can be innovative and imaginative and dynamic, but as a group – particularly as a group faced with change – we can be somewhat conservative.

"So while there was some initial hesitation, most doctors have reacted well to the process after they found that the sky didn't fall in and many actually found the feedback to be thought-provoking and useful.

"But whatever their attitude, it cannot be forgotten in the Bristol case that so many doctors knew that babies were dying unnecessarily, so many nurses knew but did nothing.

"We at the GMC believe that if such an anonymous feedback process was in place at the time, such a massive systemic and professional failure would have been identified much earlier and possibly avoided."

More than 200 participants are expected to attend the Revalidation 2014 Conjoint Seminar to be held at Hilton On The Park in Melbourne with delegates from the RACS, the Royal Australasian College of Physicians, the Royal College of Physicians and Surgeons Canada, other medical colleges, medical and health associations and councils expected to attend.



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More than $1.2 million on offer!

TRAVEL AND RESEARCH SCHOLARSHIP OPPORTUNITIES FOR 2015

The Board of Surgical Research invites Fellows, Trainees and other eligible applicants to apply for the following Scholarships, Fellowships and Grants for 2015.

PLEASE NOTE:

- **The availability of the advertised scholarships and fellowships is subject to funding.**
- **Successful applicants will be required to procure 25% of the value of the scholarship from their research department for applicable research scholarships and fellowships.**
- **These advertised opportunities are to be used as an initial guide only. Please consult the College website (www.surgeons.org/scholarships) from 3 March 2014 for detailed information, including relevant application forms and award conditions. Ensure that you read the Important General Information Section for general conditions before applying.**
- **Applications for these scholarships and fellowships must be received by midnight CST 28 April 2014**
- **Where applications are open to all SET Trainees, applicants to surgical training are also eligible to apply in anticipation of their acceptance into the SET Program. They must be accepted into the SET Program by 1 August in the year prior to the commencement of the scholarship in order to take up the award.**
- **The values of these scholarships are in $AUD unless otherwise stated.**

Research Scholarships and Fellowships - Foundation for Surgery Funded

Foundation for Surgery Senior Lecturer Fellowship ***NEW***

The College Research and Scholarships Department is pleased to advise that a new Fellowship has been developed and is now on offer for the first time. The Foundation for Surgery Senior Lecturer Fellowship is intended to provide salary support for a surgeon, early in their career, to assist them to establish themselves in an academic surgery pathway. Applications are open to Fellows of the College who are permanent residents or citizens of Australia or New Zealand. The emphasis of the Fellowship is to be clearly focused on research and/or educational activities. Funding will be provided to individual applicants who will be employed by an academic department which has agreed to match the funding provided by the College. Gross value of this Fellowship is **$132,000.** Tenure is for up to three years.

Surgeon Scientist Scholarship

Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. Gross value **$77,000** comprising **$65,000** stipend plus **$12,000** departmental maintenance. Tenure is for up to 3.5 years.

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This scholarship was established by Harry Bolton in memory of his late son, Paul. Professor Paul Bolton was a distinguished surgeon, teacher and researcher who died from colorectal cancer in 1978, aged 39. The applicant's research topic must focus on the prevention, causes, effects treatment and/or care of cancer.

Please note that from time to time new scholarships may be offered during the year and advertised on the College Website, in Surgical News and other relevant publications.

Research Scholarships and Fellowships - Foundation for Surgery Funded ... *continued*

Foundation for Surgery New Zealand Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Applicants must be a New Zealand citizen currently residing in New Zealand. Gross value **$66,000**, comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery John Loewenthal Research Scholarship
Foundation for Surgery Research Scholarship
Foundation for Surgery Catherine Marie Enright Kelly Scholarship
Foundation for Surgery Reg Worcester Research Scholarship
Foundation for Surgery ANZ Journal of Surgery Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value **$66,000**, comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery Peter King Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree with the topic relevant to the practice of surgery outside of metropolitan areas. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery Research Scholarship in Surgical Ethics
Open to Fellows, SET Trainees and members of the public with a special interest in ethical issues of modern surgery. Lay applicants must be sponsored by a Fellow of the College. Applicants must be enrolled in or intending to enrol in a higher degree with a topic relevant to ethical problems confronting surgery. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

Foundation for Surgery Louis Waller Medico-Legal Scholarship
Open to Fellows, SET Trainees and Law Graduates. Applicants must be undertaking, or intending to undertake, doctoral research on the topic of medico-legal risks and the law in this area. Lay applicants must be sponsored by a Fellow of the College. Gross value **$66,000** per annum, comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for up to 3.5 years.

Fellowship in Surgical Education
The Royal Australasian College of Surgeons and Queen's University, Kingston, Ontario, Canada, are offering a joint Fellowship to fund Fellows and SET Trainees wishing to undertake a Masters in Surgical Education at the Faculty of Health Sciences, Queen's University, Canada. The successful applicant will exclusively pursue the educational activities involved in the Master's program. The Fellowship is for a period of up to two years subject to satisfactory performance. It is valued at **AU$70,000** stipend per annum with the Queen's University providing funding for tuition and related expenses.

Research Scholarships and Fellowships - Bequest, Donation and Sponsor Funded

John Mitchell Crouch Fellowship
The John Mitchell Crouch Fellowship of **$150,000** is awarded to an individual, who in the opinion of the Council, is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area.
The Fellowship commemorates the memory of John Mitchell Crouch, a Fellow of the College who died in 1977 at the age of 36. The Council of the Royal Australasian College of Surgeons invites applications or nominations for the above Fellowship.
Applicants must meet the following criteria:

- The applicant must be working actively in his/her field.
- The award must be used to assist continuation of this work.
- The applicant must be a Fellow of the Royal Australasian College of Surgeons who is a resident of Australia or New Zealand.
- Applicants must have obtained their College Fellowship or comparable overseas qualification within the past 15 years (1999 or later)
- The successful applicant is expected to attend the convocation ceremony at the 2015 Annual Scientific Congress (ASC) of the College for a formal presentation. The Fellowship recipient must be prepared to make a 20-25 minute oral presentation at the ASC on their research work including the contribution arising from the award.
- The successful applicant is to produce a report in the format required at the end of their Fellowship for inclusion in the John Mitchell Crouch book, which is published approximately every five years.

There is no formal application form. A new application must be made for each year of application. Applications must include the following:

- A brief statement about current research work and future plans.
- Detailed curriculum vitae, including a list of publications. Included must be a list of what they consider to be their five most important publications as well as the five most important national or international lectures they have been invited to deliver.
- Important publications must also state impact factors and the impact range for their sub-speciality.

Paul Mackay Bolton Scholarship for Cancer Research
This scholarship was established by Harry Bolton in memory of his late son, Paul. Professor Paul Bolton was a distinguished surgeon, teacher and researcher who died from colorectal cancer in 1978, aged 39. The applicant's research topic must focus on the prevention, causes, effects treatment and/or care of cancer. Applicants must be currently working in Queensland or Tasmania. Young researchers, who are relatively early in their careers and show promise, may be given preference over more senior established researchers. Preference may also be given to projects which are likely to have clinical relevance within a relatively short period of time, as well as to applicants who are enrolled in or intend to enrol in a higher degree. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

Sir Roy McCaughey Surgical Research Scholarship
This fellowship was established as a result of a bequest to the College from the late Sir Roy McCaughey. Open to Fellows and SET Trainees enrolled in or intending to enrol in a PhD. The research must be conducted in NSW. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance. Tenure is for up to 3.5 years.

Foundation for Surgery Richard Jepson Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. The gross value will be **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance, with a tenure for up to 3.5 years.

Scholarship Program Coordinator, Royal Australasian College of Surgeons,
199 Ward Street, North Adelaide SA 5006.
Tel: +61 8 8219 0900; Fax: +61 8 8219 0999;
Email: scholarships@surgeons.org .
Applications close midnight CST Monday 28 April 2014.

More than $1.2 million on offer!

MAIC-RACS Trauma Scholarship
Previosly the CONROD-RACS Trauma Scholarship
A grant from the Motor Accident Insurance Commission (MAIC) matched by Foundation for Surgery funds has enabled the College to offer annual funding for research into trauma to the amount of **$66,000.** This 12 month Scholarship is open to Fellows and SET Trainees. Proposed research may be in any of the following areas: epidemiology, prevention, protection, rehabilitation and immediate or definitive management in trauma. A single Scholarship of up to **$66,000** will normally be awarded, but more than one Scholarship may be made to a total of **$66,000** in any one year. The Scholarship may be used for either or both salaries and expenses. It is not a requirement that the research be conducted in Queensland, but it must be shown that the potential benefits flowing from the research will assist the people of Queensland.

