Surgical news

Vol: 12
No:4
May
2011

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Vital Education

First class practice in the College's Skills Lab PAGE 5

The College of Surgeons of Australia and New Zealand

ON THE COVER: Important training in the College Skills Lab

contents

Where to from here?

The College asks its Fellows and Trainees for suggestions on how we can improve our service for you

Ian Civil
President

The College is now entering the time of year when it starts actively reviewing its key strategies, the activities we undertake and the budgets required to support these.

It is the time of year when we need to know of the 'great new ideas' that Fellows and Trainees want us to pursue. We can then properly assess them to allow Council to sign off allocations and adjustments in October for the following year.

It is often said that the most unifying concern about any membership based organisation is the fees. No matter whether it is a professional organisation or local sporting club, there are always issues of regulatory compliance and core functional activities that must be undertaken.

In this day of government intervention and oversight, these are becoming more rather than less burdensome. Then the 'value-added' activities drive what we all want to see as support and development for the professional activities we undertake on a day-by-day basis. It is a common formula and applies internationally as well.

It is interesting to compare the structures and budgets of our College to those of colleges overseas. Although the core functions of education, training and maintenance of standards are common to all, interaction with regulators, universities, governments, departments of health, specialty societies, regional groups and other stakeholders varies enormously. Also the ability to have activities supported by substantial endowments of many years is very significantly different.

Many Fellows would be aware that subscriptions to the colleges in the UK are less than that required in Australia and New Zealand. This also applies to training fees. The reasons include substantial revenue derived from endowments and also significant support or cross-subsidies obtained through government groups like the National Health Service (NHS).

Many of the recent initiatives of these colleges have been through the substantial increase in NHS related funding over the past 10 years that has been purposefully directed to curricula development and e-learning opportunities.

The annual subscription of this College is comparable to other medical colleges and certainly the enhanced requirements of accreditation and regulation have seen all medical college fees dramatically increase over the past 15 years. The strength of curricula, professional standards, professional development and advocacy do not occur without resources and effort.

However, that is not to say that the College cannot be significantly better in how it approaches issues. In this we need feedback on required improvements and importantly what initiatives are needed by Fellows and Trainees. We have already received substantial feedback that has allowed improved communications, particularly harnessing newer information technology.

Branding the FRACS for public awareness is a high priority. It will be no surprise then that a major review of the College IT platform is now seeing a rapid updating of all our systems that at the end of the year should give far better functionality and mobile useability.

The re-branding for the FRACS is currently being distributed. What should we be doing next? We do need your feedback.

The College does actively survey the membership. More than 70 per cent of responding Fellows believe that the College offers real benefit to them as a Fellow. More than 70 per cent are very satisfied/satisfied with the role of the College and its services such as ANZ Journal of Surgery with over 80 per cent satisfaction with *Surgical News*.

Are these figures good? Well they can never be good enough because we must always be improving. But what should we be focusing on next?

In the analysis of our budgets, I have already highlighted issues like commitment to Information Technology and the re-branding exercise. Out of each of our subscriptions we allocate money to the Research and Scholarship program of about $110; on Public Relations, Surgical News and the ANZ Journal of Surgery we spend about $190.

Our regional offices in New Zealand and all states of Australia require $310 from each of our subscriptions. It is important that Council understands where our Fellows and Trainees want services to be allocated and ways in which to improve them. This feedback allows the budgeting process to have a lot more meaning.

One of the most interesting items in the survey is the reason for people not contributing more to the College. The majority say their lack of involvement is because they have not been specifically asked. As President, I am really interested in your ideas, your contribution to the discussion about where we should be putting our attention and efforts and where your money is allocated. I would be delighted to further discuss this with you either face to face at the meetings I am attending across Australia and New Zealand or via correspondence.

RESULTS OF 2011 ELECTIONS TO COUNCIL

The results of the 2011 elections to Council were tabled at the Annual General Meeting in Adelaide on 5 May 2011.

Congratulations to all successful candidates and sincere thanks to all candidates who nominated.

The pro bono contribution of Fellows has been, and continues to be the College's most valuable asset and resource. We are grateful for their commitment.

Fellowship Elected Councillors

There were four Fellowship Elected Councillor positions.

Re-elected to Council are
Helen Elizabeth O'Connell, Urologist, Victoria
Philip Gregory Truskett, General surgeon, New South Wales

Newly elected to Council are
Richard Edward Perry, General surgeon, New Zealand
Bruce Charles Twaddle, Orthopaedic surgeon, New Zealand

Specialty Elected Councillors

General Surgery – re-elected
Samuel Patrick Baker, Queensland

Otolaryngology Head and Neck Surgery – re-elected
Robert John Black, Queensland

Neurosurgery – newly elected
Adrian Mack Nowitzke, Queensland

Urology – newly elected
Andrew James Brooks, New South Wales

Thank you to the scrutineers Andrew Roberts and Colin Russell.

Important training in the College Skills Lab

The hard work of many help the College offer invaluable services

Keith Mutimer
Vice President

One of the keystones of College activity is our commitment to collaboration and teamwork, a value I believe is essential to achieving our goal of excellence in surgical care.

I see this commitment across the College in many different ways, and one outstanding example I would like to highlight is the recent annual Cardiothoracic Surgery Trainees Course directed by Mr Andrew Cochrane.

As surgeons and trainees, we all know the benefits of working with more experienced colleagues, and this three-day course involving all Australian and New Zealand cardiothoracic Trainees provided the opportunity for participants to hear from, work alongside, and network with a range of specialists from a number of leading institutions.

The faculty consisted of 12 cardiothoracic surgeons, four perfusionists from the Alfred, Royal Melbourne, and Royal Children's Hospitals, and two perioperative registered nurses who came from the Royal Children's Hospital and the Monash Medical Centre. Held in the College's Skills Laboratory, activities ranged from anastomosing porcine

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org

Letters to the Editor should be sent to:
letters.editor@surgeons.org

Or The Editor, Surgical News
Royal Australasian College of Surgeons
College of Surgeons Gardens
250-290 Spring Street
East Melbourne, Victoria 3002
T: +61 3 9249 1200 F: +61 9249 1219
W: www.surgeons.org

ISSN1443-9603 (Print) ISSN 1443-9565 (Online)

Surgical News Editor: David Hillis

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

“For our trainees, having access to this type of intense practical experience coupled with such a breadth of experience and knowledge is invaluable.”

aortas to cardiopulmonary bypass simulation with a team of perfusionists, and coronary artery surgery on a beating heart in a simulated operating room environment.

For our trainees, having access to this type of intense practical experience coupled with such a breadth of experience and knowledge is invaluable. This was reflected in the feedback which was uniformly positive.

Evaluation is an integral part of all College activity, it means that we listen to our Trainees and objectively make decisions about future courses to more fully reflect their needs. It means our courses are constantly evolving and adapting, and this year’s cardiothoracic course was no exception.

A new introduction to the course this year was a greater emphasis on high-fidelity simulated surgery. This included a tissue-based surgery simulator developed, among others, by cardiothoracic surgeon Mr Paul Ramphal FRCS and brought over from the Bahamas for operation at our workshop.

This realistic computer-assisted simulator drives a cadaveric porcine heart to provide a simulated operating theatre environment with real-time haemodynamic monitoring and coronary blood flow.

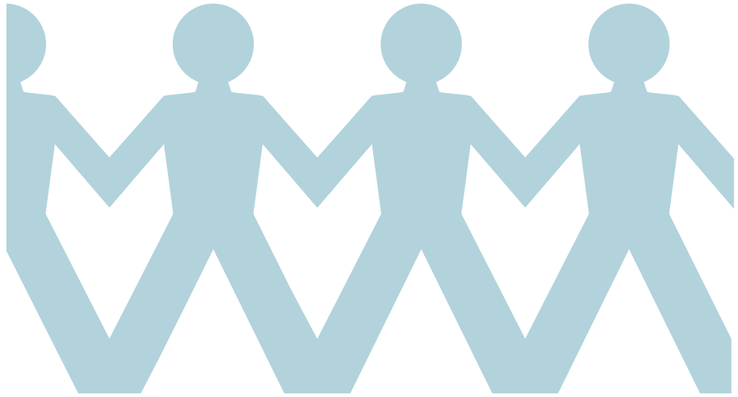
This meant that our Trainees were not only able to experience a range of procedures, but the superimposition of adverse clinical scenarios meant that they were required to exercise quick decision-making and clinical judgement.

A second simulator was the Orpheus cardiopulmonary bypass simulator provided by the perfusionists attending. Cardiopulmonary bypass (CPB) is a technique that temporarily takes over the function of the heart and lungs during surgery, maintaining circulation of blood and oxygen throughout the body. The perfusionists operate the CPB pump, often referred to as the heart-lung machine, during surgery and surgeons connect the pump to the body.

High fidelity simulation means a departure from the ‘see one, do one’ model and enables the Trainee to see several, simulate many, and then do one perfectly. For the training provider, in this case our Skills Lab, it means no live animals and therefore fewer issues with ethics, maintenance, anaesthesia and euthanasia.

Feedback on the simulations was excellent, some comments were ‘the simulation sessions provided a unique opportunity to consolidate skills and knowledge’ and ‘it was great to practise skills in a non-theatre environment and to get feedback’. One trainee wrote; “Absolutely the best course I’ve done across many specialties. Improving each year.”

Of course, simulation is only part of the mix and needs to be augmented by sound teaching, mentoring and feedback and none of our courses would be of any value without the ongoing generous support given by so many of our Fellows and other health professionals – walking the talk and actively demonstrating teamwork and collaboration alongside our staff. Thank you.



Poison’d Chalice

“And oftentimes excusing of a fault, doth make the fault worse by the excuse”
What are the benefits of the annual appraisal?

Professor U.R. Kidding

The Head of the Urology Unit sat across the table from me. I knew he didn’t want to be here. I knew that I didn’t want to be here. But we had an annual ritual to perform – the annual professional appraisal – an opportunity to assess the individual’s relationship with the organisation or a bureaucratic imposition designed to reinforce authoritarianism.

Whatever, I knew him to be a capable, caring, compassionate doctor participating in the public hospital system only for the benefit of his patients and a desire to further the development of his more junior colleagues.

I actually apologised to him for the necessity of wasting his time for an hour and then asked the fateful question – “how can your unit performance be improved?” He replied “ by providing better quality ureteroscopes, more operating sessions, a robot for prostatectomies and, come to think of it, better lasers. Oh, and by the way, how are my requests from last year coming along?” I knew I didn’t want to be here.

I mused, as I am want to do, was the appraisal concept developed by an obscure, insecure bureaucrat for the purpose of re-enforcing his or her authority? Was it really of value to visiting consultant surgeons who felt that they were donating their time to the public system?

The instructions from the HR manager had been clear – “the CEO is anxious to comply with ACHS (Australian Council on Healthcare Standards) and does not want any issues with re-accreditation! Annual appraisal and credentialing are not optional!”

I paused to contemplate where on the pecking order of hospital politics I was in relation to the HR manager. It was with relief that I realised the necessity of invoking the CEO’s name meant that I was in a pretty good place. But on the other hand I was still sitting here with the Urology Head of Unit.

Of course, as a Director of Surgery, my greatest fear would be presiding over a clinical service that contained a “rogue” surgeon that was inflicting harm without my detecting the situation. Was an annual appraisal helping me sleep better at night? – alas, no.

But the system that we had created did help my insomnia – I did trust our surgeons to oversee their registrars and I did trust the Heads of Unit to oversee their surgeons.

With a shudder borne out of sudden clarity, I realised that the only person who needed to be monitored, assessed and appraised was me! And possibly the only person who was immune from the safeguards that I had helped construct was me.

The realities of Bristol and Bundaberg suddenly became clear – what did these disasters have in common – the surgeon at the top did not have adequate safeguards in place! Would the power that I have amassed as Director of Surgery dim my own insight?

I must have looked shocked because the Urology Head was moved to ask if I was all right. I apologised for drifting off and brought his appraisal to a rapid end. I resolved to rectify the situation with the Chief Medical Officer.

I began to wonder that if I was going to continue to be a practising surgeon as well as Director of Surgery, maybe I should not be Head of Unit as well – that is, maybe I should have to answer to a Head of Unit for my personal clinical performance?

Section 39 from the General Medical Council booklet, Management for Doctors, might help – “You must be honest and objective when appraising or assessing colleagues’ performance and when providing references. The safety of patients and the public could be put at risk if you make false, exaggerated or incomplete comments about another professional’s competence or experience.” (Could have been written by the HR Manager!)

But I was already late for my next appointment. It was with an underperforming registrar – he just wasn’t making the grade. All the surgeons in his current Unit rotation had expressed concerns over his failure to progress – they were all of the view that a surgical career was not for him.

I decided to ring his Head of Unit from his previous term where he had been given a pass for an assessment. He was blunt and to the point – “hopeless – but the exam will sort him out!” The words from King John, Act IV, Scene ii, came to mind: “And oftentimes excusing of a fault, doth make the fault the worse by the excuse”.

Regretfully I realised that I had recently completed this Head of Unit’s appraisal. Why hadn’t I discussed the responsibilities of a Supervisor of surgical training – the need for careful documentation, discussions, learning plan and follow-up? The need to confront the marginal trainee!

Of course I recognise the difficulties that supervisors face – legal ramifications, justifications, etc. Why do supervisors have to find themselves caught between community benefit and individual trainee rights – often promulgated by a high-powered barrister? And as for the trainees – the inverse relationship between insight and legal redress has always intrigued me. The words of Macbeth Act 1 come to mind – “vaulting ambition, which o’erleaps itself, And falls on th’other…”

I invited the trainee in. He sat where the Urology Head of Unit had sat. He didn’t want to be here and I didn’t want to be here …

To be continued

College Disaster Preparedness assists quick response

The College Disaster Preparedness procedures have been put to the test with recent disasters

Daryl Wall
Chair, Trauma Committee

On Boxing Day 2004, when the first horrific images of the Indian Ocean tsunami began to circulate the globe, most Australians and New Zealanders were floating in a relaxed post-Christmas haze.

