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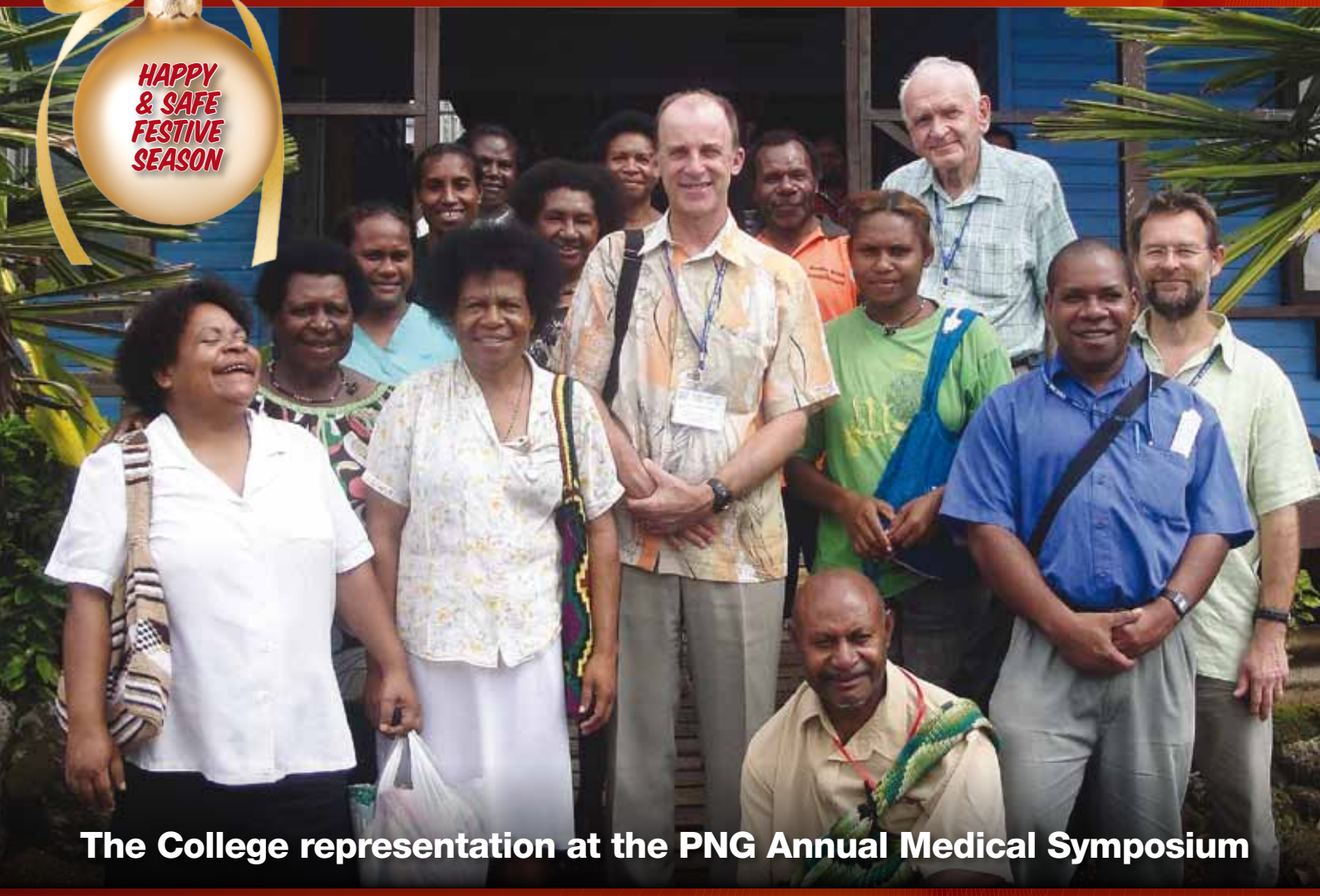
THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



The College representation at the PNG Annual Medical Symposium

[9]
RISING VIOLENCE IN EDs
The College joins with the AMA in front for workers

[12]
ANAESTHETISTS IN TIMOR-LESTE
Continued success from College program

[23]
DOUGLAS STEPHENS PRIZE
Celebrating a respected Fellow

The College of Surgeons of Australia and New Zealand

This is the last *Surgical News* for 2010

And it's a good time to reflect

Ian Civil
President

While you are reading this, there will also be the indecent haste to end of year activities, the demands of individuals and organisations to meet before one can think of end of year celebrations, the joys and contemplations of the festive season and the welcoming in of another year.

This is always a good time of year to reflect. Reflection is easy when it is about our moments of success. But it is more than that. From the perspective of the College, of our Specialty Societies and our profession, are we doing the right things, the hard things as well as the easy things to maintain the respect and the support of the community that we serve?

I had the pleasure of being invited to a recent Australian Orthopaedic Association meeting to discuss the ongoing relationship between the College and Specialty Societies. As mature organisations, it is important that the strength of our relationship continues to be enhanced and that weaknesses or areas of tension continue to be reviewed so that the bonds that keep surgery together strengthen in what are challenging times.