Eric Bishop Research Scholarship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

Francis & Phyllis Thornell-Shore Fellowship
Open to Fellows and SET Trainees enrolled in, or intending to enrol in, a higher degree. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

WG Norman Research Fellowship
Open to Fellows and SET Trainees, enrolled in, or intending to enrol in a higher degree. Applicants must be resident in South Australia, with their research being conducted in South Australia and the topic should have a trauma focus. Gross value **$66,000,** comprising **$60,000** stipend plus **$6,000** departmental maintenance with a 12 month tenure.

Brendan Dooley and Gordon Trinca Trauma Research Scholarship
Open to Fellows, SET Trainees and Medical Scientists who are conducting a research topic relating to the prevention and treatment of trauma injuries in Australia and New Zealand. This scholarship offers a stipend of **$10,000** with a 12 month tenure.

Lumley Surgical Research Scholarship
The funding for the Lumley Surgical Research Fellowship incorporates the Edward Lumley Fellowship Fund and is supported by the Henry Lumley Charitable Trust. This scholarship is designed to enable a Trainee of the College or Fellow to spend a year undertaking research in the United Kingdom. The Fellowship is valued at **$66,000** plus a return economy airfare up to the value of **$3,000.** The Fellowship is for 12 months.

Travel Scholarships, Fellowships and Grants – Bequest and Donation Funded

Stuart Morson Scholarship in Neurosurgery
The Stuart Morson Scholarship in Neurosurgery has been established following a generous donation by Mrs Elisabeth Morson in memory of her late husband. The Scholarship is designed to assist young neurosurgeons within five years of obtaining their Fellowship of the College (2009 or later) or neurosurgical Trainees to spend time overseas furthering their neurosurgical studies by undertaking research or further training. The Scholarship is also open to exceptional young surgeons who are registered to practice neurosurgery in Australia or New Zealand, but are not Fellows of the College. From time to time, the Scholarship may also be applied to assist overseas surgeons to spend time in Australia or New Zealand to further their training and/or research in neurosurgery. Overseas applicants cannot have commenced travel prior to applying for the scholarship. The value of the Scholarship is **$30,000** and is intended to assist the recipient to meet the costs of undertaking further training and/or research work in neurosurgery. This scholarship is for six months, with minimum program duration of three months.

Murray and Unity Pheils Travel Scholarship
The Murray and Unity Pheils Travel Scholarship was established following a generous donation made by the late Professor Murray Pheils. It has a value of **$10,000** and is awarded to a SET Trainee or recent Fellow of the College to assist him/her to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates wishing to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply. Applicants must not have commenced their travels prior to the closing date for applications. The Scholarship is for up to 12 months.

Hugh Johnston Travel Grant
The Hugh Johnston Travel Grant arose from a bequest of the late Eugenie Johnston in memory of her late husband, Hugh Johnston. This Grant for **$10,000** is designed to assist needy and deserving Fellows and Trainees of the College to gain specialist training overseas. Applicants must not have commenced their travels prior to the closing date for applications.

Hugh Johnston ANZ ACS Travelling Fellowship
The Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship has been established to support an Australian or New Zealand Fellow of the College to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2015, which is to be held in Washington DC, USA. It forms part of a bi-lateral exchange with the ACS and is open to Fellows who have gained their College Fellowship in the past 10 years (2004 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America. While there, they must:

> Attend and participate in the American College of Surgeons Annual Clinical Congress in 2015
> Participate in the formal convocation ceremony of that congress
> Visit at least two medical centres in North America before or after the Annual Clinical Congress to lecture and to share clinical and scientific expertise with the local surgeons.

Applicants must not have commenced their travels prior to the closing date for applications. This Fellowship is valued at **$8,000.** More information about the ACS can be found at www.facs.org

John Buckingham Travelling Scholarship
This scholarship has been established to encourage international exchange of information concerning surgical science, practice and education, as well as to establish professional and academic collaborations and friendships amongst Trainees. It is open to current SET Trainees to enable them to attend the annual American College of Surgeons (ACS) Clinical Congress. This year we have two John Buckingham Travelling Scholarships on offer. One being to attend the Congress being held in San Francisco, California, USA, on 26-30 October 2014, and the second to travel to Chicago, Illinois, USA, on 4-8 October 2015. This scholarship is valued at **$4,000**.

Margorie Hooper Travel Scholarship
The Margorie Hooper Travel Scholarship has been made possible through a bequest from the late Margorie Hooper of South Australia. The Scholarship is open to Trainees and Fellows of the College who reside in South Australia. The Scholarship is designed to enable the recipient to undertake postgraduate studies outside the State of South Australia, either elsewhere in Australia or overseas. It is also available for surgeons to travel overseas to learn a new surgical skill for the benefit of the surgical community of South Australia. Preference will be given to the latter. This scholarship is for 12 months. The stipend is **$65,000** and there is provision for accommodation and travel expenses upon application.

Morgan Travelling Fellowship
The Morgan Travelling Scholarship was established to fund a Fellow of the College to travel overseas to gain clinical experience or to conduct research for a period of approximately one year. To be eligible, the surgeon must have gained his/her Fellowship in the past five years (2009 or later). The scholarship is open to a Fellow from any specialty. The scholarship must be the only College funding secured by the Fellow, but the candidate is permitted to obtain alternative external funding concurrent with the Morgan Travelling Scholarship. The value of the scholarship is **$10,000**, and the duration is for up to 12 months. Applicants must not have commenced travels prior to closing date for applications.

Ian and Ruth Gough Surgical Education Scholarship
The Ian and Ruth Gough Surgical Education Scholarship, valued at **$10,000,** was established by Ian and Ruth Gough to encourage surgeons to become expert surgical educators. Applicants must be Fellows or Trainees of the College, with permanent residency of Australia or New Zealand. Tenure is for one year.

Scholarship Program Coordinator, Royal Australasian College of Surgeons,
199 Ward Street, North Adelaide SA 5006.
Tel: +61 8 8219 0900; Fax: +61 8 8219 0999;
Email: scholarships@surgeons.org .
Applications close midnight CST Monday 28 April 2014.

CLINICAL DECISION-MAKING

A new course and on-line learning resource

Sound and efficient decision-making are hallmarks of an expert surgeon. Unfortunately, those experts are often unable to explain their thinking processes, or to teach their Trainees and colleagues how they do it. Surgeons and staff of the Royal Australasian College of Surgeons worked together to develop a model to explain the processes around clinical decision making, and used this understanding and knowledge to devise a Clinical Decision Making (CDM) training course.

How did it come about?

The College recognised the need to provide International Medical Graduates (IMGs), Trainees, supervisors and other interested parties with more detailed information around the decision-making process in the clinical setting.
In conjunction with the Royal Australasian College of Physicians and the Royal College of Physicians and Surgeons of Canada, the CDM resource has been developed as a way to help participants understand the conscious and subconscious techniques employed to make clinical decisions, as well as outlining the stages of the clinical decision-making process.

Who is it for?

This resource, to be completed ahead of the face-to-face component of the course, is suitable for IMGs, Trainees, supervisors and anyone who wishes to educate themselves and others about the process of making clinical decisions.

What does it cover?

The online CDM resource consists of four modules, ideally worked through sequentially, and should take around two hours to complete. These modules should be completed approximately two weeks ahead of the face-to-face component of the CDM course, so that the lecture time can be decreased and the discussion time increased.

Why teach CDM?

CDM is one of the College's nine competencies, and is one of the main components assessed in the Fellowship Examination. However, because an experienced surgeon rapidly processes their thoughts, this type of thinking is frequently not available for others to understand or learn from.
This section provides a brief overview of the model used to make CDM explicit, the ways decisions are made (consciously and subconsciously) and some of the challenges involved in teaching CDM.

A model for teaching and learning CDM

- Provides some background on the development of this model, those involved and the four identified stages of the CDM process.

Stage 1: The initial encounter

- Examines the thinking processes during the initial encounter with the patient and/or their clinical data, breaking it down into the various stages of patient treatment and management, with an opportunity for reflection at the end of the session.

Stage 2: Pre-operative

- Looks at the different thinking processes, anticipation and preparation, employed ahead of performing a procedure, particularly in relation to the level of experience and familiarity with performing that specific procedure.
- Participants are encouraged to reflect upon treatment of a recent patient in the context of the session content.

Stage 3: Intra-operative

- Considers the components and stages of thinking processes experienced during performance of a procedure.
- Provides an opportunity for reflection of content in the context of a participant's own intra-operative experiences.

Stage 4: Post-operative

- Explores the thinking processes, drilling-down to some of the specific components, that can happen after a procedure has been performed, as well as considering the procedure from different perspectives (the patient, the practitioner and the team).

How does it help me?

This resource provides participants with a better understanding of the CDM processes, ways in which to apply these to daily practise, and a method for successfully teaching CDM skills to others.

What are the benefits?

There are many benefits to accessing this resource, such as:

- increased familiarity with the stages of clinical decision-making, as well as the ways in which practitioners make decisions;
- an overview of how the four stages of clinical decision-making can be applied when working as a procedure;
- the benefits of reviewing clinical decisions from the perspective of the patient, the practitioner and the team;
- better understanding of clinical decision-making and how to apply this to daily practise;
- an understanding of how to teach clinical decision-making processes to others.