As the enormity of the disaster became apparent, however, scores of Australasian surgeons attempted to offer their services to help the hundreds of thousands of wounded. Yet most were unsuccessful in their efforts, with no central point of contact, the Christmas closure of the College and few organisations open at the time.

The disconnect between those surgeons willing to help and the international disaster response systems that could have allowed it, was brought into such stark relief the College stepped in and established a Disaster Preparedness Working Party (now the Disaster Preparedness Sub-Committee) set up under the umbrella of the College Trauma Committee.

The Disaster Preparedness Sub-Committee established a database of hundreds of Australasian surgeons willing to respond at times of a disaster and has worked closely with Federal and State emergency response authorities to ensure those names are easily and immediately accessible.

The list of willing volunteers is sent to the Chief Medical Officer of Australia, the Chief Health Officer in each state and territory and managers of disaster response teams in jurisdiction across Australasia.

Mr Daryl Wall, Chair of the Trauma Committee with oversight of the Disaster Preparedness Sub-Committee, said the system was already working so well that Australian surgeons were in Christchurch less than 24 hours after the February earthquake.

"Clearly the system we have put in place is effective because I was immediately contacted to go to Christchurch, was ready to go in two hours and arrived there as part of the Queensland response team within 18 hours," he said.

"Many surgeons wished to help in this disaster, but only ten percent of those were called upon given the extraordinary ability of local Christchurch surgeons to manage the crisis with the help offered them by others in New Zealand.

"Upon arrival we set up a field hospital and distributed volunteers through Christchurch Hospital to relieve staff, many of whom, by then, were severely fatigued.

"The Director of Surgery in Christchurch, Dr Greg Robertson, performed outstandingly in managing the crisis. Within 24 hours of the earthquake, 431 people had received treatment for wounds and fractures while the volunteers (AUSMAT) cared for and treated about 700 people in the field hospital, thereby greatly reducing the burden on Christchurch Hospital.

"Yet all of us who went to help could only admire the courage and resilience of Cantabrians, who were extremely brave and devoted to caring for each other."

Mr Wall said the aim of the Disaster Preparedness Sub-Committee was 'to establish a policy for disaster preparedness which would include a database of surgical resources that is current, sustainable and simple in its application'. The database should include the collection of data from volunteer surgeons regarding trauma training, vaccinations and a basic equipment list. We also encourage the development of all resources to enable a rapid response to the disaster and as such to liaise with Federal and State disaster authorities.

Working with Government

There is a new Federal Government authority established to centralise national disaster response efforts which co-ordinates the services not only of surgeons, nurses and paramedics, but non-medical personnel such as fire fighters and logisticians.

Known as the Australian Medical Assistance Team (AUSMAT), the authority plans to operate its own data-base of volunteers, with information of available surgeons taken from the list provided by the College.

With responsibility for the standards of participants and the selection and transfer of personnel, it also provides training to volunteers at the National Critical Care and Trauma Response Centre established in 2006 and located at the Royal Darwin Hospital.

Mr Wall said the creation of AUSMAT and the close liaison between it and the College would streamline the ability of surgeons to not only assist in times of disaster, but to access training to ensure that surgeons are as well-prepared as possible for the conditions they may encounter.

"One of the very special courses run out of the Royal Darwin Hospital is called the Disaster Surgical and Anaesthetic AUSMAT course. This is a course carried out in austere environments and is presented by people who have served in disasters such as Banda Aceh, Haiti, the Sudan and Pakistan, and includes surgeons such as Dr Annette Holian who has served in four disasters," he said.

"This course is not so much about trauma surgery, but about all the issues that surround care in a disaster such as the safety of volunteers, organisational principles, psychological aspects of disasters for surgeons and victims, cultural and political awareness, operational logistics and codes of conduct.

"All these aspects are crucial to ensure that volunteers upon their arrival do not add to the magnitude of the human disaster.

"This course, along with the Definitive Surgical Trauma Care (DSTC) course is considered essential for all volunteers and I would urge all surgeons wishing to assist in times of disaster to give consideration to participation in these courses."

Mr Wall said surgeons from all surgical specialties are required in times of disaster; however, not all surgeons are ready to serve. Physical preparation is required, the surgeons should be free of complex medications, have up-to-date vaccinations, be able to leave swiftly for the disaster zone, have a strong sense of partnership, teamwork and a sense of humour.

He said the Disaster Preparedness Sub-Committee was also keen to advocate for the streamlining of expertise and logistical capabilities of the military medical services with civilian volunteers.

"Upon arrival we set up a field hospital and distributed volunteers through Christchurch Hospital to relieve staff"

"Australasian surgeons who work within a military framework have enormous experience and expertise and we would like to better incorporate that into training and serving and we hope in time that our disaster response can be integrated." Mr Wall said.

"The benefits of military involvement in management of transport, logistics, safety and expertise would be an advancement in transferring surgeons where they need to be, yet we must remain aware of cultural sensitivities. There will always be certain territories and occasions when a military presence would be less welcome than a team sent under a civilian banner."

Although the AUSMAT data-base will come on line later this year, the College would continue to collect names of those wishing to serve in disaster zones and would pass those on to the federal and state and territory agencies which are then expected to contact those surgeons for additional information.

Mr Wall, the Director of Surgery and Senior Liver Transplant Surgeon at the Princess Alexandra Hospital in Brisbane, particularly praised the work of Mr Robert Atkinson who led the Disaster Preparedness Working Party from its inception in 2005 and recognised the work of Mr Sudhakar Rao, chair of the Disaster Preparedness Sub-Committee.

"The success of surgical deployment to Christchurch can be attributed to Robert Atkinson's tireless efforts to solve the problems that the Boxing Day tsunami made glaringly apparent," he said.

"Now we have even pushed forward this work by designing information to advise community volunteers working in a disaster anywhere in the world on wound management in the first instance.

"Currently, wounds caused in disasters are sometimes badly mismanaged and dangerously mishandled.

"The specific error many people make is to close the wound. It is an instinctive response, I think, but it must stop and we are hoping to promote this message internationally."

PROCESS COMMUNICATION MODEL

is a method of communicating with colleagues in such a way as to prevent a team or an individual from becoming dysfunctional, including ourselves.

The course aims to help participants:

- **> Establish relationships necessary to lead and develop teams**
- **> Motivate people according to individual needs**
- **> Identify signs of distress within individuals and develop ways of responding**
- **> Communicate with patients in a way that suits their preferred style of communication**

The course is on offer on:
22-24 July, Melbourne
26-28 August, Sydney

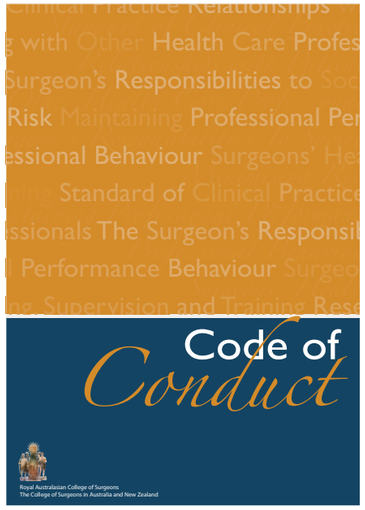
Participants need to complete a diagnostic questionnaire which forms the basis of an individualised report about each person's preferred communication style so don't miss out and register now!

For more information please contact Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit **www.surgeons.org** – select Fellows then click on Professional Development

Code of Conduct

A revised and updated Code of Conduct is now available

Michael Grigg
Chair, Professional Standards



Adam Smith wrote "the Wealth of Nations" more than 200 years ago and in it he described the concept of professions. Society adopted the concept of professionals – highly trained, skilled individuals who put a patient or client's benefit above their own.

Smith recognised the importance of professionals having autonomy, but proposed balancing the freedom of autonomy with the responsibility of self-regulation through the establishment of guilds or professional associations.

The Royal Australasian College of Surgeons is the professional association of surgeons in Australia and New Zealand. It exists to establish and maintain high standards of surgical care for our communities and by so doing protect the autonomy of surgeons caring for individual patients.

The College has a Code of Conduct – the manifestation of our standards and evidence of our commitment to self-regulation. The Code of Conduct describes who we are as surgeons by describing the values we espouse. It is a public document and not exclusively for surgeons – it will be read and absorbed by those external to our profession and is intended to further reinforce our professional status.

The Code has been developed to be compatible with the Australian Medical Council (AMC) Code of Conduct as adopted by the Medical Board of Australia and the Medical Council of New Zealand (MCNZ) Good Medical Practice Code.

Each section of the College Code has also been aligned with a section of the Fellowship pledge. In taking the Fellowship pledge, surgeons undertake to uphold the College's standards of professionalism.

If you have not recently had the opportunity to attend the Convocation ceremony at the ASC I urge you to consider attending. It is quite moving to witness the convocating Fellows taking the pledge and I am confident that it will increase the pride that you have in your profession.

Many important issues relating to professionalism are addressed in the Code, such as second opinions, advertising and bullying and harassment. The Code also includes references to College policies, position papers and guidelines, so that readers may find the relevant College document on a variety of topics.

The Code has been derived from input from all facets of the College including all College regional committees and surgical specialty groups.

The revised Code was launched at the Annual Scientific Congress in Adelaide in May. You will find a hard copy of the Code of Conduct included with your May edition of Surgical News. Please take the time to read the Code, discuss it with your colleagues, and contact me if you have any questions or concerns about the content.

Cycling Surgeon

College EDSA for New Zealand, Allan Panting uses the bike for leisure

Allan travels with his wife Sunny. Middle: Changing those flats; The qualities of riding in Wanaka.

New Zealand orthopaedic surgeon Mr Allan Panting, the Executive Director of Surgical Affairs NZ, lives and works in Nelson, described as a pocket of paradise in the top northwest corner of the South Island. Once a runner, Mr Panting swapped the foot-slogging for the pleasures of cycling and now, with his wife Sunny, spends his free time riding through some of the most beautiful places on earth – from Croatia to Italy to the glorious country outside his own back door. He talks to *Surgical News* about the benefits of the bike.

When and why did you take up cycling?

As a broken-down runner with repeated calf injury after almost 30 years of regular road running, I cycled intermittently during periods of recovery. When I was challenged to complete a mountain bike event approximately eight years ago, I purchased a new mountain bike and began cycling regularly. With modern technology I found cycling fun and became hooked on this form of exercise as an alternative to running.

Do you ride only for recreation or do you compete?

While I predominantly ride to maintain general fitness and for pleasure, I also participate in a number of organised events.

If you race, where have you competed and what results have you achieved?

Events in which I regularly participate and enjoy are the Rainbow Rage and the Graperide. The Rainbow Rage is a mountain bike ride of 106 km in the top half of the South Island where my personal challenge is to ride the relatively steep Island Saddle (most riders have to push their bike up the 2-3km climb) and also to complete the ride in less than five hours (achieved once!). The focus on the Graperide, a 101 km road race through the Marlborough Sounds and vineyards, is to get my wife, Sunny, around the circuit rapidly, intact and still smiling.

Do you undertake annual riding holidays? If so where have you been and what was the experience like?

Since commencing cycling, Sunny and I have participated in a number of organised tours of 10 to 14 days duration – usually alongside some other surgical colleagues. These have included the Camino de Santiago de Compostella, (the Pilgrims Trail) in Spain, cycling Venice to Pisa in Italy, riding in Costa Rica, island hopping in Croatia and 1,000 km around the south of the South Island in New Zealand. Each one of these has been a great experience seeing a small section of the world at a slower pace with time to meet local people, enjoy coffee, wine and good food while at the same time becoming progressively fitter.

Where will you be going this year?

We do not have a trip planned this year, but next year we plan a six-week trip cycling from St Petersburg to Istanbul. (Perhaps best not to mention this to David Hillis!) This is a ride of approximately 4,000 km through an historic and interesting part of Europe.

How much training is necessary before embarking on such a ride and what do you do to prepare?

The preparation required is comparable to that for any other sport – a gradual increase in the time spent on the bike to get muscles and backside prepared for longer periods and harder activity. While our basic fitness enables us to comfortably ride for two hours or more at any time, longer or more competitive events demand more regular training. This requires riding increasingly frequently (up to five or six times each week); a mixture of longer steady riding for periods of two to four hours to develop stamina interspersed with shorter harder rides (such as repeated circuits of 15 minutes around a sharp hilly course) to improve strength. Perhaps it is this preparation and the associated anticipation that heightens the enjoyment of the event.

What is your favourite ride?

Living in Nelson we are fortunate to have a great mixture of road cycling and mountain bike trails. In addition we often spend time in Wanaka and I can strongly recommend the mountain bike tracks there as offering a variety of levels in a particularly relaxing and scenic environment.

Do you mostly ride alone or in a group and which of these do you prefer and why?

While I prefer to ride with others to enjoy the social aspect, because of my work commitments a significant amount of my riding is completed alone. I am particularly fortunate in that Sunny also enjoys cycling and we regularly ride together.

What type of bike do you ride?

I have two bikes I ride regularly, a dual suspension mountain bike and a lightweight carbon fibre road bike. Both are great bikes and fun to ride.

Do you find cycling benefits your professional life?

Cycling provides a good form of relaxation and exercise to maintain basic fitness, but it is more forgiving on muscles and joints than running.

How difficult is it to find the time to train with a busy practice?

As with most activities in life it becomes a matter of prioritisation and deciding to set aside time on a regular basis to relax and maintain general fitness. Training for specific events demands more time, but it is possible to plan for training rides of three to five hours.

When did you take up the position of NZ Executive Director of Surgical Affairs?

I have been fully involved as EDSA New Zealand since August 2009.

What do you hope to achieve during your time in this position?

During my time in this role I hope I am able to assist fellow surgeons become better informed of the value of the College in their professional lives.

With Karen Murphy

Important research for rehabilitation surgery

Dr Michael Wagels has made an important revelation for Trauma surgery with the help of the College

Contrary to a long-standing belief, muscle-flaps used in lower limb reconstructions can form their own blood supply, according to the 2010 CONROD-RACS Trauma Fellowship recipient Dr Michael Wagels.