How do I access it?

The CDM resource can be accessed through the College's website by those who have registered to attend the CDM face-to-face course. Should there be difficulty accessing it, please contact help.desk@surgeons.org for assistance.

How can I find more information?

Visit the Professional Development page on the College's website

What are the journal articles on the College's model of CDM?

Clinical decision making: how surgeons do it, was published in 'The ANZ Journal of Surgery', Vol. 83: 6, 2013. Diagnostic conversations: Clinical Decision Making in surgery – Part 1 is published in a new online journal, 'Diagnosis', Volume 1: 1, 2014, edited by Mark Graber

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PAUL CASHIN
MBBS, FRACS

One of the great frustrations and criticisms that we, as surgeons, have levelled at Government, both State and Federal, is the lack of discussion and consultation with regards to significant Public Health policy making and implementation as it affects us. This has been a gripe over many years.

With this in mind the Victorian Regional Committee, recognising this deficiency, and having heard the complaints, has undertaken to meet with Health Department senior officials and the Victorian Health Minister to discuss many of these issues.

This accelerated in 2012 with meetings to discuss waiting list strategies and get a bilateral understanding of the pressures affecting both groups. The key factor was the bilateral, non-threatening nature of the discussions, as I think there were genuine concerns from the Department that the discussions may be too adversarial.

After these initial discussions, meetings with the Health Minister were organised with the Victorian Regional Committee (VRC) Executive and various Fellows with specific issues to discuss and present to the Minister. These meetings took place every two to three months and were ably led by Regional Committee Chair Mr Robert Stunden who has developed a very constructive working relationship with the Department.

Issues presented to the Minister included regionalisation and organisation of cancer service delivery and surgery, the pressures of case load and auditable outcomes for cancer surgery, the 'four hour rule', transition of paediatric to adult Urology services, the issues around the public Bariatric surgery waiting list to name but a few.

The Health Minister, assisted by his senior advisors, clearly demonstrated an intimate understanding of the issues around surgical service delivery in Victoria, which for some of us political cynics, was pleasantly and surprisingly encouraging.

With some robust discussion around these issues, the Minister was frankly honest about the organisational and financial pressures facing the Victorian State Government and also very open to the discussion of new ideas from those of us practicing at the surgical coal face.

Further to these meetings, as part of the Victorian ASM in Ballarat last year, the Directors of Surgery from each of the city and country major hospitals met at Sovereign Hill for a pleasant evening of discussion. Topics included the problems with rural workforce, partnerships between city and regional hospitals, regionalisation of services and the important increasing role of regional surgery. Although Health Department representatives were meant to attend, they were unable to make it but robust discussion occurred and gave a framework for further presentations to the Minister

The spin-off associated with these meetings has been the establishment of an unprecedented level of communication, leading to the Victorian Regional Committee being contacted now, at regular intervals, by the Minister and Department, for advice and opinion with regard to the issues facing them.

While the opinions given may not necessarily be what they wanted to hear, the relationship and respect between the two groups has led to a very open working relationship.

The plan on both sides is to continue these meetings in 2014 and beyond with various presentations on topics of concern to many areas of surgery. This greater level of understanding and communication, supported bilaterally, can really serve as a template for future governments, in all areas of the country, and was a real highlight of 2013 for the Victorian Regional Committee.

CASE NOTE REVIEW

Colonoscopic perforation – inappropriate delegation results in misdiagnosis and delay

GUY MADDERN
CHAIR ANZASM

An elderly patient underwent a colonoscopy for new onset bloody diarrhoea; Crohn's colitis was diagnosed. Patient was subsequently reviewed by the admitting consultant physician (not the endoscopist) because of distension and pain. An erect abdominal x-ray (AXR) was ordered; the AXR was reviewed by a medical officer (non-radiologist) who advised the consultant there was no free air under the diaphragm. When reviewed the next day, the patient was not unwell, but was 'not right'. The notes suggested that the medical staff were reassured because the measurement of the abdominal girth had remained unchanged.

Shortly thereafter, the radiologist's formal report on the AXR noted that the x-ray showed air under the diaphragm. The patient was transferred to another hospital where a repeat AXR and chest x-ray (CXR) were performed, showing air in the peritoneal cavity. A laparotomy was commenced and a subtotal colectomy and ileostomy were undertaken by an unsupervised senior Trainee. The patient had a difficult postoperative course and died from sepsis, several days later. The death was reported to the Coroner, but not investigated further.

Assessor's comments

The cause of death was possibly a colonic perforation. This is a recognised complication of colonoscopy and was probably not preventable. The critical event was the misdiagnosis of the AXR and the resultant delay in dealing with the perforation, which could be classified as an adverse event and preventable.

It would seem that the initial AXR was interpreted incorrectly. Air under the diaphragm can be subtle; had the original AXR been interpreted correctly, the surgery would have been 12-15 hours after the colonoscopy and the outcome may have been different.

Hospitals and surgeons should be mindful of the need for appropriate x-ray review after-hours and should perhaps consider the use of picture archiving and communications systems (PACS) to have films reviewed by an off-site radiologist.

The delay in diagnosis may have been compounded by a several hour delay after transfer. Abdominal girth measurements were shown in several studies over 30 years ago to be inadequate at diagnosing colonic perforation as they are not reproducible.

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HEALTH COSTS

DAVID CLOSE
FRACS (OLHNS)

We are bombarded with reports that the cost of health care in Australia is increasing at an unsustainable rate. Modelling by Deloitte Access Economics suggests that in 2050, health and aged care costs will consume 45.8 per cent of total Commonwealth spending, up from 27.9 per cent in 2010.

As surgeons we drive a proportion of this expense by requiring and indeed demanding that our hospitals provide the latest in expensive equipment. When I commenced surgery in 1980, surgeons had to provide their own instruments and disposable items in private hospitals – including operating microscopes! Anaesthetists provided their own drugs. Not surprisingly this was an effective method of constraining theatre costs!

Since that time the complexity and extent of instrumentation has increased dramatically, particularly with the advent of endoscopic procedures. But observation suggests that no-one in an operating theatre, surgeon included, has a good knowledge of the cost of the items involved in each procedure.

The surgical instrument and equipment makers have a vested interest in manufacturing, promoting and selling as many expensive items as they can convince us to use. Their legitimate aim is to make money for their shareholders. And the profit is much greater if the item is single-use only.

In my own field of ENT I used a harmonic scalpel for many years for dissecting tonsils. This was a wonderful instrument with a handle and fixed blade, resterilised and used hundreds of times. But when the control unit suffered a minor problem the company refused to repair it, declaring that it was obsolete and had been replaced by a unit requiring a single-use blade that costs several hundred dollars. Regretfully I returned to "cold steel" dissection.

Our fees are not a significant factor in the published figures, although perhaps in the minds of patients. Some extreme fees may be hard to justify, but the MBS fees, on which the private funds base their payments, have had average increases of only 2 per cent per year over the last seven years.

According to the AMA, MBS fees have increased by about 70 per cent since 1985 whereas CPI has increased by over 300 per cent and AWE by about 250 per cent. The AMA-recommended fees have increased by about 280 per cent. And the Labor Government deferred the November 2013 indexation increase until July 2014! Many of us also offer at least some fee reduction to card-holders, including the ever-increasing proportion of pensioners.

In comparison, the private funds are being granted yearly increases of about 6 per cent per annum which are clearly justified. The Centre for Independent Studies reports that health costs have risen by an average 7.75 per cent a year for the past decade.

Do we surgeons and our body, the RACS, have a responsibility to take an active part in trying to reduce the apparently unsustainable upward trend of treatment costs? Can we continue to ask for and use ever more expensive equipment as we move into the age of image-guidance and robotic surgery, applauding the technological advances while expecting taxpayers and private fund members to pay for it all?

Perusal of recent copies of 'Surgical News' reveals very little, if any, mention of the cost of surgery to the Australian nation. Is this realistic? In the light of the Australian health cost explosion and its effects on surgical practice can the College really expect to hold itself above involvement in politics and economics?