Following more than two years of research conducted at the Princess Alexandra Hospital in Brisbane and the University of Queensland, Dr Wagels has found via animal studies that neovascularisation in muscle flaps can occur naturally, is faster than predicted and is most prolific at that part of the flap furthest from the vascular pedicle.

This finding could be of key importance to surgical teams treating lower limb trauma given current concerns relating to the capacity of muscle flaps to survive re-operation.

Dr Wagels, a plastic and reconstructive Trainee, said the experimental evidence favouring neovascularisation was based on the use of a pure muscle model which had never been done before.

"A problem that has long faced both plastic and reconstructive and orthopaedic surgeons in the management of lower limb trauma, as perhaps caused in a motor vehicle accident, is the distal part of the leg which has a relative deficiency of soft tissue," he said.

"We need to cover the bone after fractures have been treated to prevent complications such as osteomyelitis and non-union. In the past there has been great concern about going back in, which is necessary in up to 30 per cent of cases, most commonly to treat non-union. The fear is that accidentally interrupting the blood supply to the soft tissue flap would cause failure of the flap and a failed soft tissue reconstruction predicts delayed amputation.

"Reconstructive surgeons have always believed that a muscle flap was forever dependent on its intrinsic blood supply, but I have demonstrated that this is not true and that muscle flaps can create a new blood supply network that can support the entire muscle flap. We have known this about skin-containing flaps since the 1960s."

Dr Wagels said that one of the primary reasons that this issue is important relates to the choice of flap for lower limb trauma reconstruction.

> *"Experimental evidence favouring neovascularisation was based on the use of a pure muscle model which had never been done before."*

"There are different reasons surgeons choose one flap over another, and the perceived risk of and associated with re-exploration weighs in to this, but there was no real science to back that up.

"This discovery is one piece of a large puzzle that will ultimately need clinical experimentation to put together. In order to do that sensibly, there are other issues that need to be sorted out such as classification of the severity of injuries that need reconstruction. Only then can this variable be controlled in properly designed studies that compare outcomes for different types of reconstruction, including whether the soft tissue reconstruction is composed primarily of muscle or skin."

Human trials are expected to begin within the next three to five years.

"Following the human trials we should be able to say when a surgeon can go back in and where they can go back in to maximise healing of the injury and hopefully reduce the need for amputation."

Dr Wagels has conducted his research as part of a PhD under the principal supervision of Dr David R. Theile and associate supervisors Dr Shireen Senewiratne and Dr Dan Rowe.

So far, he has presented his findings on 15 occasions at Plastic and Reconstructive Surgery Conferences in India, Vienna and Hamburg and at the RACS' Annual Scientific Congress (ASC) in Perth.

He has won the Neville Davis Prize as awarded by the Queensland RACS and the Research Prize awarded to trainees at the ASC in 2010.

He has also been the recipient of a National Health and Medical Research Council grant for the past two years.

The CONROD-RACS Trauma Fellowship carries a stipend of $50,000 and is given to scholars conducting research into such areas as epidemiology, prevention, protection, rehabilitation or immediate or definitive management in trauma. 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 that state.

Dr Wagels said he hoped to have his thesis completed by the end of this year, but would likely continue his research endeavours throughout his career.

"This is exciting research because it has the potential to change clinical practice and I expect that I will be working on it one way or another throughout my professional life," he said.

"I have greatly enjoyed the experience of framing research questions and working through all the problems, one after another, to get an answer. For example, once we discovered that neovascularisation did occur, we needed to know how it occurred, where it occurred and how long it took because different parts of the muscle create a blood supply at different rates, while a muscle flap that is not in contact with skin may show less neovascularisation. We have since gone on to look at ways of optimising the neovascularisation response" Dr Wagels said.

"Sometimes that has been difficult, in that the questions and problems at times seem to stretch on and on, but it is enormously rewarding when you take a step forward.

"I am particularly grateful for the College's support not only in facilitating this research opportunity, but also because it allowed me to spend more time than would otherwise have been possible with my wife and baby son in his precious early years."

With Karen Murphy

The Carpal Tunnel Syndrome & the Two Fat Ladies

More musings and memories of my surgical mentors

Felix Behan,
Victorian Fellow

Driving along the Lorne cornice late in 2010 I was listening to ABC FM and heard an interview with Margaret Throsby and Clarissa Dickson Wright, one of the *Two Fat Ladies* of BBC fame and the daughter of the eminent London Surgeon Dickson Wright.

Keith Henderson, an octogenarian and fellow Parkville resident, alerted me years ago in our Royal Parade discussions to the reputation of the late eminent Arthur Dickson Wright, who came to Melbourne in the mid-1960s as the guest speaker of the Neurological Society of Australia.

My mind was thus drawn to explore the link between neurosurgery and the treatment of carpal tunnel syndrome. Why? In 1947, it was Dickson Wright together with Russell Brain from Queen's Square London who published in the Lancet, five well documented cases of surgical Carpal Tunnel Release, explaining the link between neurosciences and carpal tunnel surgery. This led me to understand the background to this significant contribution to hand surgery.

Dickson Wright was born in Dublin in 1897. In the Great War, he served in the Battle of the Somme as a balloonist in the Royal Flying Corps. I recently saw an SBS documentary describing how co-pilots in Tiger Moths recorded events on film in the 1914-18 saga. No doubt he would have been a member of the Royal Flying Corps as a balloonist and a pilot, used to carrying on daredevil exploits in the service of his country. Thus we have a surgical mind accustomed to the cutting edge.

He became Professor of Surgery in Singapore, married Molly Bath (whose father Tom Bath came from Queensland, was born in Gympie and served in the Queensland Mounted Light Infantry in the Boer War; hence the Australian link with his daughter Clarissa). He eventually returned to London as a Senior Surgeon at St Mary's and Prince of Wales Hospital.

Wright was a "Renaissance man" as well as a surgical scion of his day, with his expertise and knowledge extending to almost every surgical sphere. It was Lord Porritt in his obituary for Dickson Wright who said that he fulfilled the definition of "well" quite admirably "he cut well, he sewed well and thankfully his patients did well". As an after-dinner speaker he excelled, while holding the surgical fraternity in his palm.

One fat lady

Clarissa Dickson Wright was his youngest daughter, born in London after the war. Three months after her birth, the family finally settled in St Johns' Wood, under the shadow of her father who was a rather stern disciplinarian. Clarissa was bright and qualified as the country's youngest barrister at 21 and could command the legal profession in the same manner as her father commanded respect from his surgical colleagues.

In her childhood days, she recalls how her father created a home atmosphere which was quite disturbing – tense, frightening and even violent – "a toxic environment". She repeated on the Throsby program how on the day her mother died of a heart attack in 1975, the light was on in her bedroom still in the evening after returning from that fateful Ascot race meeting. Clarissa sought solace from a friendly neighbour and in the typical English manner was offered a cup of tea. She asked instead for what was being drunk at the time, which turned out to be whisky. She polished it off like any soothing lemonade in two to three mouthfuls. She told Margaret Throsby that she had never experienced such emotional relief and satisfaction from a drink ever before and said "it was the start of my downfall".

When her mother died she left her an inheritance of £2.8 million, which lasted only until 1983. She recalled on one Christmas occasion, she finished the bottle of Margaux, having finished the bottle of Beefeater beforehand, then she knew she was an alcoholic. This eventually led to her personal disintegration and she became a homeless bankrupt having drunk through her impressive inheritance, before finally she sought assistance.

During the interview, Clarissa was first to clarify in my mind the difference between a cook and a chef. Her answer simply is that "a cook will look into the fridge and think how to make a meal with what is there. A chef has a refined approach requiring the best of ingredients usually at an exorbitant cost and gives you the novelle cuisine meal in which often the white ceramic of the plate shines through the sparse food arrangement".

Subsequently in one of the BBC television shows she met Janet Patterson. Pat Llewellyn of the BBC thought the two honourable ladies, Clarissa and Janet, could do a program motoring around the English countryside in a Triumph Thunderbird with a sidecar, cooking wholesome English fare at various country estates to combine a travelogue with an invitation to experience gourmet delights.

The popularity of the program still remains high with up to 70 million viewers worldwide. The caption of the "Two Fat Ladies" has stood the test of time. Yes they were well endowed, but the multiple types of variety food and location had created a television wonder. Clarissa said that people love the show because it had a "touch of anarchy", and she attributes this forthrightness to her Australian ancestry and added that she likes being honest – a refreshing contrast to what we see on television almost daily.

Back to Dickson Wright himself, who died on 18 February (the date I penned these lines), 1976. In Lord Porritt's obituary on Dickson Wright himself delivered in 1976 in St Martins in the Field (which I passed many times in London on my way to do migrant examinations at Australia House). He described Dickson Wright as a gregarious personality, who chose his friends selectively.

Wright's self-confident and self-opinionated witty style created a brash exterior disguising his underlying introspection. He had the habit in clinical practice of absolute dedication to all his patients, and they reciprocated accordingly by recovering. Surgically he was a master craftsman, one of the last true general surgeons, with his detailed knowledge of anatomy, meticulous surgical technique, a controlled speed of execution, but most importantly "cool in crisis". This made him a consummate personality in the operating theatre.

Following his return from Singapore to St Mary's, in spite of the war interruption he remained there for almost 30 years. His ready wit, his clever teaching and his epigrammatic utterances made him a father figure for student education. It was well-known that he was apparently tireless and often asserted "that resting and reading were much more valuable than the hours of unconsciousness spent in the arms of Morpheus". The French philosopher Paul Valery (1871-1945) even said in a somewhat synoptic way; "a serious minded person has few ideas, but people with ideas are never serious", as was Dickson Wright.

Back to Carpul Tunnel

In the "Proceedings of the Royal Society of Medicine" (1946), Dickson Wright stated that the operation to release the carpal ligament was done at the suggestion of Dr Russell Brain, the neurologist, who described this form of neuritis as compressional neuro-attrition of the median nerve precipitating a neuropathy requiring surgical release. In that original article in the Lancet in 1947, they discussed the multiple aetiological causes of this syndrome including work-related factors, still a controversial point today. If one has the diathesis, aggravated by work, where does liability lie?

Coincidently, Okutsu, the international Japanese hand surgeon, in the recent publication of Hand Surgery 2010 wrote an article titled: "How I developed the world's first evidence-based management of carpal tunnel". It is the story behind his patent applications for his endoscopic carpal tunnel release instrument. In Western medicine, patent applications are seldom made. Yet they are beginning to surface in certain areas e.g. gene therapy and these are sometimes regarded as a point of controversy. Even Fleming refused to apply for patents with Mellanby before leaving for America to produce penicillin in 1942 (with penicillin spores sewn into his clothing for security) and on his arrival the American drug firms applied for patents, delayed production and subsequently the English had to pay royalties.

By way of conclusion, patents imply a pecuniary purpose not common in Western medicine. Yet this perspective is well summarised by the French philosopher Rousseau (1712-1778), who wrote "the money we have is the means to liberty, that which we pursue is the means to slavery".

Audit an important part of CPD

Participating in the College's audit activity can help improve our services

Guy Maddern,
Chair, ANZASM Steering Committee

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) program has been operational for more than eight years, and following on from its success in Western Australia, the College has implemented the project nationally, with all states and territories contributing from 2010.

The College has a strong commitment to working with government to improve the quality of health care in Australia. ANZASM is an independent, peer review audit of all surgically-related deaths. The audit is designed to identify and monitor improvements in the quality of surgical care through the collection and analysis of patient mortality data.

The overall aim is to prevent system and process errors that affect the delivery of safe, efficient and effective surgical care. Through research, reporting and analysing this data, ANZASM will improve the quality and outcomes of surgery.

Participation in ANZASM was deemed a mandatory Continuing Professional Development (CPD) activity (Category 1 – Surgical Audit and Peer Review) in January, 2010. The ethos for this was to ensure complete participation by Fellows in this activity in all States and Territories in Australia, as well as in New Zealand when the audit becomes available.

Mandatory participation relates only to those hospitals where the audit is available. Fellows are asked to confirm their participation in ANZASM through their annual CPD return, either through CPD Online or the hard copy Recertification Data Form. Each year 3.5 per cent of Fellows will be selected to verify one component of their CPD return, which may require them to provide evidence of participation in ANZASM.

Participation in the audit is initially confirmed by ANZASM when the surgeon completes and authorises a signed participation form, which is lodged into their local project office database.

Fellows, for the purposes of CPD, are required to register at their local project offices even if they have not had a death during the audit period. This will be confirmed by a consent statement soon to be placed on all surgical cases, first and second-line assessment forms. All information regarding a surgeon's participation in ANZASM is covered by Qualified Privilege.

The rationale behind having Qualified Privilege is to encourage participation by ensuring that information generated by the audit is entirely confidential and de-identified. Qualified Privilege ensures that information can in no way be made public and in particular will not be made available for use in any civil proceedings.

ANZASM is a quality assurance program within Australia and is declared under the Commonwealth Qualified Privilege Scheme and the Commonwealth Health Insurance Act 1973. Those engaged in the project are authorised to do so by association of health professionals and it is in the public interest prescribed in regulation 23C to 23G of the Health Insurance Regulations 1975.

Determining future verification and confirmation of re-certification will require Fellows, who have had deaths, to return surgical case cases, first and second-line forms, within three months. If there are any problems in achieving this timeline, early notification to the project office is essential. In cases where a Fellow has had no deaths, their participation will be verified by the registration of their details at their local project office.

In order to assist Fellows in the completion of these forms, a new electronic interface system has been designed that will provide Fellows with a way to capture audit information directly into a template of the Surgical Case Form, as well as first-line assessments on-line. I hope that this initiative will benefit you as a user and will encourage input of cases through the online system.

More information is available by contacting your local project office by going to: www.surgeons.org/racs/research-and-audit/audits-of-surgical-mortality

Thank you for your ongoing support

New challenges and the NZ health system

New Zealand is little different to most countries in trying to improve health care while lowering the cost to government

John Kyngdon
Chair, NZ National Board

The common aim of governments everywhere is to provide better care and improved health for populations, but at lower cost. The reforms of the health service in the UK over the past decade have provided a political framework for New Zealand's National Government and "targets" were quickly introduced. However, as we already have a lean, predominantly publicly funded system this made achieving targets challenging.

Bang for our buck

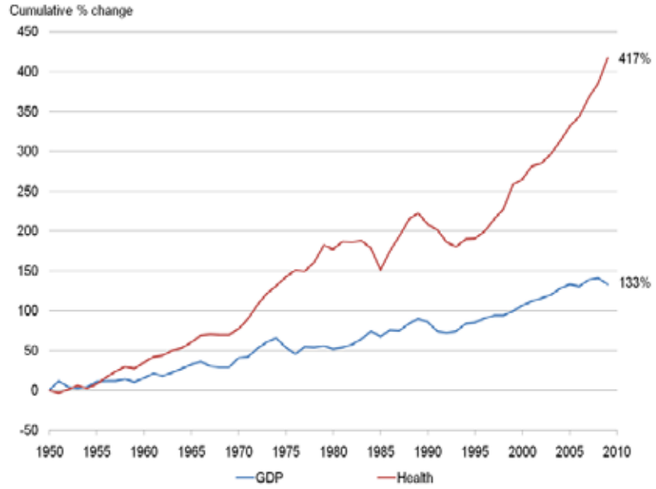
New Zealand spends less per capita on health than Australia (USD$2,500 for New Zealand and USD$3,300 for Australia), although this is 9.8 per cent of New Zealand's GDP while the Australian figure is 8.5 per cent of GDP. Both countries spend less than America, whose figures are USD$7,300 per capita and 16per cent of GDP (WHO data).

New Zealand, suffering from a relatively low GDP, gets a good "bang for the buck". Our average life expectancy is high (82 years for females and 78 years for males) and international quality of life measures consistently rate New Zealand very highly. Pharmaceutical costs are low as PHARMAC, a government agency, negotiates prices with pharmaceutical companies; but this also somewhat limits our choices.

We spend less on expensive 'end of life' drugs. Prioritising or rationing results in patients with more serious conditions accessing publicly funded care, but this has led to an increasing volume of unmet surgical need for the less serious conditions. Unfortunately health care costs continue to outstrip the growth in GDP (as shown in the graph) and serious further constraint must be faced.

Surgeons fit for purpose – changing the workforce

The Medical Council of New Zealand (MCNZ) determines practitioners' fitness to practice



unsupervised in New Zealand. Fellowship of the Royal Australasian College of Surgeons leads to vocational registration. International Medical Graduates (IMGs) have their training and experience reviewed by specialist advisory bodies which make recommendations to the MCNZ.

Whereas previously MCNZ most often accepted and acted upon College advice in respect to surgical IMGs, this is currently less frequently accepted, particularly where completion of the Fellowship exam is recommended. Increasingly, MCNZ appears to expect hospitals, through their Credentialing Committees and other internal processes, to identify and manage any errant practice.

It has recently been suggested that non-surgeons should complete some surgical work under delegation, that surgeons should be generalists in their specialty and that a "New Zealand College of Medicine" be formed as a means of controlling the workforce to better meet New Zealand needs.

Some of these views conflict with established medical opinion and bring connotations of lower standards. We need to counter those ideas if we are to ensure that there are adequate numbers of surgeons being trained with appropriate skills. This could be assisted by expansion of surgical training in some specialties into the private sector and into more of the smaller provincial hospitals. New Zealand (and Australia) needs surgeons with general skills in their specialty to provide acute surgical services in metropolitan, provincial and rural hospitals.

Disaster preparedness

The Christchurch earthquake has reminded us that disasters occur anywhere and can seldom be predicted. It was fortunate that this disaster did not seriously damage Christchurch Hospital and that there were sufficient local surgeons to deal with the multitude of patients in the initial period, many of whom had serious crush injuries.

The New Zealand National Board congratulates them on their handling of the crisis and extends commiserations for the personal losses they and many other medical colleagues suffered. This is a timely reminder for us to improve our national database of "willing surgeons" for when the need arises.

This should identify appropriate skill sets and availability timeframe so that it can be determined who might be best suited for the needs of a particular situation and who would be available for the initial and the secondary phases of a disaster.

Obligations in issuing medical certificates

The medical profession must stay objective when issuing certificates that can be held to legal account

Michael Gorton,
College Solicitor

If a doctor issues a medical certificate that is untrue in any way, the doctor may be exposed to charges of fraud, disciplinary proceedings or professional misconduct hearings. In light of this legal exposure, doctors should have a thorough understanding of the obligations associated with issuing medical certificates and the role they are obliged to play in acting both as patient advocate and objective assessor.

Balance between patient advocate and objective assessor

Justifiably so, doctors seek to maintain a good relationship with their patients. However, often it is the pursuit of maintaining this good relationship that thrusts doctors into situations in which they are faced with conflicting interests.

Despite the fact that in recent years, with the inclusion of a variety of other health professionals, the number of qualified providers of medical certificates has swelled, medical practitioners remain the primary source of certificates. Through the provision of these medical certificates, doctors act as gatekeepers to various sickness related benefits, including sick leave, disability pensions, accident compensation claims and workcover claims.

In undertaking this vital role and assuming this position of trust, medical practitioners have a legal responsibility to objectively judge and accurately and honestly report a patient's level of disability. Despite this obligation to remain impartial, doctors often feel a conflicting desire to advocate for their patient. In fact, international studies have suggested that 'for most GPs [in the UK] their responsibility to the patient outweighed responsibilities to the Department of Work and Pension or to the employer' [Hussey S, "Sickness certification in the UK: Qualitative study of views of GPs in Scotland"].

Furthermore, studies have suggested that because of these internal conflicts many GPs experience negative emotions when conducting a fitness for work consultation [Arrelov B: "Dealing with Sickness certification – a survey of problems and strategies among GPs and orthopaedic surgeons"].

This situation in which many doctors feel negatively predisposed to the medical certification process is concerning. However, to an extent, the concerns that doctors exhibit may be alleviated through a more realistic appreciation of the costs of issuing medical certificates – on both patient and society – and the legal responsibilities owed by doctors in performing this role.

The costs of issuing medical certificates

Over the past decade there has been a significant boost in the number of requested sickness certificates in Australia. This increase, which parallels the experience of many other western nations, can be seen both in the employment and social security contexts.

This can be seen in the increased number of people taking days off work for health related reasons and the vastly increased numbers of people who are accessing disability support pensions [Thompson S: "Innovations in disability employment policy and practice"].

What may come as a surprise to many is that, quite apart from the significant economic burden sickness related absences from work impose on society [the ABS estimates it is some $36 billion dollars annually], individuals who enjoy prolonged absences from work often pay a significant personal toll.

Long term workless has been equated with smoking 10 packets of cigarettes per day and once a person 'commences on certified work absence, they commonly start down a slippery slope that leads to long term worklessness' [Dunstan D: "Are sickness certificates doing our patient's harm"].

The reality is that worklessness has the potential to contribute to financial hardship, a progressive deterioration in physical and psychological health and a diminished quality of life and self-worth.

Undoubtedly in many cases medical certificates are legitimately warranted by a patient's ill health and, to that extent, doctors should not compromise their clinical judgment. However, in the war of competing interests, doctors should have a clear-eyed appreciation of the effects repeated health related work absences can have on the individual and should not necessarily act on the assumption that sick leave is in the patient's best interests, and therefore, when requested, a doctor is obliged to be forthcoming in this regard.

Legal obligations

The position of medical practitioners issuing medical certificates is made more difficult by statutory regulations requiring individuals to produce medical certificates to support an application for sick leave. As a result of this statutory regime, doctors are often placed under pressure to provide the certificate that has been requested.

Employees covered by the National Employment Standards of the Fair Work Act 2009 (Cth) must give their employer notice that they will be absent due to personal illness or injury as soon as practicable [section 107(2)]. Under the Act, employees are not obliged to automatically produce evidence of illness to be entitled to sick leave; despite this, employers have the right to request it at their discretion, even after only one day's absence.

And, whilst the Act does not compel automatic production of a medical certificate, some industrial instruments provide that a health practitioner's certificate must be produced to support an application for sick leave after a certain number of days.

As a means of providing guidance on this issue, the Medical Board of Australia's 'Code of Conduct for Doctors in Australia' states that good medical practice involves:

'Being honest and not misleading when writing reports and certificates, and only signing documents you believe to be accurate;

Taking reasonable steps to verify the content before you sign a report or certificate, and not omitting relevant information deliberately;

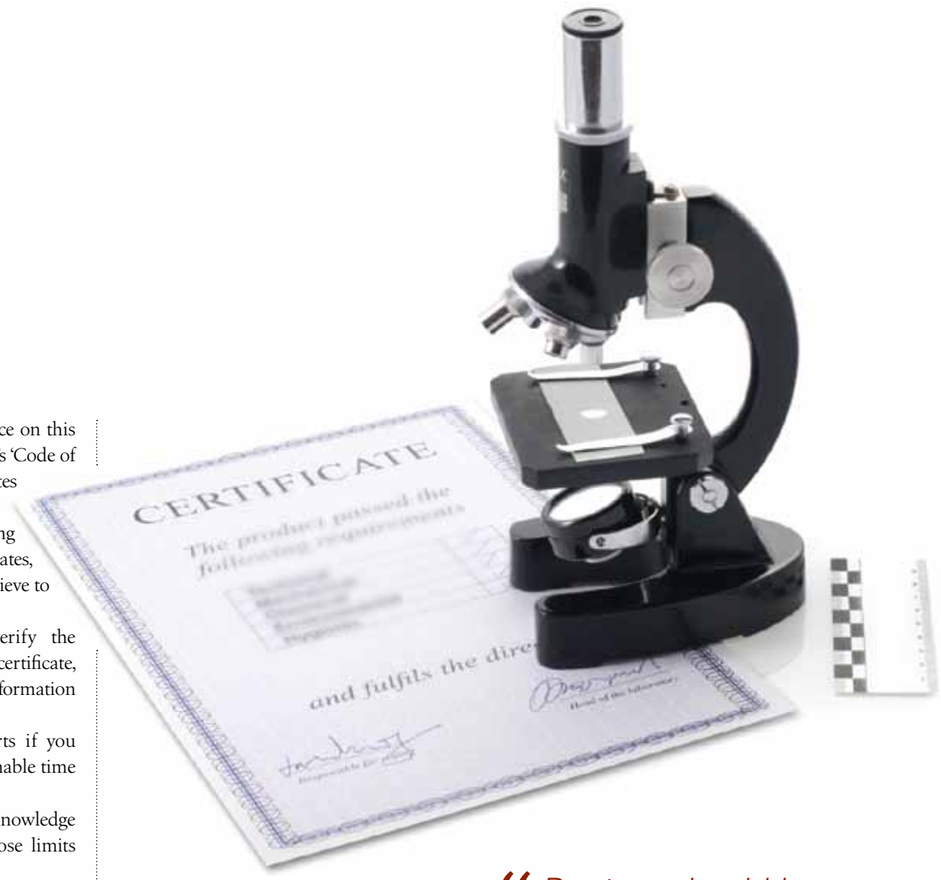
Preparing or signing and reports if you have agreed to do so, within a reasonable time frame;

Making clear the limits of your knowledge and not giving opinion beyond those limits when providing evidence.'

Furthermore, Courts recognise the difficult position doctors are often placed in when asked to issue medical certificates. In Health Care Complaints Commission v Karalasingham the NSW Court of Appeal expressed the need for a 'degree of flexibility to be accepted in relation to doctors issuing medical certificates.' That this is so, is because more often than not an individual, while not feeling up to attending work, will nevertheless deem seeing a doctor pointless and unnecessary.

In these circumstances, where, in effect, the patient is compelled by legal obligation to attend a medical practitioner, the Court has acknowledged it is 'inevitable that medical practitioners will be invited sometimes to provide such certificates based on little more than the history given by the individual [HCCC v Karalasingham].'

Putting to one side the obvious difficulties associated with issuing medical certificates, doctors are obliged to look to the Code of Conduct in order to determine the content of their duty. This means acting with integrity and honesty in reaching a sustainable conclusion, based on a medical history, physical examination and known facts, as to whether they believe the patient is sick and to what extent, and if so, issue a certificate to that effect.



> *"Doctors should have a thorough understanding of the … role they are obliged to play in acting both as patient advocate and objective assessor"*

Contents of medical certificates

Irrespective of the flexible standard that the Court has adopted in assessing the conduct of doctors in issuing medical certificates, some fundamental do's and don'ts remain.

A suitable medical certificate should:

- **Identify the health practitioner issuing the certificate, for example, by the letterhead on the certificate;**
- **Include the date on which the certificate was written;**
- **State that the employee was not fit for work on the days identified;**
- **Identify the duration for which the patient will be unable to attend work;**
- **Where necessary, summarise the condition or disability observed.**

In writing a medical certificate, ideally it should state that the medical practitioner was consulted by the employee during his/her illness. A certificate stating that the employee visited the practitioner after an illness is no better than a statement by the employee that he/she was ill, as, all the doctor has to rely on is the same statement.

Fundamentally, it is important that doctors actually state that the employee is/was genuinely ill. In this respect, it is sufficient to state that the employee consulted the medical practitioner and that the medical practitioner believes the employee's state of health to be consistent with what the employee has told him.

So while an illness may be reported after the event and deemed to be true by the doctor, and a doctor may issue a certificate attesting to that fact, doctors may never "backdate" a sickness certificate to cover a period of illness before the date of the consultation. A certificate or report should be dated at the date of consultation or when written. To do otherwise invites a complaint of professional misconduct and potential criminal action.