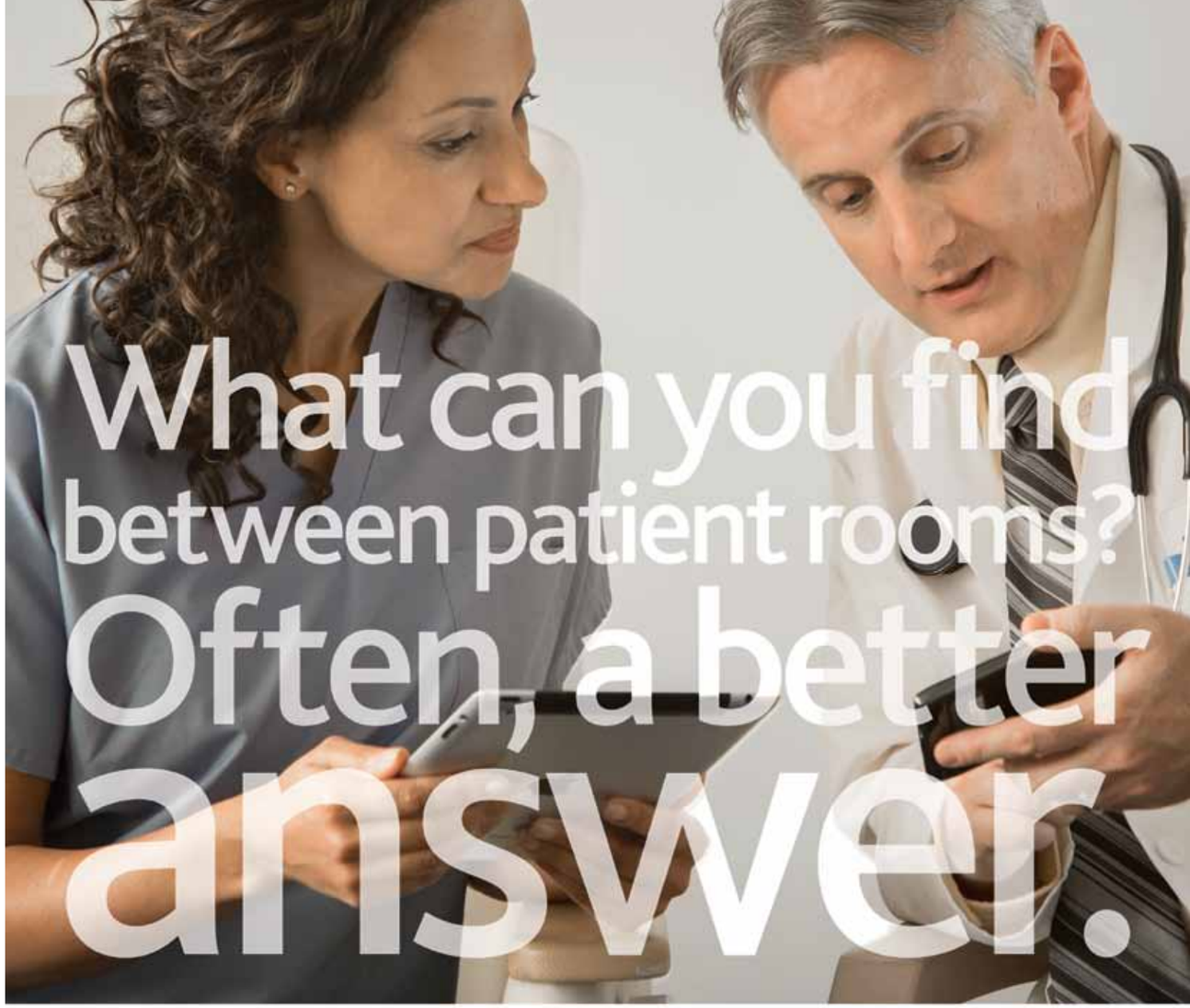
It seems that we are at the mercy of the big surgical companies whose aim is to make us spend more on their products. Their sponsorship has become essential to our courses and meetings. But we have the power of being the end-users.

Perhaps in every operating theatre there could be a whiteboard on which the cost of each piece of equipment is entered. The College website could include a site where surgical companies are obliged to enter the costs of their equipment, with members encouraged to add their comments. Coordination with the other Colleges could be considered. There are undoubtedly many possible initiatives. Fellows could be asked to make suggestions. Research scholarships on surgical economics could be encouraged and funded. Our meetings could include appropriate segments and forums.

If we surgeons do not commit to involvement in cost containment, the escalating demands of health care on state and national budgets will result in practice limitations by private funds and Government.

Medibank Private is already contracting specialists to treat Defence Force members at reduced fees, and one wonders whether their contracting of GP clinics will result in similar referral restrictions. There will also be increasing and irresistible pressure on the availability and standards of public hospital care.

Comments welcome: editor@surgeons.org



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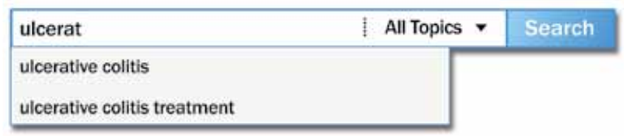

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HOW TO AVOID DISCRIMINATION CLAIMS

Doctors are both employers and service providers, and anti-discrimination laws will apply

MICHAEL GORTON
COLLEGE SOLICITOR

Doctors and health professionals can face discrimination claims, both in relation to those they employ, as well as the patients they treat. Doctors are both employers and service providers, and anti-discrimination laws will apply.

Discrimination can occur through treating a person less favourably because of their race, gender, disability, sexuality, etc. Discrimination can also indirectly occur where a requirement is imposed, or a condition is in place in the way that treatment occurs, that affects a higher proportion of people of a particular race, religion, gender, etc. than others.

It would be presumably rare that any doctor or health professional would refuse to treat a patient, or treat them differently, simply because of their race, religion, gender or other attribute. Most people understand their legal obligations in this regard. We like to assume that at the heart of every medical practice is a willingness and compassion to treat all people, regardless of their background.

The attributes to which anti-discrimination legislation applies include:

- age
- sexuality
- physical features
- sex or gender
- race or religion
- impairment or disability
- political or religious belief
- marital or parental status
- pregnancy

In seeking to avoid discrimination in relation to patients, doctors should be aware of issues such as:

- Cultural and religious requirements of particular clients;
- Ensure that a refusal to treat a patient is not on the basis of gender, race, religion or other attributes;
- Be sensitive to issues of treatment in relation to issues of sexuality, particularly where HIV/AIDS or Hep C patients may be involved;
- Patients with a disability may require special assistance in order to receive treatment (obviously premises should be accessible by those with a disability);
- For some patients, English will not be their first language, and the offer of translation services may be necessary in order to properly assess patients and explain diagnoses;
- Be aware of cultural issues of some groups in relation to privacy and confidentiality, sensitivity for male doctors in touching female patients, and for some, touching the head in some cultures.

It is generally recognised that being more culturally aware will make you a better doctor, attract more patients, and avoid unnecessary misunderstandings or claims. Australia and New Zealand embrace a multi-cultural community, and awareness of these issues will greatly improve your ability to offer high levels of service to your patients.

Medical Colleges have policies and Codes of Conduct in relation to discrimination and harassment. Apart from legal obligations under anti-discrimination law, all doctors are subject to professional obligations (for example, under the Code of Conduct issued by the Medical Board of Australia).

Discrimination can also take place in the work environment. Employers have an obligation not to discriminate against employees. There are also circumstances where employees should not discriminate against other employees. For example, the Medical Journal of Australia has recently noted that over 54 per cent of female Australian general practitioners have experienced sexual harassment from patients, and that they have experienced high levels of harassment and bullying from colleagues.

The best method of avoiding claims of discrimination is to be more aware of these issues, have appropriate policies in your workplace, and understand your legal obligations.

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2013 John Mitchell Crouch FELLOWSHIP

The recipient of the 2013 Fellowship – Professor Russell Gruen FRACS

The John Mitchell Crouch Fellowship is the premier research award of the Royal Australasian College of Surgeons. It is separate from Foundation Grants and independently funded. The Fellowship commemorates an outstanding younger Fellow of the College who died in 1977 on the threshold of a highly promising career. John Mitchell Crouch was a young surgeon who showed astute clinical, organisational and research abilities and this award is made to an individual who, in the opinion of Council, is making an outstanding contribution to the advancement of surgery.

SUE PLEASS
SCHOLARSHIP PROGRAM CO-ORDINATOR RACS

Professor Gruen is a committed surgeon-scientist.

Professor Russell Gruen (pictured left) is a general and trauma surgeon at The Alfred Hospital in Melbourne, Professor of Surgery and Public Health at Monash University, and Director of the National Trauma Research Institute (NTRI).

Under Professor Gruen's leadership, the NTRI has developed research programs to improve care of the injured through more effective treatments, higher quality care, and better trauma systems.

Professor Gruen graduated from the University of Melbourne (1992) and completed a PhD on delivery of surgical services to remote communities in Australia as a RACS Surgeon Scientist and Trainee in general surgery.

In 2002-2003 he was a Harkness Fellow in Health Policy and a Fellow in Medical Ethics at Harvard University, during which time he focused on medical professionalism and the contributions surgeons have made to quality improvement and public health.

After completing a Fellowship in Trauma Surgery and Surgical Critical Care at Harborview Medical Centre in Seattle (2006), Professor Gruen returned as an active clinician and researcher, first at the Royal Melbourne Hospital and University of Melbourne and then, from 2009, at The Alfred Hospital and Monash University. In 2010 he was a James IV Association of Surgeons Traveling Fellow, and in 2011 he became the third surgeon to be awarded an NHMRC Practitioner Fellowship.