National Breast Cancer Audit

The National Breast Cancer Audit will build on its past success under the direction of the Breast Surgeons of Australia and New Zealand

David Walters
Clinical Director
James Kollias
Chair of NBCA Steering Committee

The National Breast Cancer Audit (NBCA) is a quality assurance activity established in 1998 as an initiative of the Breast Section of the Royal Australasian College of Surgeons (RACS) with the aim of improving and maintaining the quality of care received by early breast cancer patients in Australia and New Zealand. The activity is an approved audit under the RACS Continuing Professional Development program.

As of late 2010, the audit has been directed and funded by the Breast Surgeons of Australia and New Zealand (BreastSurgANZ). A new clinical director has been appointed, David Walters, who will provide regular input to the audit staff on data queries and management issues.

The NBCA has achieved much success since its inception and is acknowledged as an important tool for surgeons, as well as providing excellent research opportunities. The newly appointed Chair of the NBCA Steering Committee, Mr James Kollias, has been invited to speak about the audit's success at the annual meeting of the British Association of Breast Surgery in May.

Data collection

Throughout 2009 and 2010, a working party, chaired by Dr Peter Willsher, concentrated on increasing the NBCA's coverage of breast cancer in Australia and New Zealand. Projects that came out of this group included a process of identifying and contacting non-participants, promoting the ease of data entry thanks to the Minimum Dataset option and increasing the awareness of the audit outside of the surgical community.

Another important boost to coverage of breast cancer cases comes from our institutional upload program. An institution (e.g. hospital, registry) with an existing database can apply to become part of this program. If there is enough commonality between datasets, and if there is enough data to warrant the expense, their data will be converted and uploaded into the NBCA. Eight institutions are currently involved in the institutional upload program. The program in 2010 uploaded almost 6,000 cases.

Overall, a total of 262 surgeons contributed data to the NBCA in 2010. Almost 16,000 cases were submitted during this time. The database now contains more than 100,000 cases of breast cancer, with 87,000 invasive cases and 13,000 ductal carcinoma in situ (DCIS) cases.

Assessment

With the implementation of a new Key Performance Indicator (KPI) in March (postmastectomy radiotherapy for high-risk invasive breast cancer), the NBCA now provides self-assessment for surgeons against five KPIs.

These assessments can be accessed through the Breast Surgery Summary screen of the online data entry portal. Surgeons who contribute through institutional upload or paper forms can also log-in to access these assessments.

Research

The NBCA published two research papers in 2010: Disparities in access to breast care nurses for breast surgeons: a National Breast Cancer Audit survey. Breast, 2010 Apr;19(2):142-6; and Patterns of surgical treatment for women with breast cancer in relation to age. The Breast Journal, 2010;16(1):60-65.

The Chair of the NBCA Steering Committee, Mr James Kollias, will be presented current NBCA research at the College Annual Scientific Congress (ASC) in May. This research is concerned with post-mastectomy radiotherapy for high-risk invasive breast cancer.

A previous presentation of NBCA research into the use of the Van Nuys Prognostic Index for the treatment of DCIS won the BreastSurgANZ prize for best paper at the 2010 ASC. This research will be published in a peer reviewed journal.

The NBCA is also working on research into axillary surgery for DCIS, the uptake of sentinel node biopsy for invasive breast cancer and the use of Trastuzumab in Australia and New Zealand.

Collaboration

Since 2008 the NBCA has collaborated with the National Breast and Ovarian Cancer Centre (NBOCC) on a project examining survival of Australian patients recorded in the audit, using data from the National Death Index (NDI).

A paper on the NBCA/NDI linkage was published in the ANZ Journal of Surgery in late 2010. Further research analysed survival from breast cancer according to age, surgeon caseload, treatment centre location and health-insurance status.

This collaboration will continue in 2011, examining the effects of declining treatment, as well as bilateral synchronous cancer. Thanks to funding provided by the Cancer Society of New Zealand, a linkage is being attempted with the New Zealand Ministry of Health Mortality database. If this is successful, the analyses will include information on New Zealand patient survival, as well as comparisons between Australia and New Zealand.

Collaboration with BreastScreen Aotearoa resulted in analyses on tumour characteristics and treatment of New Zealand patients. Publication is currently being sought for a paper based on part of this research.

Acknowledgements

BreastSurgANZ and the National Breast Cancer Audit team would like to take this opportunity to acknowledge the dedication of the breast surgeons contributing to the audit. Without the support of these surgeons over the years, the audit would not have succeeded.

Visit www.surgeons.org/nbca for information about the National Breast Cancer Audit or email the NBCA Helpdesk breast.audit@surgeons.org to subscribe to our newsletter.

Autologous fat transfer for breast augmentation

An article on the systematic review appeared in a previous issue of *Surgical News*. Here is the information prepared for patients.

> *"More high quality studies are needed to provide information on which patients would benefit most from being treated with this procedure."*

Guy Maddern,
ASERNIP-S Surgical Director

In autologous fat transfer for breast augmentation (AFTBA), surgeons take fat cells from the patient's own body and inject them into the breast to increase its size. AFTBA can be used to increase the size of a normal breast (cosmetic) or as part of the reconstruction of a breast after surgery (reconstructive).

In 2002, the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) looked at research studies on the safety and effectiveness of this procedure. In 2010, this information was updated, in the light of new ways of taking images of the breast and new research studies.

The following summary is a plain English summary of the full ASERNIP-S systematic review on autologous fat transfer for breast augmentation available at www.surgeons.org/asernip-s/publications.htm. This information for patients was prepared by a team of surgeons, consumers and researchers.

Main messages

Scientific studies have been done to see whether AFTBA is safe and effective; however, studies included in this updated review did not directly compare AFTBA with other breast enlargement techniques. From the limited evidence, ASERNIP-S found that:

- AFTBA appeared to be at least as safe as the other breast enlargement techniques. Previous research indicated that calcification of fat injected into the breast may make it more difficult later to detect breast cancer, but the studies included in this review did not report on this.
- The effectiveness of AFTBA could not be directly compared to that of the other techniques. It appeared that AFT could increase breast size, but not as much as the other techniques.
- More high quality studies are needed to provide information on which patients would benefit most from being treated with this procedure.

What other types of surgery can increase the size of the breast?

Breast implants

A breast implant is a silicone shell containing either saline (salt water solution) or silicone gel. During cosmetic surgery, the implant may be placed directly under the tissues of the breast, or behind the muscle on the chest wall. For reconstructive surgery, a tissue expander creates a cavity behind the muscle. The most common complications include shrinkage of scar tissue around the implant, skin wrinkling and low rates of infection and rupture.

Flaps

Autologous tissues (from the patient's own body) can be taken from the abdomen, buttock or back of the chest wall. An advantage is that tissue flaps provide a large increase in breast size, but complications can occur at the site it is taken from.

Autologous fat transfer for breast augmentation

Autologous fat transfer occurs when fat cells are taken from one part of a patient's body and transplanted into another part of the same patient. To enlarge the breast, fat cells are sucked by liposuction from the donor site, for example the thigh, and injected into the breast. Small quantities are usually transplanted at a time because the fat cells need to develop their own blood supply or they will die.

- **Main advantages of AFTBA:** no implant complications; a more realistic breast feel; no large scars.
- **Main disadvantages of AFTBA:** need repeated surgical procedures; injected fat cells can die and form cysts, or be reabsorbed; calcification of fat cells may mask breast cancer detection. However, complications only occurred in a small number of patients.

The aim of the ASERNIP-S review was to look at the safety and effectiveness of autologous fat transfer for breast augmentation, compared with saline and silicone gel breast implants, and flap procedures.

What is the evidence?

The scientific studies did not directly compare AFTBA with other techniques for breast augmentation; however, the ASERNIP-S Review Group found that:

- **Safety:** The most common complications with AFTBA were death of fat cells, calcification and cysts; these only occurred in a small proportion of patients. There were no data connecting these complications with long-term detection or presence of breast cancer. For implants, the main complications were shrinkage of the scar tissue around the implant, skin wrinkling and low rates of infection and rupture. For the flap procedures, complications included cell death and hernia if the flap was taken from the donor site in the abdomen. Multiple procedures may be required to achieve the final result.

- **Effectiveness:** It was not possible to compare how well AFT worked compared with the other techniques for breast augmentation, as the different studies reported on this in different ways. Patient satisfaction was high after AFT, as well as after reconstructions using tissue expanders with breast implants and abdominal flaps. The main complaint after AFT, however, was the limited increase in breast size; implant or flap procedures could be used at the same time as AFT when a large increase in breast size is needed.

(Review published in 2010)

Glossary

AFTBA: autologous fat transfer for breast augmentation
AUTOLOGOUS: relating to the patient's own body
CALCIFICATION: calcium build-up in tissues
CYST: abnormal swelling in the shape of a sac, containing liquid or semi-liquid
HERNIA: bulging of an organ or tissue through an opening in surrounding tissues
LIPOSUCTION: fat cells from the body are sucked into a tube connected to a vacuum pump
SALINE: salt water solution
TISSUE EXPANDER: is inserted between layers of muscle under the breast, and inflated to create a pocket of space in which the breast implant is placed
LITERATURE REVIEW: ASERNIP-S conducts literature reviews on the safety and effectiveness of new surgical techniques before they are widely accepted into the health care system. Each review collects all relevant information, or evidence, on new and standard techniques used to treat a medical condition. The quality of evidence is assessed. ASERNIP-S then makes recommendations on the safety and effectiveness of the procedures that are then endorsed by the College.

What is ASERNIP-S?

The Australian Safety and Efficacy Register of New Interventional Procedures Surgical (ASERNIP-S) is a program of the Royal Australasian College of Surgeons. ASERNIP-S conducts literature reviews on the safety and effectiveness of new surgical techniques before they are widely used. Each review collects all relevant information, or evidence, on new and standard techniques used to treat a medical condition. The quality of evidence is assessed. ASERNIP-S then makes recommendations on the safety and effectiveness of the procedures that are endorsed by the College, sent to hospitals and surgeons in Australia and overseas, and published on the website with summaries for consumers.

This consumer summary may be downloaded from the consumer information page of the ASERNIP-S website at: http://www.surgeons.org/asernip-s/consumer

For more information, please contact:
Eleanor Ahern, Senior Project Officer - Consumer
199 Ward Street, North Adelaide
South Australia 5006
T: 61 8 82190900
F: 61 8 82190999
E: asernipsconsumer@surgeons.org
W: www.surgeons.org/asernip-s

The changing face of surgery

As you become more experienced, be prepared for change both inside and around you

Richard Martin
Deputy Chair, Younger Fellows Committee

Everything changes. The world is constantly changing, evolving, and reshaping itself. Unrelenting and irresistible, change is inevitable.

Japan is now 2.5m closer to the US. The clean green safe power alternative of nuclear energy has proven itself to be none of those things, and the Middle East is now competing with Fukushima for being the hottest, most dangerous place on earth.

Shift happens

Surgery is no exception. Despite our ongoing attempts at horizon scanning, no one can truly see the change that's coming.

So how do you future proof yourself? How to avoid becoming obsolete as a surgeon? How do you prepare for change?

Having a broad general knowledge and skill base is essential to adapting to change. Sub-specialise too far and you risk being made irrelevant when technology advances (highly selective vagotomy being one example). Don't specialise at all and you're halfway obsolete already.

Learning as much as possible as a Registrar and Fellow is one important step towards being future proof. This seems on the surface to be 'blindingly obvious', but once graduated as a consultant, it is extremely difficult to keep up with reading and refreshment of knowledge, let alone trying to gain new skills and to be involved in research.

Identify which skills you think will be useful to set yourself apart from your peers, and use your fellowship to gain these before becoming a consultant. Starting as a full time public consultant is a good way to gain further skills, experience and confidence. Rural locums are not only a great way to help our country colleagues, but to also to develop and maintain a good general skill base, and to get out of your comfort zone.

Take advantage of all the College has to offer and become involved. The College is there for you from the "cradle to the grave", and there is as much to learn from other faculty members while teaching on College courses, as there is to impart to the students on those courses

Self reflection is our "inner compass" for change. Every operation can be refined and improved with each repetition, but only if we pay close attention to the heuristics, mull them over, and improve on them the next time. This auto evaluation is probably one of the most important (and undervalued) components of professional development.

Change in surgery is generally evolutionary rather than revolutionary. Having a good collaborative relationship with your peers is important to keep abreast of new thinking in other specialties, which may ultimately filter into your own.

Most new advances started life long ago in the archives of surgery, awaiting technology to catch up and enable those dreams to become reality. Regularly reading the history books is both enjoyable and enlightening, and like Hollywood, surgery never met an old idea it couldn't remake.

It is inevitable that different craft groups will evolve to perform operations previously considered the mainstay of other specialties, and that progress will lead to separate sub-specialised craft groups forming in their own right.

It is to the betterment of all when cooperation and collegiality lead to the birth of a new specialisation, rather than interested groups haggling and competing with each other, and risking, ultimately, becoming themselves marginalised and irrelevant in the process.

Change is not always for the better, but it is inevitable nonetheless (except from a vending machine!). Mastering the basics, having a broad skill set, regular reading and self evaluation will prepare you to adapt and adopt when change comes.

Being involved in your college and cross fertilising with your peers will help you focus as you scan the horizon for change. To be prepared you need to be involved and informed. "The most successful people are those that are good at plan B".

Professional Development WORKSHOPS

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

>Sustaining Your Business

27-29 May 2011, Brisbane

Effective business and financial planning is more important than ever for both private clinical practices and the broader health service delivery environment. This two and a half day workshop provides the foundation for the development and implementation of business plans to sustain business growth and performance. It explores financial management; from the preparation and analysis of responsible budgetary plans, decision making, management and reporting to the development of estimates and capital investment proposals.

>Supervisors and Trainers for SET (SAT SET)

28 June, Sydney

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. Participants will 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. The workshop offers an opportunity to explore strategies to improve the management of trainees and focuses preparing for, conducting and reviewing a mid-term meeting. It is also an excellent opportunity to gain insight into legal issues.

>Keeping Trainees on Track (KToT) *NEW*

11 June, Perth; 11 June, Sydney; 25 June, Melbourne;

'Keeping Trainees on Track' is a new workshop in the 'Supervisors and Trainers for SET' (SAT SET) series. Over 3 hours it explores how to performance manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. Participants are also given the opportunity to learn methods for encouraging self-directed learning by establishing expectations at the start of term meeting.

>AMA Impairment Guidelines Level 4/5: Difficult Cases

6 July, Brisbane; 26 August, Perth

The American Medical Association (AMA) Impairment Guidelines inform practitioners as to the level of impairment suffered by patients and assist with decisions about 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 evening workshop provides surgeons with a forum to review their difficult cases, the problems they encountered and the steps applied to resolve the issues.

>Process Communication Model (PCM)

22-24 July, Melbourne; 26-28 August, Sydney

Patient care is a team effort and a functioning team is based on effective communication. PCM is one tool that you can use to detect early signs of miscommunication and turn ineffective communication into effective communication. PCM can also help to detect stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand. The College is investigating how PCM can assist surgeons to improve their communication skills.

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

2011 DATES:
MAY – SEPTEMBER

NSW

>11 June, Sydney
Keeping Trainees on Track (KToT)

>28 June, Sydney
Supervisors and Trainers for SET (SAT SET)

>8 August, Sydney
Surgeons and Administrators: Working Together to Bridge the Divide

>26-28 August, Sydney
Process Communication Model

>TBC, Sydney
Occupational Medicine

QLD

>27-29 May, Brisbane
Sustaining Your Business

>6 July, Brisbane
AMA Impairment Guidelines Level 4/5: Difficult Cases

>5 August, QLD ASM
Practice made Perfect

>5 September, Brisbane
Keeping Trainees on Track (KToT)

TAS

>23 September, Hobart
Keeping Trainees on Track (KToT)

VIC

>25 June, Melbourne
Making Meetings More Effective

>12 July, Melbourne
Keeping Trainees on Track (KToT)

>22-24 July, Melbourne
Process Communication Model

>29-30 July, Melbourne
From the Flight Deck: Improving Team Performance

>13 September, Melbourne
Keeping Trainees on Track (KToT)

WA

>11 June, Perth
Keeping Trainees on Track (KToT)

>26 August, Perth
AMA Impairment Guidelines Level 4/5: Difficult Cases

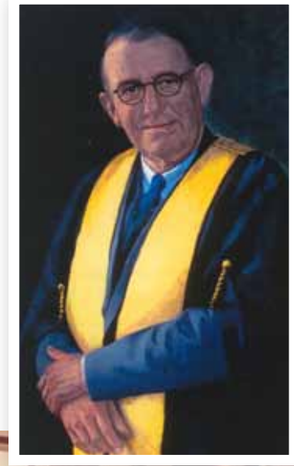
NZ

>17 August, Auckland
Keeping Trainees on Track (KToT)

The Court in evolution

Recent changes to structure improve continuity and share workload

Spencer Beasley
Chair, Court of Examiners



Meeting of the Court in Wellington in 1969, under the chairmanship of Alistair MaEachern, chairman 1964-70. He was the first to attend NZ Court meetings as a routine, thanks to the evolution of air travel during that period. Inset: W.A. Hailes proposed the idea of a Court and combined its chairmanship with his role as Censor-in-Chief until his death in 1949

The evolution of the Court of Examiners is fascinating and worth recounting. During the earliest years of the College's existence, Credentials Committees (later called Censors) in each of the Australian states and New Zealand reported through the Director-General (later called the Censor-in-Chief) to the Council upon the merits of candidates for Fellowship.

But from 1934 this system was replaced by the formation of two Boards of Censors (one in each country, for geographical reasons, and in particular because of the long time it took to travel by steamer between Australia and New Zealand) with the Censor-in-Chief as chairman ex officio of each board.

He was responsible for approving the training and experience of candidates who applied for Fellowship; once approved, they would appear before a Board of Censors of the College where they had to justify their suitability for Fellowship, backed no doubt by glowing references and a list of surgeons with whom they had worked.

In 1943, the then censor-in-chief, W.A. Hailes, introduced new regulations providing for a two-part Fellowship examination, the second part to be conducted in general surgery, gynaecology, urology, ophthalmology, orthopaedics and laryngo-otology. The Boards of Censors were abolished and, in 1946, the first Final examination conducted by a Court of Examiners was held.

There were several well-meaning changes of regulations, which attempted to deal with the situation of mature surgeons, many with British Fellowships and extensive wartime experience; but these mostly succeeded only in creating further anomalies, and in some circles the College was seen as being indecisive, or lacking clear direction.

By 1966 some stability of structure had been achieved: the Australian Court of Examiners numbered nine general surgeons along with two each for the specialties – and a couple of neurologists for the benefit of the Ophthalmology candidates.

There was a parallel New Zealand court, albeit somewhat smaller. Once trans-Tasman travel by air overcame many of the geographical barriers, the Chairman of the Court attended examinations in both countries.

The Court Chairman was by convention always an Australian, although it was not until 1993 that this was enshrined in regulation.

About 10 years ago, a system was put in place whereby the Court Chairman elected by Council could be from either country, but the deputy Chair had to be from the other country. In the past decade this has led to much shuffling of positions, as the Chair of the Court is only elected for a year at a time, and the vagaries of Council elections have meant that there could be three different Court Chairs in as many years.

If one was from New Zealand, it meant that there had to be an equal number of changes of Deputy Chairs. The risk was loss of continuity and corporate memory. In addition, the Chair of the Court now has considerably more work to do than a few years ago, and the Deputy position brings with it similar responsibilities.

For this reason, the structure of the Court has now changed slightly, with the appointment of two Deputy Chairs, one from each country. They are appointed (but not simultaneously) for a period of up to three years, allowing the benefits of overlapping tenure.

This arrangement means that the smooth running of the Court has become less dependent on the nationality of the Chair because of the greater continuity provided by the deputies. As the Court functions become increasingly complex and specialised, this must be considered a good initiative.

And it is not just the chair and deputies who have become busier. The role of Senior Examiner in a specialty now entails significantly more work than it did before. There is a lot more to this role than just preparing examination papers. To share this load the senior examiners now have deputies (some of whom may in due course take over in the role of senior examiner).

These may be interpreted as minor refinements in a story of gradual evolution of the Fellowship examination, but they are all part of the process to improve its quality and consistency.

“Swee Tan was tempted to stay at Oxford but Max Lovie had been impressed with Swee’s year at Hutt Hospital and persuaded Swee to return to New Zealand ”

Congratulations on your achievements

RACS Excellence in Surgical Research Award

Professor Swee Tan is the recipient of the Royal Australasian College of Surgeons’ Excellence in Surgical Research Award. The Award is made to a Fellow who has made an outstanding contribution in the field of surgical research.

Swee Tan was born and educated in Malaysia. At the age of 19, he travelled to Kuala Lumpur to further his education and to learn English. He was awarded a scholarship to Melbourne University School of Medicine, graduating MBBS in 1986.

Professor Tan commenced his post-graduate medical career as a House Surgeon at Waikato Hospital in New Zealand and completed his basic surgical training in 1998. He was drawn to plastic surgery and was successful in achieving selection to begin advanced plastic surgical training scheme in 1989. He completed three years of training, initially in Christchurch and then his final year in Wellington, which was to have a significant bearing on his future career.

He was awarded FRACS in 1992 and as was the custom, headed to the United Kingdom to further his post graduate education. Swee had a particular interest in craniofacial surgery and following a year as a senior registrar at Mount Vernon Hospital, gained Fellowship posts in craniofacial surgery, firstly in Oxford with Professor Michael Poole and subsequently at the Harvard Medical School in Boston.

Swee Tan was tempted to stay at Oxford but Max Lovie had been impressed with Swee’s year at Hutt Hospital and persuaded Swee to return to New Zealand. He was appointed a visiting Consultant Plastic Surgeon at Hutt Hospital in 1996. He developed a large private practice but, with Max’s untimely death in 2000, he gave up his practice to become the full time Director of Plastic Surgery at Hutt Hospital. Upon completing his term as Director of Plastic Surgery in 2006, he was appointed Director of Surgery at Hutt Valley District Health Board, a post he still holds.

Roles of honour

Early in his career, he became interested in vascular anomalies and developed a research interest that has become internationally recognised. His research has greatly enhanced our understanding of vascular anomalies and has resulted in over 100 publications plus visiting lectureships throughout the world. He completed his PhD at the University of Otago in August 2001 with a thesis titled ‘The Cellular and Molecular Bases of Haemangioma’. He has held numerous academic and research posts and since 1996 has been the Founder and Director of the Centre for the Study and Treatment of Vascular Birthmarks, a national referral centre at Hutt Hospital.

In 1998, Swee Tan established and was subsequently appointed the inaugural Chairman of the Gillies McIndoe Research Foundation. The Foundation in turn established the Gillies McIndoe Research Institute at Hutt Hospital. In 2008, he was appointed Professor of Plastic Surgery by the University of Otago based in Wellington.

Swee Tan was elected to the Council of the Royal Australian College of Surgeons in 2007, having already served with distinction in many College and professional roles. In 1996, Swee established the Annual New Zealand Plastic Surgery Registrar Training course. His enthusiasm inspires those around him and continues to stimulate trainees. He has supervised a number of surgical trainees undertaking PhD research. He is an active member of NZAPS and participates in their education programs. In addition, Professor Tan is the immediate past President of the Australia New Zealand Head and Neck Cancer Society.

He remains a devoted family man. His wife, Sanchia, and children, Cherise, Elysia and Michael, are the pride of his life.

Swee Tan is an exceptional surgeon, always striving for excellence, and a researcher of international acclaim. He has inspired colleagues and trainees to follow, and stimulated their interest, in research. He is a deserving recipient of the Royal Australasian College of Surgeons Excellence in Surgical Research Award.

Citation kindly provided by David Theile FRACS

ROWAN NICKS INTERNATIONAL AND PACIFIC ISLANDS SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the 2012 Rowan Nicks International Scholarship and the 2012 Rowan Nicks Pacific Islands Scholarship. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to be leaders in their home countries.

The 2012 Rowan Nicks International Scholarship is offered to qualified surgeons from Bhutan, Cambodia, Indonesia (with preference to applicants from outside the major capital cities of Jakarta and Surabaya), Laos, Mongolia, Myanmar, Nepal and Vietnam. It is intended to provide an opportunity for the surgeon to develop skills to manage a department and become competent in the teaching of others in their home country. It is emphasised that the objectives of the scholarship are leadership and teaching and it should not be used solely to develop surgical skill.

The 2012 Rowan Nicks Pacific Islands Scholarship is reserved for qualified surgeons and candidates who have completed the MMed examination from the Pacific Islands in the Western Pacific rim, including Papua New Guinea. It is aimed at promoting the future development of surgery in the Pacific Islands by providing a period of selective surgical training with the specific purpose of fostering the scholar’s potential to provide surgical leadership in his/her home country.

These scholarships are usually awarded for a period of between three and 12 months and cover the scholar’s travel expenses between their home country and Australia or New Zealand. A living allowance will be provided equivalent to AUD$36,000 for up to 12 months or appropriate pro-rata for a Scholarship in Australasia. The Scholarship does not cover any costs associated with the scholar’s family members. The Scholarship is tenable in a major hospital (or hospitals) in Australia or New Zealand, and appointees will attend the Annual Scientific Congress of the College if they are in Australia or New Zealand at the relevant time.

Applicants should be under 45 years of age, fluent in English (applicants must provide evidence that they meet the English language requirements for registration with the Medical Board of Australia or Medical Council of New Zealand by the time selection takes place), and be a citizen of the country from which the application is made. Applicants must undertake to return to their country on completion of the scholarship program.

Closing date for these Scholarships is 5pm – Monday 6 June, 2011

A copy of the application form for either Scholarship is available at our website: www.surgeons.org.

Please contact:
Secretariat,
Rowan Nicks Committee
Royal Australasian
College of Surgeons
College of Surgeons’ Gardens
250 - 290 Spring Street
East Melbourne VIC 3002

Email: international.scholarships@surgeons.org
Phone: + 61 3 9249 1211
Fax: + 61 3 9276 7431

Accommodation for Visiting Scholars

Through the RACS International Scholarships Program and Project China, young surgeons, nurses and other health professionals from developing countries in Asia and the Pacific are provided with training opportunities to visit Australian and New Zealand hospitals. These visits allow the visiting scholars to acquire the knowledge, skills and contacts needed for the promotion of improved health services in their own country, and can range in duration from two weeks to twelve months.

Due to the short term nature of these visits, it is often difficult to find affordable accommodation for visiting scholars. If you have a spare room or suitable accommodation and are interested in helping, please send us your details. We are seeking individuals and families who are able to provide a comfortable and welcoming environment for our overseas scholars in exchange for a modest rental and eternal appreciation.

If you would like to be contacted by the College if the need for accommodation in your area arises, please register your details by contacting the International Scholarships Secretariat on the details below. We are currently seeking accommodation in Melbourne, Geelong, Sydney and Adelaide for visits in the latter half of 2011 and 2012. We would love to hear from you!

International Scholarships Secretariat
Royal Australasian College of Surgeons
College of Surgeons’ Gardens
250-290 Spring Street, East Melbourne, Victoria 3002
T: + 61 3 9249 1211 F: + 61 3 9276 7431
E: international.scholarships@surgeons.o

‘Cool’d a long age in the deep- delvèd’ past

– discovering the College’s extraordinary surgeons


Dew (third from right) as a medical student c1912

The College history includes characters with a wealth of experience

Mike Hollands,
Treasurer

Sir Harold Robert Dew (1891-1962) was the University of Sydney’s first Bosch Professor of Surgery. Appointed in 1930, Dew had an impressive academic record, culminating in major awards like the Jacksonian Prize (1924) for an essay on malignant disease of the testicle, and the David Syme Research prize for work on hydatid disease.

This led in turn to his seminal work, Hydatid Disease Its Pathology, Diagnosis and Treatment published in 1928. Significantly, the physician, Robert Scot Skirving who was not always complimentary about Dew, commented that he was ‘the author of the best book on hydatid disease in the world’.