Professor Gruen has more than 100 peer-reviewed publications, including many as first author in leading journals such as 'The Lancet', 'JAMA', 'BMJ', 'BJS', and 'Annals of Surgery', with over 1000 citations.

He was Series Editor for a Clinical Series on Trauma Surgery published in 'The Lancet' in September 2012. He has received research funding totalling more than $13 million, leads a Centre for Excellence in Traumatic Brain Injury Research for the Victorian Transport Accident Commission, and a five-year program grant on knowledge translation in traumatic brain injury. He is lead investigator of an NHMRC-funded multicentre trial of pre-hospital tranexamic acid in severely injured patients.

Professor Gruen chairs the Australian Trauma Quality Improvement Program steering committee, co-convenes the Asia Pacific Trauma Quality Improvement Network, and is leading development of a trauma systems knowledge base for the WHO Global Alliance for Care of the Injured. He is a member of the RACS Trauma Committee, the RACS Board of Surgical Research, and is the Australian National Delegate to the International Society of Surgery.

Developing a Career in Academic Surgery

Monday 5 May 2014, 7:00am – 4:00pm

SANDS EXPO AND CONVENTION CENTER
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Provisional Program

7:00am Registration and Breakfast

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

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

9:00am MORNING TEA

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

SESSION 2: CAREER DEVELOPMENT 9:40am - 11:20am
Chairs: Julie Ann Sosa (Durham, USA) and Philip Crowe (Sydney)

9:40am I want to be an academic surgeon. What can I do as a:
Medical Student . . . . . *Arthur Richardson (Sydney)*
Trainee – The pros and cons of fulltime surgical research during training. . . . . *Tarik Sammour (Auckland)*
Fellow . . . . . *Vincent Lam (Sydney)*
Consultant. . . . . *Mark Smithers (Brisbane)*

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

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

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

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

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

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

2:40pm AFTERNOON TEA

SESSION 4: A CAREER IN ACADEMIC SURGERY 3:00pm - 4:00pm
Chairs: Timothy Pawlik (Baltimore, USA) and Frank Frizelle (Christchurch)

3:00pm Choosing and being a mentor . . . . . *Andrew Hill (Auckland)*
3:20pm Work-life balance . . . . . *Julie Howle (Sydney)*
3:40pm On the shoulders of giants . . . . . *Russell Gruen (Melbourne)*

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

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

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

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

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

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

Late last year South Australian Fellows, partners and guests attended an intimate dinner in the Committee Room of the Adelaide Oval for the presentation of the inaugural Sir Henry Newland Award. Recipient Professor Donald Simpson, AO received this Award in recognition for a career-long contribution to the discipline of Surgery and the provision of surgical services to South Australia. The citation given by Professor Nigel Jones, Neurosurgeon, is repeated here in full in recognition of Professor Simpson's contribution.

2013 SIR HENRY NEWLAND AWARD

The citation for the inaugural recipient Professor Donald Simpson, AO

PROFESSOR NIGEL JONES
NEUROSURGEON

I am honoured to present to you Professor Donald Simpson, AO as the inaugural recipient of the Sir Henry Newland Award for services to surgery in South Australia. Some may question the choice of a subspecialist paediatric neurosurgeon for such a general award, but there could be no more appropriate recipient of this honour.

Both Professor Simpson and Sir Henry Newland were Adelaide boys, attending St Peter's College and the University of Adelaide, a half century apart. Both contributed significantly to surgery in South Australia and Sir Henry, though a plastic surgeon, was also described as a pioneer of neurosurgery and was an Honorary Surgeon at the Adelaide Children's Hospital for many years. Professor Simpson also has an international reputation for much more than paediatric neurosurgery.

Professor Simpson went to Oxford in 1951 and, after a period of neuroanatomical research, commenced neurosurgical training in 1953. He completed the FRACS in Adelaide in 1958. He subsequently held clinical appointments at the Royal Adelaide Hospital, the Queen Elizabeth Hospital and the Adelaide Children's Hospital.

At the same time he held a clinical academic appointment at the University of Adelaide, rising to Clinical Professor in 1987. He resigned from his position as Director of Neurosurgery at the Adelaide Children's Hospital in 1985 and concentrated on head injury research as a Senior Research Associate at the NH&MRC Road Accident Research Unit.

During his time with RARU he played a significant role in studying the causation and effects of road accidents and was a strong supporter of the introduction of bicycle helmets, although he has been quoted as saying he has never had occasion to wear one himself.

He continued to take neurotrauma call at the Royal Adelaide Hospital and ran a weekly head injury teaching ward round for the Trainees. His neuroanatomy tutorials, with an emphasis on the limbic system, were a highlight of the training program.

Prof Simpson became well known in the international neurosurgical world for his landmark studies on the recurrence of meningioma after surgery. Indeed the Simpson grading system for surgical resection of meningiomas is still widely used and referenced.

He has also made a significant impact in many other fields.

In 1958 and 1959 he visited New Guinea as a member of the University of Adelaide group investigating kuru and in later years was a member of the NH&MRC working party on Creutzfeld Jacob disease.

In 1960 Professor Simpson and Dr Dinning operated on two children with hydrocephalus, inserting the first shunts in South Australia. Subsequently he was also involved in changed paediatric neurosurgery immensely.

Professor Simpson was a member of the South Australian Craniofacial Unit from its inception in 1975. He has travelled frequently to promote neurosurgery, particularly in Vietnam, and was made an Honorary Member of the Neurosurgical Society of Vietnam in 1997.

He was a founding member of the Neurosurgical Research Foundation and has raised both funds and awareness for neurosurgical research in South Australia. He served as president from 1993 to 2004 during which time the first neurosurgical chair was established at the University of Adelaide with funds from the Neurosurgical Research Foundation.

Professor Simpson has served this College very well. He has been a member of the Court of Examiners and Chairman of the Surgical Board (Neurosurgery), a member of the RACS National Road Trauma Committee, and convener of the Section of History of Surgery and Anaesthesia. He has been on several editorial boards, NH&MRC Working Parties and a member of numerous international societies. He was President of the International Society for Paediatric Neurosurgery in 1985-1986 and Patron of their Sydney meeting last year (2012).

In 1980 Professor Simpson was appointed a Member of the Order of Australia "for services to handicapped children" and this was followed by appointment as an Officer of the Order of Australia in 2004 "for services to medicine in the fields of neurosurgery and neurotrauma as a researcher and academic". He was honoured by the University of Adelaide in 1985 with the degree of D Univ in recognition of his long and meritorious service to the University.

(L-R) South Australian Chair Mr Peter Subramaniam, Professor Donald Simpson AO and College President Associate Professor Mike Hollands. (Opposite L-R) Associate Professor Hollands presents the award to Professor Simpson.

Professor Simpson's expertise extends well beyond neurosurgery and medicine – he is a true polymath. His colleagues in Oxford described him, many years later, as the most typical Oxonian scholar, even though he was Australian.

Wicked sense of humour

Apocryphal stories abound, but those who have been fortunate enough to work with him know that most are based on fact. He is a linguist, as are many of the Simpson family, and would often be seen with a French or German book in his pocket. He is also a historian, having completed a Dip. Appl. Hist. in retirement. He has presented on the meeting of Baudin and Flinders in Encounter Bay and published a paper on the French medical scientists accompanying Baudin in the Australian Journal of French Studies.

Another of his publications discusses the neurosurgical contributions of Ambroise Paré. He referenced Homer in a memorable talk on helmets, having read the original to document the number of times helmets were mentioned. Despite his always professional demeanour, he also has a wicked sense of humour that often takes people by surprise.

Professor Simpson always reminded us of the human side of neurosurgery. It is one thing to learn how to put in a shunt, but another to know when this is the appropriate thing to do, and yet another to counsel and support patients and family through difficult times.

Not only do his patients hold very fond memories of him, he always remembered them. It was commonplace to call him in the middle of the night about a patient he had operated on 20 or 30 years earlier and for him to recall everything about them and their illness as well as their parents and siblings.

Weekends were spent preparing and coding case notes and public holidays were like any other day. It was not unknown for him to see a routine referral on Christmas Day and to review the patient in a week, on New Year's Day. His dedication to his patients made it a very hard act to follow once they reached adulthood and were transferred from the Children's Hospital to the Royal Adelaide.

Professor Donald Simpson has been a mentor to generations of Adelaide neurosurgeons. His contributions extend well beyond neurosurgery and paediatrics to include trauma surgery, road safety, anatomy, pathology and medical history. He is a role model and an inspiration. We recognise someone who has been a true pioneer in his chosen field, but then has spread his efforts widely to benefit not only surgery in South Australia but also all South Australians.

BUSY ASC CALENDAR

Younger Fellows sessions all planned

JAMES LEE
CONVENOR 2014 YOUNGER FELLOWS FORUM

Each year the Younger Fellows Committee (YFC) organises a variety of events to facilitate engagements and interactions among its members and Trainees.