Like so many of his generation, Dew who completed his Medical degree in 1914, enlisted in the Royal Army Medical Corps. Serving in France with the 57th Field Ambulance, he was known as ‘Bloody hell Dew’. His letters home were copied into exercise books by his wife and are now in the College Archive. They provide an interesting record of his experiences.

6/10/15

I am now back with the ambulance after a week in the trenches with mud up to my ears very nearly and I am not sorry to be where I can get a decent bath and a nice warm bed. Winter has now set in and the whole country is a mass of mud.

In 1918 Dew also served in Egypt – at Kantara (or El Qantara), which was to become the ‘stamping ground’ of Sir Benjamin Rank at the beginning of World War II.

26/1/18

At present I am at Kantara on the canal marking time while a new laboratory is being built. There are several of us here waiting to do laboratory work. I am keen to get on with it.

As Officer-in charge of Cholera at the 3rd Egyptian Stationary Hospital, Dew was also involved in pathology and surgery. He did not return to Australia after the war, but stayed in Egypt until about the middle of 1919. His pathological specimens of diseases like dysentery and schistosomiasis were sent back to Australia.

12/1/19

I am at present doing a lot of pathological work. I am on the War Museum Committee and Fairley (Sir Neil Hamilton Fairley) who is living here with me and I are having a great time putting up and preserving specimens for Australia.

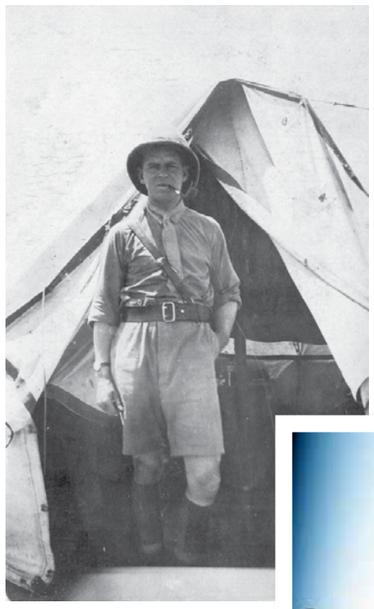
Lingering in Europe until 1920, Dew also completed some postgraduate work and successfully obtained Fellowship of the English College. Collaborating again with Fairley, an expert on tropical diseases, Dew returned to Australia and while working at the Walter and Eliza Hall Institute in the 1920s, continued to investigate diseases identified during his sojourn in Egypt.

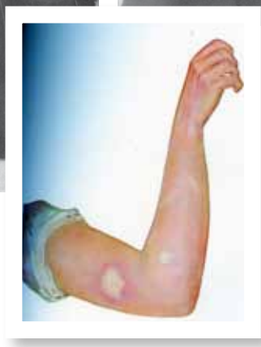
Concurrent with his appointment at the University of Sydney in 1930, Dew spent seven months as the English College’s Hunterian Professor. He continued to be intrigued by all aspects of hydatid disease and his Hunterian lecture was entitled Hydatid Disease - some interesting complications.

A Foundation Fellow of RACS, Dew was involved with surgeons such as Sir Thomas Dunhill, Sir Henry Newland and Sir Albert Coates in the RACS Surgical Section and in 1935 their discussion about hydatid disease was published the Medical Journal of Australia. Dew concluded the discussion by drawing attention to the College’s Hydatid Registry and observing that ‘formalin was being used too strong, in too large quantity, and too much was being left behind’ ... and it was ‘almost useless with multiple daughter cysts’.

Dew’s visit to Harvey Cushing in America attracted him to the budding neurosurgical specialty and inspired his 1936 Bancroft Lecture about intra-cranial surgery. A founding member of the Neurosurgical Society of Australia, Dew was instrumental in introducing neurosurgery to Sydney. The specialty was first established in 1935 at one of the University of Sydney’s Clinical Schools, the Royal Prince Alfred Hospital.

At the University of Sydney one of Dew’s first actions (with Charles Lambie) was to overhaul the clinical curriculum and oversee construction of the new medical school. From 1937-1956, Dew was an influential member of the National Health and Medical Research Council so it is not surprising that he was an advocate for research, particularly into subjects like blood coagulation and cardiac surgery. Letters in the archive such as those to Sir Howard Florey in 1948, suggest that Dew also promoted talented researchers like RD Puflett and Bruce Sinclair Smith.





Far Left: Dew in Egypt 1918. Left: Intradermal reaction, Casoni skin test, from HR Dew’s Hydatid Disease. Above: HR Dew as Bosch Professor of Surgery 1930

At times, Dew was not averse to political comment. In a letter to RG Casey on 6 June, 1940, he says:

…another rather foolish thing in the opinion of many of us is the spending of about a million of tax payers’ money on building military hospitals which are to be like palaces, when the Randwick and Caulfield type of buildings would do perfectly well…while there seems no doubt that it would save a lot of overhead if temporary wards were tacked on to present existing hospitals.

Active on a raft of committees ranging from the RAAF Research Flying Personnel Committee during WWII to the editorial committee of the ANZJS, Dew’s administrative flair was obvious. His long association with the RACS began as a student of the Melbourne Continuation School, the precursor to Melbourne High School on the Spring Street site and culminated in his Presidency of the College (1953-54). His portrait in oils by William Dargie is in the College Collection.

In 1959, Dew suffered a stroke and had a first-hand encounter with neurosurgery. According to John Royle who was a second year resident in the Neurology/Neurosurgery unit at the Royal Melbourne Hospital when Dew was admitted to the unit, his stroke involved a haemorrhage into the occipital lobes at the rear of the brain. There was some blood clot in the area and the neurosurgeon, John Curtis decided to evacuate the clot surgically.

Royle was assisting at the operation which was done under local anaesthesia. As it was on the occiput, Dew was face down on the operating table and apart from the operating area, everything was covered with drapes. Halfway through the operation, from beneath the drapes came a loud voice. ‘What the bloody hell are you doing Curtis? I was boring holes in people’s heads before you were born. I never took this long’. John Curtis made a suitably soothing reply and the operation concluded successfully.

Three years after this incident ‘Bloody Hell Dew’ was dead. Although not renowned for his skill in the operating theatre, Sir Harold Dew was an exceptional administrator, impressive teacher and innovative researcher – in short, a quintessential academic surgeon.

With Elizabeth Milford, College Archivist

In Memoriam

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

>Emil Popovic,
WA Neurosurgeon

>William G. Doig,
Vic Orthopaedic surgeon

>John Buckingham,
ACT General surgeon

>Robert A. McMahon,
Vic Paedeatric surgeon

>Phillip Hunt,
Vic General surgeon

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

Informing the College

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

ACT Eve.edwards@surgeons.org
NSW Beverley.lindley@surgeons.org
NZ Justine.peterson@surgeons.org
QLD David.watson@surgeons.org
SA Daniela.giordano@surgeons.org
TAS Dianne.cornish@surgeons.org
VIC Denice.spence@surgeons.org
WA Angela.D’Castro@surgeons.org
NT college.nt@surgeons.org

Stepping forward for Trauma Prevention

The Trauma Committee congratulates Brian Owler, a Fellow of the College for speaking out about road trauma. The Westmead Hospital surgeon contacted the NSW Government last year about developing a road safety campaign after becoming increasingly frustrated with the multiple cases of trauma he was witnessing in his hospital. He has become the lead spokesperson for a confronting RTA ad campaign "Don't rush" and "Take the slow down pledge".

We encourage all Fellows to use their initiative and step forward to advocate for trauma prevention or other health issues, where they see the need. The College media office can assist you to speak out and gain College support.

Daryl Wall – Chair, RACS Trauma Committee
Danny Cass – Chair, RACS Road Trauma Advisory Subcommittee


Trauma Committee

Fear of rising dog attacks – a call for action?

The College Trauma Committee has had its attention drawn to the seemingly ...

RACS SA, NT & WA ANNUAL SCIENTIFIC MEETING

11 - 12 AUGUST 2011

VOYAGES ATRIES ROCK RESORT (ULURU)

Have you any to your story?

Thank you for dog story

I read your article on dog attacks (***Surgical News***, Vol 12, No 2, pages 16-17) with interest and was glad to see that the bullmastiff breed was not listed as one of the six breeds most responsible for attacks on humans. Bullmastiffs are often unfairly implicated in canine vs human altercations. Also, as a group, I think that patients fronting up to ED with grazes, scratches and minor lacerations (often on hands or forearms, older children and adults under 75 years) sustained from just playing with their dogs (often young boisterous ones) would need to be excluded from this sort of analysis. Any dog lover would understand this.

Thank you for your interest in man's best friend.

Dr Brian Miller FRACS, Princess Alexandra Hospital, Brisbane.

In defence of canines

I would like some more consideration here regarding the dog attack story (*Surgical News*, Vol 12, No 2) and my view is as follows.The relationship between dogs and human beings goes back 10,000 years and has proved to be a most successful relationship. As much as humans have modified dogs to meet their needs, dogs have in many ways shaped how human beings behave.

In some ways we are both pack animals with a hierarchy and the dog needs to know his or her place in that hierarchy and be trained to be suitable for the complex society in which we live.

There are strange things in the relationship as there is evidence that patting your dog will lower your blood pressure and people with dogs, particularly the elderly, seem to have a better quality of life. There is no doubt when it comes to safety and security a dog is the best burglar alarm with senses way beyond human beings.

The barking of a dog at night gives security for the owner and a message to those who would intrude. In fact when my street was burgled a few years ago they found a map with all the dogs marked and these houses were left alone.

The downside is when a dog, out of control, does something serious, for example, biting a human being. In fact I have personal experience as one of my young children was bitten at a neighbourhood function. The dog was fed and the child went across to pat the dog which bit her while defending his food.

Thus there are responsibilities on all sides and my experience as an Emergency Doctor at Princess Margaret Hospital in Western Australia was considerable in regard to dog bites with the anecdotal view at the end of my rotation. If I was a dog I would have bitten most of them anyway as they were mostly small boys with a very bad attitude.

This is not intended in anyway to justify bad dog behaviour, but to indicate the complex situation which requires responsibility in regard to the choosing, training and long term commitment and responsibilities that goes with owning a dog. In many ways, I would seek dialogue with dog owner groups before seeking to influence, in a collaborative manner, the circumstances that lead to a dog attack.

That we are looking for further research around the World, I would see as being very wise.

To add another dimension, the older age group is worthy of consideration, as owning a dog has a number of advantages.

Once giving lectures on osteoporosis, I recommended buying a dog, given that muscle activity against gravity is one of the major reasons that osteoporosis is prevented.

Nonetheless, I did recommend a reasonably large dog which was hairy, so that if the elderly person did fall down they could grab the fur and be cushioned as they came down.

All of this needs considerable exploration both anecdotally and with as much evidence as possible to formulate policy, but as a dog owner I would request great care in blaming the dog in isolation. I am most pleased to see that Bouvier-Briard crosses are not represented in the five breeds.

Finally I would comment that the Australian Defence Force over the years has been active in my experience in Indigenous communities helping and I am aware of one Victorian Army Officer and Veterinary Surgeon who did a large amount of desexing to impact upon the dog numbers.

Rob Atkinson
Chair, SA Trauma Committee

Don't over-react to dog bites

I read with interest and some concern your article on dog attacks. While there is no denying that a dog attack can be a terrifying experience, your article seemed to imply that dog attacks were surging out of control.

Once again education is the key, both for dogs and humans. A properly socialised dog is less likely to become fearful and react accordingly in stressful situations. Ideally, puppies should attend training at an early age, not just to teach them obedience, but also to show them how to interact with other dogs and humans.

Children too need to be taught how to interact with the family pet and dogs belonging to other people. Sudden movements that can be perceived as threatening, grabbing the dog while it's eating and staring the dog in the eye at close range can all lead to accidents.

RSPCA Qld has a mobile education unity called EMU that teaches thousands of children a year about animal welfare and how to 'prevent a bite'.

Australia is also one of the least 'dog friendly' nations in the world. Despite the fact that dogs are enormously popular and a billion dollar industry with pet food and products, they are basically barred from everywhere apart from the backyard and the dog park.

In Europe they are very much a part of society and welcome on buses, hotels and restaurants. At the RSPCA we all too often come across dogs that are chained in the backyard 24 hours a day, seven days a week. Is it any wonder that they strike out?

The level of cruelty to animals also appears on the increase. In recent times we've seen a puppy cut to death with secateurs. It took 40 minutes for the dog to die and its agony was videotaped on a mobile phone. We've also seen a Labrador bashed in the head with a hammer and a tyre anvil shoved up its rectum.

While the breeds you mentioned will always feature highly in any statistics, other smaller breeds are just as - if not more - likely to bite. It's just that getting bitten by a Chihuahua is less likely to result in serious injury.

Before we over-react to dog bites, let's not forget the myriad of benefits that pets can and do bring to our lives.

Seniors with dogs go to the doctor less. Dogs help to relieve everyday stress and for people aged 65-78, they are a major factor in initiating conversations with passersby. They promote social interaction, decrease the feeling of loneliness and isolation and increase morale and optimism.

Helping to care for another creature can also potentially teach children a sense of empathy and responsibility. They can also be a great comfort in times of conflict or grief, since they offer unconditional affection.

In short the benefits are endless. In most cases dog bites tend to be the fault of humans; either an uneducated human interacting with an uneducated dog or an irresponsible owner who frankly, to quote Gone with the Wind, simply "didn't give a damn."

Michael Beatty
Media and Community Relations
RSPCA Queensland

Memoirs of Surgical Investigator

Some past researchers embodied the term 'sick with work'

Bernard Catchpole,
WA Fellow

I spent one study leave attached to a university department where many patients with gut disease were treated. Consequently, stomas – openings of the gut to the surface – were common.

I'd gone there to study how colic developed in the gut. The professor told me of a surgical registrar who would like to join me. We had an excellently equipped and staffed lab to work in.

Before leaving Perth, I'd had a 1.75 meter 5-channel tube made. Equipped with a 250ml balloon, it had two perfusable sensing ports orad (on the mouth side) to the balloon and two aborad (or beyond it).