Some of these events take place around the time of the Annual Scientific Congress. Therefore, as we plan our trips to Singapore in May, it is time we review what is on offer this year for the younger Fellows and Trainees.

It is with great pleasure that the YFC presents the inaugural Younger Fellows Sessions on the afternoon of 6 May, convened by Jason Chuen.

We are honoured to welcome Sandra Wong from the University of Michigan as the section visitor, as well as a strong line-up of local and international speakers: Guy Maddern, Russell Gruen, Tim Pawlik, Ben Olesnicky, Brian Loh, and the YFC Chair, Richard Martin.

The presenters will speak from personal experience on diverse topics such as career development, pitfalls in private practice, and managing a social media presence as a surgeon. These topics are relevant to both Younger Fellows and Trainees.

The Younger Fellows fun will continue into the evening at the Younger Fellows and Trainees (YF&T) Dinner, at the Aquarium, situated in Resorts World on Sentosa Island.

This is not just any ordinary aquarium. It boasts the biggest underwater viewing panel in the world; 36 × 8 metres to be exact. This year's YF&T dinner at the ultimate party venue in Singapore is the must-go social event of the conference. Just organise your wake-up call for the following day's 7am master class ahead of time. Transfers to and from the Aquarium are included in your YF&T dinner ticket.

The 2014 Younger Fellows Forum will be held at the Hard Rock Hotel, Sentosa, on the weekend before the ASC. This year, the Forum will be hosting 20 Younger Fellows from all over Australia and New Zealand, as well as overseas Fellows from the USA, Singapore, Thailand, Hong Kong, and Edinburgh.

There will also be a half-day of combined sessions with The Australian and New Zealand College of Anaesthetists (ANZCA) new Fellows conference.

It is through these exchange programs that the YFC help maintain existing, and forge new relationships with surgical colleges globally. Although applications are closed for this year's Forum, interested younger Fellows are advised that applications are open for future Forums between August and December each year.

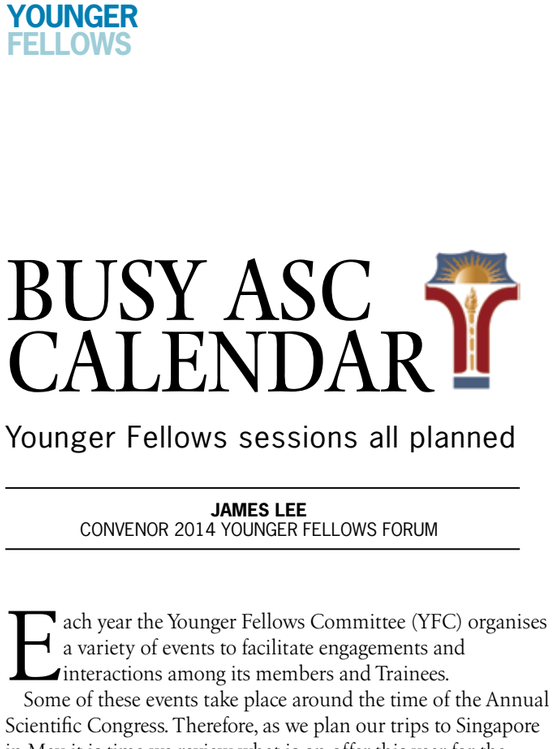
For those not attending the 2014 ASC, there are also other activities and opportunities throughout the year. In return for hosting overseas Fellows at the Younger Fellows Forum, there are opportunities for RACS Fellows to participate in the Leadership Exchange program with the Academic Surgical Congress (February), or attend the Annual Scientific Meeting of The Royal College of Surgeons of Thailand (July).

Other opportunities include the Covidien Travelling Scholarship and the Preparation for Practice Course.

These activities offer support to our Younger Fellows and opportunities to be engaged in the wider College and surgical communities.

If previous years are anything to go by, participation levels are high, so younger Fellows are encouraged to plan ahead and register for events early.

Visit the Younger Fellows Committee web page accessed from the Fellows links on the College home page or your ASC provisional program to learn more. Alternatively, contact the Younger Fellows Secretariat, Monique Whear. (Monique.Whear@surgeons.org)



ANZGOSA
Australia & New Zealand Gastric & Oesophageal Surgery Association

Post Fellowship Training in Upper GI Surgery

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

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

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

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

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

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

Applications close 5pm, Friday March 28th 2014.

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

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

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

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

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

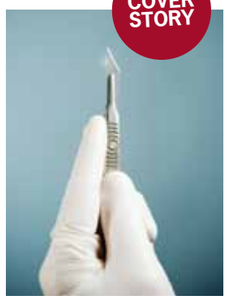
Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), to Leanne Rogers, Executive Officer ANZHPBA, P.O. Box 374, Belair S.A. 5052, or email anzhpba@gmail.com.

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

Applications close 5pm, Friday March 28th 2014.

“The competition for Traineeships in surgery is so fierce now that students need to focus on a career in surgery almost from the later years of medical school, yet they get limited exposure to actual surgery”

COVER STORY



An initiative by the College’s Queensland Regional Committee to enhance engagement with undergraduate medical students and promote surgery as a future career choice has been a resounding success

‘SCALPEL BATTLES’

BY **KAREN MURPHY**

In 2013, Brisbane ENT Head and Neck Surgeon Dr Bernard Whitfield, the Chair of the College’s Queensland Regional Committee, liaised closely with the Royal College of Surgeons Edinburgh to adapt for Australian purposes a national surgical skills competition that has been run across the UK since 2011.

That collaboration resulted in the first ever Surgical Skills Competition designed specifically for Australian medical students.

Held on October 19 as a ‘proof of concept’ trial, the competition involved 17 medical students from three Queensland Medical Schools rotating through five test stations supervised by senior consultants who graded participants on their skills in knot tying, suturing, cyst removal, laparoscopy and anatomical theory.

The competition was considered such a success, that medical student organisations have now agreed to host similar competitions at their respective universities in 2014 to act as regional heats for an expanded state-wide competition.

The competition took place over three hours on a Saturday morning and a trip to the 2014 Queensland Annual State Meeting was offered as first prize.

Dr Whitfield, who works at the Princess Alexandra and Logan Hospital in Brisbane, said that when he heard of the competition in the UK he thought it could prove a valuable tool in encouraging the best and brightest of Australian medical students to pursue a career in surgery.

He said that while historically there had been limited contact between the RACS and undergraduate medical students, the practice of engaging more with prospective surgical Trainees had now changed.

“The competition for Traineeships in surgery is so fierce now that students need to focus on a career in surgery almost from the later years of medical school, yet they get limited exposure to actual surgery,” he said.

“That can result in any initial interest in a career in surgery waning over time.

“If you ask medical students in their first week, they will all say they want to be surgeons, but by the end of medical school the majority choose to become GPs, 30 per cent to become physicians or paediatricians and only 10 per cent choose specialties such as surgery.

“We thought this competition would be a great way to both boost our engagement with medical students as a profession while working to attract the best cohort of students to surgery and the feedback from the students involved has been overwhelmingly positive.”

Dr Whitfield said the students in the trial competition came from the University of Queensland, Griffith University in Southport and Bond University on the Gold Coast. Students from James Cook University in Townsville were unable to attend due to logistical and travel considerations in October, but will have the surgical skills competition delivered to them in April.

He said all four Queensland Medical Schools had now agreed to hold their own competitions, with scoring criteria and design guidelines provided by the College’s Regional Committee to select the top candidates to compete in a state-wide ‘grand-final’ later this year.

He said that after collaborating with the Royal College of Surgeons Edinburgh, he and other surgical educators adapted the competition design to add anatomy and make certain tests more difficult to push local medical students to show their best.

After finessing the design of the competition, he then approached both university Deans and local medical student’s surgical interest groups to nominate participants.

“One of the great benefits of such a competition is that it encourages medical students to practice their skills and hone-up on their anatomy in the lead-up to the competition,” he said.

Queensland Regional Committee Chair Dr Bernard Whitfield provides the example

The University of Queensland team achieved Best Overall Score University Category.

Dr Whitfield present First Prize to Justin Kelly of Griffith University.

"In my generation, we practiced on real human beings in stitching up wounds for example, but that is no longer a core part of undergraduate medical education.

"That means that many medical students will get their medical degree, but have very little experience in conducting actual surgical interventions which we know they find quite troubling.

"So we hope this competition not only helps to increase their skills, but their confidence.

"Those medical students who are interested in a career in surgery soon come to realise there is no guarantee of a training position so that anything they do or achieve in medical school to stand out could be crucial.

"Then, if medical graduates do become surgical Trainees and can show their supervisor in the first week that they can suture, tie knots and know their anatomy, their careers will get off to a fine start."

Dr Whitfield said the Surgical Skills Competition would not have been possible without the generous support of Johnson & Johnson, its subdivision Ethicon and the Odyssey Specialist Group.

He said Johnson & Johnson had provided six laparoscopic trainers and the pork bellies used at the suturing and cyst removal stations while Ethicon had provided suture material, a knot tying board and booklets detailing surgical knots.

He also thanked the faculty who had willingly given their time to supervise and mark contestants and Ms Cindy Parker, the Executive Officer QRACS, for her significant contribution in organising the competition.

He said that now the competition had proven such a success, he hoped other states might follow Queensland's lead so that Australia could run a national competition such as that held annually in Britain.

The results of the inaugural Queensland RACS
Surgical Skills Competition were:

First Prize – Justin Kelly (Griffith University)

Runner Up – Jane Leadbeater (Griffith University)

Best Anatomy Score – Kelvin Ho (University of Queensland)

Best Surgical Skills Score (tied) – Justin Kelly (Griffith University) and Darius Ashrafi (University of Queensland)

Best Overall Score University Category – University of Queensland.

Volunteer faculty who supervised the trial competition were Associate Professor Julie Mundy (anatomy station), Dr Bernard Whitfield (cyst removal), Drs Alison Smith and Andrew Scott (knot tying station), Drs Charles Nankivell and Chris Cole (laparoscopy station) and Professor Philip J Walker (suturing station).

Senior Lecturer Fellowship

New Fellowship announced for funding in 2015

ASSOCIATE PROFESSOR IAN BENNETT
CHAIR RESEARCH, AUDIT AND ACADEMIC SURGERY DIVISION

The College's Research and Scholarships Department is pleased to advise that a new Fellowship will be advertised for the first time in March 2014 for funding in 2015.

The Foundation for Surgery Senior Lecturer Fellowship, which was developed and driven by the Section of Academic Surgery, with input from the Board of Surgical Research, is intended to provide salary support for a surgical Senior Lecturer early in his/her career, to assist them to establishment an academic surgery pathway.

There will be two Fellowships offered simultaneously with the allocation of the Fellowships preferably being equally distributed between metropolitan and provincial centres.

Applications for the Fellowship are open to surgeons in Australia and New Zealand who are establishing or advancing an academic career.

Affiliation with a University academic Department of Surgery or hospital Department of Surgery will need to be provided confirming the institution's support for the applicant in the proposed Senior Lecturer position.

The Fellowship will be valued at a Foundation for Surgery Research Fellowship level and the expectation is that co-funding will be provided by the academic institution to the same amount as the Fellowship.

The Fellowship will be awarded for up to three years but annual progress reports will be required. The Fellowship funding will be paid on behalf of the successful candidate to the academic administering institution which has agreed to match the funding provided by the College.

The Fellowship recipient will be chosen on the basis of his/her written application detailing the research to be undertaken, and academic and educational opportunities that may result from this. Preference will be given to candidates who have attained or are seeking to attain a higher degree e.g. PhD or Masters, but this will not be essential.

Prospective applicants should refer to the College website when it is advertised in March at www.surgeons.org/scholarships for additional information regarding Fellowship conditions and requirements.

I thank the Section of Academic Surgery and the Board of Surgical Research for their input and support of this important initiative.

Royal Australasian College of Surgeons
2014 WA, SA, & NT
ANNUAL SCIENTIFIC MEETING

The Pullman Resort,
Bunker Bay, WA

Theme: The introduction of new technology in Surgical techniques - the do's and don'ts!
Convener: Mr Richard Martin

If you would like to contribute to the content of the meeting, please email your ideas and suggestions to ***college.wa@surgeons.org***

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OUTCOMES AND IMPACTS

Evaluation shows success of the Rowan Nicks scholarships program

JOHN MASTERTON FRACS
CHAIR, ROWAN NICKS SCHOLARSHIPS COMMITTEE

Dear Fellow Surgeons

Many or indeed most of you will have heard of Rowan Nicks the Sydney cardiac surgeon who in his lifetime and after his death in 2011 has been a great benefactor of our College and established a series of scholarships targeting young surgeons from Africa, India and more recently South East Asia and the Western Pacific.

The Program has been going now for more than 20 years. In order to identify the benefits and the defects of it we developed a questionnaire examining these aspects. From the responses obtained we have written a paper which has just been published in 'The Australian and New Zealand Journal of Surgery'. I attach a copy of the abstract of this paper which, I hope, will be of some interest to the Fellowship.

As part of the ongoing development of the Rowan Nicks Scholarship we established a lectureship and have struck a medal commemorating Rowan. This lectureship is in its third year and up until now has been given by a distinguished speaker at the International Forum of the Annual Scientific Congress (ASC).

I am particularly happy to report that this year at the combined ASC of RACS and ANZCA in Singapore, the Rowan Nicks Lecture will be given by Datuk Harjit Singh who was a scholar hosted by Professor Russell Strong in Brisbane in 1993.

Datuk Harjit Singh is a distinguished member of the Malaysian surgical fraternity and has fulfilled many of the ideals that Rowan Nicks espoused when initiating the Scholarship.

Evaluation of the medium-term outcomes and impact of the Rowan Nicks Scholarship Programme

Reference: Masterton, J. P., Moss, D., Korin, S. J. and Watters, D. A. K. (2014), Evaluation of the medium-term outcomes and impact of the Rowan Nicks Scholarship Program. ANZ Journal of Surgery. doi: 10.1111/ans.12493.

Abstract

Background

Rowan Nicks was a cardio-thoracic surgeon in Sydney. He endowed the Rowan Nicks Scholarship Program of the Royal Australasian College of Surgeons which was initiated in 1991 to provide opportunities for clinicians from developing countries so that they return to their countries as leaders and teachers. This paper's objective was to evaluate the outcomes and impact of the scholarship on individuals and their communities.

Methods

A survey was undertaken of 34 eligible scholars of whom 29 participated. It was directed at whether objectives were achieved in technical skills, patient management and in competency in research and leadership.

Results

98 per cent of scholars returned to work in their home country. 28 of 29 were working in their chosen specialty and had returned to their former positions. The clinical/operative skills obtained were regarded as useful by 86 per cent and 22 of 29 (76 per cent) scholars reported they had gained worthwhile leadership and administrative skills. Improved clinical outcomes for patients were achieved as evidenced by reduced mortality and less disability. There was also a positive impact on health systems. The best documented of these were improved trauma management, development of paediatric surgery in rural Bangladesh, a new cardiac unit in Myanmar, organ transplantation and better injury outcomes in Papua New Guinea.

Conclusion

The Program has resulted in potential and actual leaders returning to their homes countries where they positively impacted on health and surgical services. This has resulted in a reduced burden of surgical disease in the scholars' countries as measured by less death, disability and deformity.

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

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

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

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

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

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

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

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

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

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

Tenure: 3 - 12 months

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

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

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

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

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

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

Tenure: 3 - 12 months

Application forms and instructions are available from the College website:
www.surgeons.org
Closing date: **Monday 2 June, 2014.**
Applicants will be notified of the outcome of their application by **30 October 2014.**

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

THE FIRST MEDICAL X-RAY?

Is it possible to answer who produced the first medical X-ray in Australia?

ELIZABETH MILFORD
COLLEGE ARCHIVIST

Discovered accidentally by the German physicist Wilhelm Roentgen in 1895, the X-ray was to significantly advance the practice of medicine.

Roentgen had been experimenting with vacuum tubes and cathode ray generators when he discovered a new form of radiation – X radiation (X for unknown) that could penetrate substances and produce varying levels of transparency to the rays. Using a photographic plate he 'projected an image of his own hand which showed the contrast between the opaque bones and translucent flesh'.

The true nature of these unknown rays was not understood until 1912 when Max von Laue who won the Nobel Prize for his work, discovered that X-rays are an electromagnetic form of radiation with a shorter wavelength and higher energy than visible light.

The X-ray was soon embraced by the medical profession and in 1896 an X-ray department was set up at the Glasgow Royal Infirmary. During the first Italian-Abyssinian War, X-rays were first used in a military context and helped locate bullets in wounded soldiers.

Australians were also quick off the mark. In March 1896, Professor Thomas Rankin Lyle of Melbourne University produced an X-ray of Professor Orme Masson's foot and according to *The Argus*, he later demonstrated the 'medical uses of X-rays'. At the University of Adelaide, Professor William Bragg was also experimenting with X-rays and his radiograph of his six-year-old son's broken elbow was purportedly the first recorded use of a medical X-ray in Australia.

Leo Coates X-rays a patient at the 1st Australian Stationary Hospital (1ASH), Lemnos 1915

Documentation in the College Archive suggests that there were unusual practitioners of the new technology. The Catholic priest and physicist, Father Joseph Slattery began teaching Science at St Stanislaus College, Bathurst in the early 1890s. In early 1896 he produced his first radiograph and in July, he took what is also claimed to be the first medical X-ray.