A slow infusion pump would keep channels filled with water. The object was to induce mild colic and record how it was produced by the gut. Local contractions would be sensed via the ports up the catheters to transducers and thence to a 6-channel polygraph. The subject would hold a bell-push to signal discomfort or pain.

My co-worker had great difficulty in tube swallowing so it usually fell to me to be the subject at that stage of the study. It was easy to locate the position of the tube end during swallowing as the ports picked up the characteristic contracting patterns of stomach and duodenum as the tip progressed down the gut. I lay on a couch behind the polygraph unable to see the recording.

The morning came to try to induce colic by internal gut wall stimulation. I collected from the Pharmacy a bottle containing Ipecacuhana Syrup, the standard irritant limit used to induce vomiting. The bottle contained five child doses or two and a half adult doses. Down went the tube and I lay down clutching the bell-push. My colleague was organising the polygraph, pump and syrup injections to go down the tube.

I lay for almost one hour and had disappointingly felt nothing, nor had anything significant appeared on the polygraph. We just had not induced colic. Failure! I asked how much syrup had been injected and was told – "Oh – all of it". A bit dismayed, I pulled up the tube and we eventually left the lab for lunch.

Some minutes later en route to the dining room, I knew my gut was beginning to complain. It wanted a lot of diluting fluid in its lumen to water down the syrup, and my circulation was quickly trying to provide it. If I didn't lie down at once voluntarily, my gut would make me!

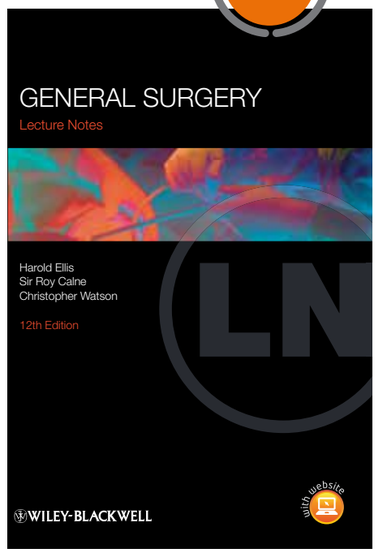
Fortunately we were passing a toilet and I lay down in it promptly, staving off a faint. Eventually, after parting with the diluting fluid, my circulation came to terms with the event and I reached the dining room where I consumed a litre plus of fluid.

It was the day of my wedding anniversary and I had recovered sufficiently to take my wife out to dinner in the evening. However, my mind was still on my gut and the problems of inducing colic. What a way to celebrate! The final outcome of this tale is to be found in "A study of the genesis of colic" *Lancet* 1, 211-215, 1988.

Welcome to the Surgeons' BOOKCLUB

Highlighted in this month's issue are recent and new titles from across the spectrum of books available from John Wiley & Sons.

BOOK OF THE MONTH 20% Discount



Lecture Notes: General Surgery, 12th Edition

Harold Ellis, Sir Roy Calne, Christopher Watson. 9781444334401 | Pbk | 432 pages | March 2011

~~AU$49.95~~ **/ AU$39.96**

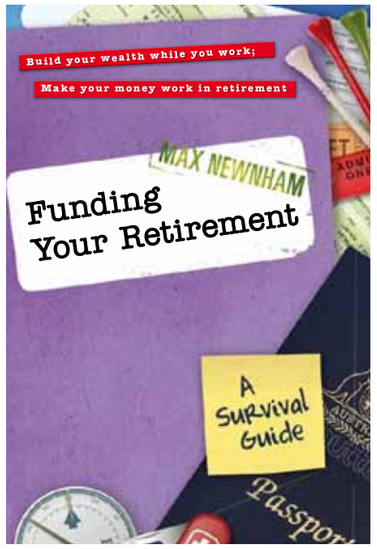
The 12th edition of General Surgery Lecture Notes introduces the student to the principles of common surgical operations and systematically covers all clinical problems where surgical intervention is indicated.

Now in full colour throughout and fully-supported by a website of self-assessment questions and answers, this popular and classic text will appeal to all medical students and junior doctors who want a concise introduction to the fundamental aspects of general surgery and will provide the core knowledge needed for Finals and the MRCS examination.

Key features include:

- Offers a comprehensive overview of surgical techniques
- Contains a wide range of colour illustrations
- Fully supported by hundreds of self-assessment questions and answers at www.testgeneralsurgery.com

15% Discount



Funding Your Retirement: A Survival Guide

Max Newnham

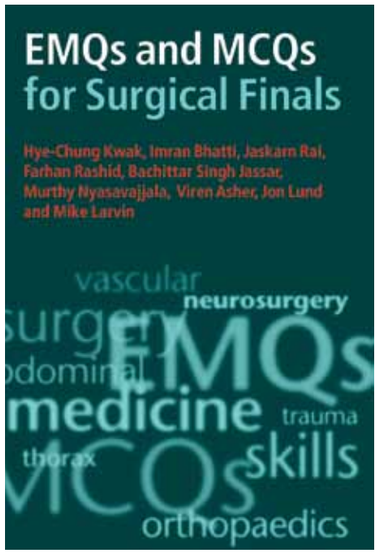
9780730375081 | Pbk | 312 pages | April 2011

~~AU$32.95~~ **/ AU$28.00**

Many Australians aren't financially prepared for retirement. And the retirement savings of many more Australians nearing or in retirement were seriously affected by the GFC. Australians need to know how to build their wealth while they work and make their money continue to work hard for them in retirement. If you don't pay for it – who else will?

Funding Your Retirement: A Survival Guide is a practical financial guide for any Australian – but particularly baby boomers – interested in ensuring they have a financially secure retirement. Author Max Newnham guides readers through the basics of investing and retirement, and then moves into strategies for wealth creation to ensure a comfortable retirement. Finishing with important information on estate planning, risk management and taxation, this is a complete and accessible guide to preparing for and enjoying your retirement.

15% Discount



EMQs and MCQs for Surgical Finals

Hye-Chung Kwak, Imran Bhatti, Jaskarn Rai, Farhan Rashid, Bachittar Singh Jassar, Murthy Nyasavajjala, Viren Asher, Jon P. Lund, Mike Larvin

9781405199414 | Pbk | 352 pages | February 2011

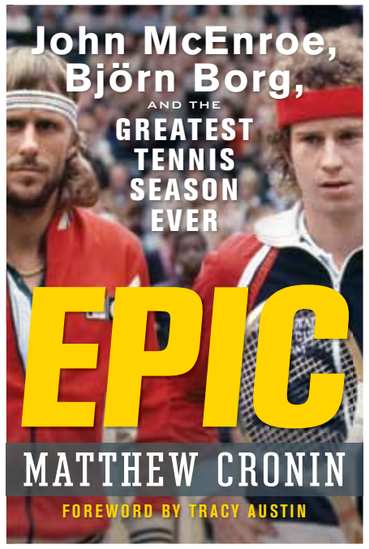
~~AU$39.95~~ **/ 33.96**

Revise and prepare for surgical finals with a wide range of questions and comprehensive answers that test your knowledge and help you learn

EMQs and MCQs for Surgical Finals is a unique study and revision resource for final examination practice covering all surgical sub-specialties. Each section of the book begins with a brief outline of the surgical topic followed by a range of clinically based questions to test both knowledge and understanding.

This is an essential resource for surgical finals preparation and will assist in providing a rapid refresher, testing understanding, indentifying areas of weaknesses and consolidating knowledge. All in all, a real must-have for any student sitting final surgical examinations.

15% Discount



Epic: John McEnroe, Björn Borg, and the Greatest Tennis Season Ever

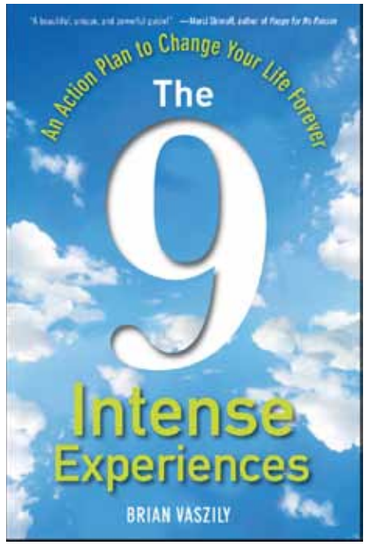
Matthew Cronin

9780470190623 | Hbk | 312 pages | April 2011

~~AU$32.95~~ **/ AU$28.00**

The epic 1980 Wimbledon final that ended with John McEnroe's defeat by his idol, Björn Borg, is considered the greatest tennis match ever. The US Open final later that year, when McEnroe got his revenge, is considered the greatest US Open ever. These two matches marked McEnroe's transformation from tennis player into an American icon, the high point of tennis's gigantic leap into the national consciousness, and the beginning of Borg's rapid and surprising decline. This book takes you back to that amazing summer at the height of the golden age of tennis.

15% Discount



The 9 Intense Experiences: An Action Plan to Change Your Life Forever

Brian Vaszily

9780470596357 | Hbk | 288 Pages | March 2011

~~AU$32.95~~ **/ AU$ $28.00**

Do you ever feel stuck in a rut in your job or relationships? Do you feel trapped in a seemingly endless 'to-do' list that removes you from the core of who you are and what you are truly meant to be? The 9 Intense Experiences leads you on a powerful journey to quickly overcome emotional barriers and set you on the path to achieve what you desire most. This is a fun, bold, rapidly-effective new approach to achieve happiness and success in life.

Also available at 15% off in our best selling How To series at this special price:

How to Display Data 9781405139748
How to Present at Meetings 2E 9781405139854
How to Read a Paper 4E 9781444334364
How to Succeed at the Medical Interview 9781405167291
How to Succeed at Medical School 9781405151399
How to Survive a Medical Malpractice Lawsuit 9781444331301
How to Survive a Peer Review 9780727916860
How to Survive in Medicine 9781405192712
How to Teach Continuing Medical Education 9781405153980
How to Write a Grant Application 9781405197557

WILEY-BLACKWELL

To Order

Contact Customer Service by phone on 1800 777 474
Provide your name, contact details and payment details.

Wiley accepts Visa, MasterCard and Amex only
Postage is charged on all orders: AU$7.50 within Australia and AU$25.00 to New Zealand

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

RACS Discounts

Wiley-Blackwell offers College Fellows discounts on All Wiley-Blackwell titles.

20% discount is offered on the Book of the Month.

15% discount is offered on all other books.

You must quote Promo Code
RCS11

Foundation for Surgery
Passion. Skill. Legacy.

thank-you

for donating to the Foundation for Surgery

Victoria
Mr Alan Crosthwaite
Dr Peter Hardy-Smith, OAM
Mr John Henderson
Mr Raymond King
Mr Stephen Kleid
Mr Marinis Pirpiris
Mr Harry Tsigaras
Wangaratta Private Hospital
Mr Mark Whitty
Dr Alex Wood

New South Wales
Mr Ratnakar Bhattacharyya
Dr Alfred Lewis
Mr Andrew Mitterdorfer
Mr Keri Prabhakar
Mr John Sheehy
Mr Mark Sywak
Mr John Quain

WA
Mr Dibyendu Gope
Mr Gerard Hardisty

Hong Kong
Mr Ting Au
Mr James Cheng
Mr Chun-Hung Chow

Malaysia
Mr Peter Ng

Oman
Mr Raad Almehdi

Singapore
Mr Siew Cheah

USA
Mr Peter McKeown
Mr Michael Rutter
Dr Anthony Schaeffer

Western Samoa
Mr Toga Potoi

Total $7,889

Your passion.
Your skill.
Your legacy.

Your Foundation.

YES, I would like to donate to our Foundation for Surgery.

With every donation over $1000, the College is able to support Research & International Outreach Programs.

Name: Speciality:

Address:

Telephone: Facsimile:

My cheque or Bank Draft (payable to Royal Australasian College of Surgeons) for $ ☐☐☐☐☐.☐☐

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

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

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

Card Holder's Name - Block Letters Card Holder's Signature Date

I would like my donation to go to:

☐ General College Bequests ☐ International Development Program
☐ Scholarship and Fellowship program ☐ International Scholarship Program
☐ I have a potential contribution to the Cultural Gifts Program
☐ I do not give permission for acknowledgement of my gift in any College Publication

Please send your donations to:
Foundation for Surgery

AUSTRALIA & OTHER COUNTRIES
Royal Australasian College of Surgeons
College of Surgeons Gardens
250 - 290 Spring Street
EAST MELBOURNE VIC 3002

NEW ZEALAND
PO Box 7451
Wellington South New Zealand
Tel: +61 4 385 8247
Fax: +64 4 385 8873

Foundation for Surgery
Passion. Skill. Legacy.

GAMMEX®
Powder-Free

AMT®
Antimicrobial Technology

Antimicrobial technology for surgical gloves.

When the Outside Gets Inside

The first surgical glove that fights back: GAMMEX® Powder-Free Glove with AMT™. It is the surgical glove that gives you a new level of protection in the event of a glove breach.* Available only from Ansell, the glove's unique internal coating contains chlorhexidine gluconate for ongoing action against invading viruses and bacteria.

For further information please contact:

Telephone 1800 337 041
Facsimile 1800 803 578
protection@ap.ansell.com
www.gammexpfamt.com

During in vitro laboratory testing, GAMMEX Powder-Free with AMT:

- Kills >99% of an HCV surrogate and 99% of HIV-1 strain Mn as early as one minute following exposure.
- Kills >99.7% to >99.999% of eight common healthcare facility associated infection bacteria, comprising gram-positive, gram-negative, and drug-resistant bacteria as early as one and two minutes following exposure.

In vivo laboratory testing confirms that the internal antimicrobial coating remains active against *S. aureus* after two hours of wear.

GAMMEX Powder-Free with AMT contains natural rubber latex, which may cause allergic reactions.
* GAMMEX Powder-Free with AMT is not proven to protect against blood-borne infections where the skin is broken, cut, or punctured.
Australia Patent No. 703926 and New Zealand Patent No. 556353. AU and worldwide patents pending.

Ansell