The patient was an ex-student of the school, Eric Thompson whose hand had been badly damaged by shotgun pellets. Using a Crookes tube and a '5 inch coil', Father Slattery was able to make a good picture of the injured hand. Eric Thompson's doctor had considered amputating the hand, but Slattery's image was so good that Doctor Edmunds managed to extract the pellets and the hand was saved.

For the next 15 years, Father Slattery served the Bathurst community and it was a 'familiar sight to see patients being brought to the College, as to a hospital.'

In the early 20th century, the use of X-rays became commonplace and they were used in the Boer War and World War 1. In 1913 William Coolidge invented the Coolidge Tube —an improvement which allowed X-ray machines to 'produce more accurate visualisation of deep seated anatomy and tumors'.

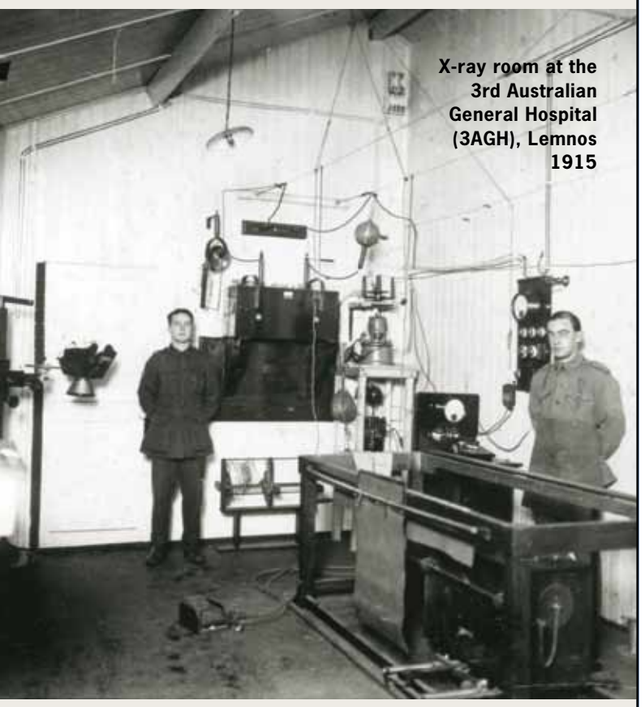
At the end of World War 1, French scientist Marie Curie stated that: "The use of X-rays during the war saved the lives of many wounded men; it also saved many of them from long suffering and lasting infirmity."

Curie became Director of the Red Cross Radiology Service in 1914. She and her daughter Irène worked at radiological posts at 'the front' and were instrumental in creating radiology vans known by the soldiers as 'Petites Curies.'

X-rays were used by the medical services at Gallipoli and the 3rd Australian General Hospital at Lemnos had both Pathology and X-ray units. ▶

"The use of X-rays during (WWI) saved the lives of many wounded men; it also saved many of them from long suffering and lasting infirmity."

X-ray taken by Father Joseph Slattery, 1896



X-ray room at the 3rd Australian General Hospital (3AGH), Lemnos 1915

Joseph Verco who was sent to Gallipoli as a surgeon became interested in radiology of chest wounds when working at the 1st Australian Stationary Hospital, Lemnos.

After the war he became the Radiotherapist at the Adelaide Hospital, promoted the idea of chest X-rays as a public health measure and later became President of the Royal Australian and New Zealand College of Radiologists.

Foundation Fellow, Sir John Ramsay joined the Launceston General Hospital in 1897 and X-rays, particularly the potential for deep X-ray therapy to treat cancer, were among his many interests. When they became available he installed improved X-ray machines in the hospital and journeyed to Germany in 1919 so that he could purchase the latest X-ray equipment from Siemens.

Although from the early 1900s there was an increasing awareness of the dangers of X-rays, John Ramsay's experiments with X-rays led to permanent scarring on his face and hands.

So who produced the first medical X-ray in Australia? This is a question that is impossible to answer, but what is certain is that the X-ray fascinated a number of individuals and the cumulative effect of small refinements and discoveries led to the widespread adoption of what is still an integral part of medical therapy.

Thank you for donating to the Foundation for Surgery

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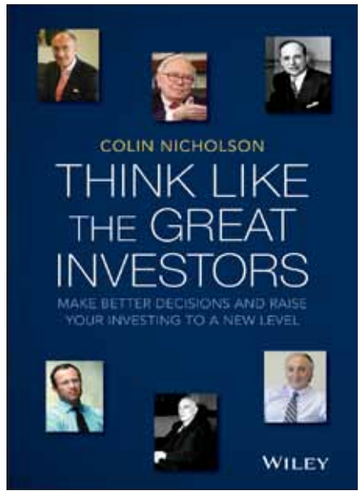

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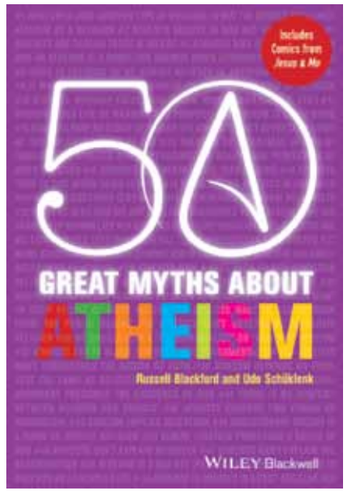

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Russell Blackford and Udo Schuklenk
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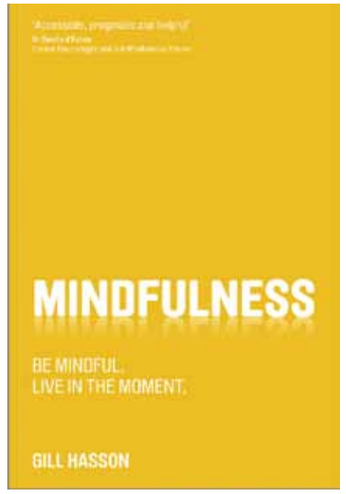

Mindfulness: Be mindful. Live in the moment

Gill Hasson
214 pages, July 2013

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Too often, life just races by. You don't fully experience what's happening now, because you're too busy thinking about what needs doing tomorrow, or distracted by what happened yesterday. And all the time your mind is chattering with commentary or judgement.

Mindfulness allows you to experience the moment instead of just rushing through it. Being mindful opens you up to new ideas and new ways of doing things, reducing stress and increasing your enjoyment of life.

With ideas, tips and techniques to help you enjoy a more mindful approach to life, you'll learn how to:

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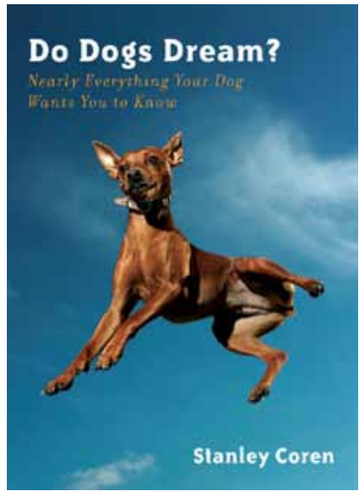

Do Dogs Dream?: Nearly Everything Your Dog Wants You to Know

Stanley Coren
160 pages, July 2012

~~A$30.95~~ | **A$20.12**
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Do dogs dream? Can they recognize themselves in the mirror or understand what they're seeing on television? Are they more intelligent than cats? People have a great curiosity—and many misunderstandings—about how dogs think, act, and perceive the world. They also wonder about the social and emotional lives of dogs. Stanley Coren brings decades of scientific research on dogs to bear in his unprecedented foray into the inner lives of our canine companions, dispelling many common myths in the process. In a conversational Q&A format with illustrations, Coren answers approximately 75 questions often asked of him during his nearly fifty-year career as a dog researcher, combining the authority of an expert with the engaging delivery of a guest at a cocktail party.

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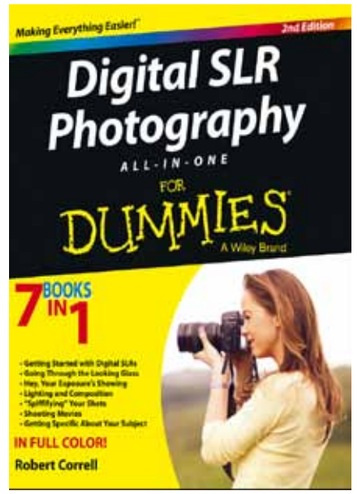

Digital SLR Photography All-in-One For Dummies, 2nd Edition

Robert Correll
672 pages, May 2013

~~A$50.95~~ | **A$33.12**
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This new edition gets you up to "shutter speed" on the latest camera technologies, including the new consumer-targeted full-frame models and pro-features that are now incorporated in consumer-focused units. Veteran author and professional photographer Robert Correll walks you through how a camera works, what lenses to use, how to set exposure, and how to capture the shots that define a portfolio.

Fully updated to cover the latest generation of cameras and boasting more than 700 pages, this must-have resource explores the latest in tools and offers additional content, including video and interactive tools so that you can enhance your photography knowledge.

- Covers the basics of DSLR mechanics and explains how settings affect the final photo
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