However, I also had the pleasure of listening to the Hon Geoffrey Davies AO, an Expert Community Advisor on the College Council who was presenting at the AOA Scientific Meeting. His address was 'Professionalism of Surgeons: a Collective Responsibility'.

For those who have not personally met Geoff, he is an internationally renowned lawyer and former Supreme Court Judge, who also undertook the enquiry into Dr Patel in Queensland. He knows both the joys and the profound sorrows of our health care systems, surgical practice and our required standing as professionals. His contribution at our Council and at our various meetings has been one of substantial and considered thought with incredible insight as to how the external world views us.

Maintaining standards

I had previously listened to and read his address 'Professionalism: the James Prior Memorial Lecture'.[1] He commented at the October AOA meeting that issues he had raised about professionalism had "sunk like a stone, leaving not even a ripple behind." He was specifically speaking about our requirements to understand our standards and ensure that the people within our profession maintain those standards. Whatever the tools, we need to understand the decisions and performance of all of our members. Equally he believes that our profession needs to be as focused as our predecessors were in serving the public particularly in those areas of practice where public benefit could substantially outweigh personal benefit. As he stated there are two reasons

> *"As prompted by the Hon Geoff Davies, are we properly considering and supporting the key requirements that our communities want in a safe and effective surgical service?"*

why this is the case. Firstly it is part of our professional duty of public service. Secondly and perhaps more pragmatically is that government will undertake this task if it is not ▶

“This College along with many others remains concerned that training opportunities for specialty careers are not being addressed and that efforts to expand opportunities in the private sector need much more serious consideration and support by government.”

demonstrably undertaken by the profession.

This should and does promote profound reflection. Are we doing what we must do to maintain the standards that we hold important? Do we know what our standards are compared to our colleagues? Are we sure that there is a collective effort that all of our standards are at the level required for our communities?

There is no doubt that Government is now progressing broad agendas of reform across the health system supported by far more rigid regulatory effort. When Government undertakes this, the results are cumbersome and at times hazardous. The introduction of the Medical Board of Australia was going to produce streamlined and more effective support and administration. Six months on and the ground-swell of complaints are growing. Registration issues are still confused and stories of the public not being protected by some Medical Practitioners continue to be highlighted in the lay press.

Mapping the future as surgeons

Health Workforce Australia has been formed to ensure the health workforce of tomorrow is trained and experienced, but it now appears that today's medical graduates will not be guaranteed intern positions to complete their registration requirements. This College along with many others remains concerned that training opportunities for specialty careers are not being addressed and that efforts to expand opportunities in the private sector need much more serious consideration and support by government.

Figures published through the year clearly demonstrate that both Australia and New Zealand rely too much on importing medical graduates and specialists from overseas countries. This is now so much of a problem that the World Health Organisation wants the governments of both countries to commit to decreasing this dependence so the health systems of less well-off countries can have the work force they require.

So, it is time for reflection. The College and the Specialty Societies continue to mature and this needs to include the relationships that guide our common activities and requirements. As prompted by the Hon Geoff Davies, are we properly considering and supporting the key requirements that our communities want in a safe and effective surgical service? If we do not fully address these issues, our destiny as professionals could be effectively removed from our hands.

These are some important issues that demand the reflection of all Fellows.

At the same time, I wish all of you a joyous Festive Season, a very successful New Year, a time of good health and warmth. I look forward to seeing you all further in 2011.

Reference

1. Davies GL. Professionalism: the James Pryor memorial lecture. *ANZ J Surg* 2007;77(10):818-23.

Life-saving workshops not only for surgeons

GPs come away from the course not only competent, but confident to perform life-saving procedures.

Keith Mutimer
Vice President

Some readers may remember a story that made headlines in May last year when one of our Fellows talked a rural GP through the drilling of a burr hole in the head of a critically injured boy, saving the child's life. The 12 year-old had fractured his skull when he fell off his bike. His mother detected a bump on his head and took him to Maryborough Hospital where the boy deteriorated to the point where he was having opisthotonus seizures and death was imminent. Using a sterilised household drill from the hospital's maintenance department, and following instructions given over the telephone, the GP performed the trepanation through the boy's 5 mm thick skull, used forceps to widen the hole to approximately 1 cm and inserted a drainage tube. This allowed the clot to escape, relieving the pressure on the brain and allowing the boy to be safely airlifted to the Royal Children's Hospital for further treatment.

According to the College Fellow at the other end of the phone the GP stayed cool, calm and collected throughout – but you can imagine how confronting this situation must be for the inexperienced GP.

The core business of the College is the ongoing education and training of surgeons and as such we share in the wider responsibility for appropriate surgical care for all. As surgeons we need to ensure that where surgical services cannot be provided by a fully trained surgeon, the doctor providing the surgery is equipped with the skills and training to the level of their expertise. In most cases this means the local GP. This is especially significant in rural and remote communities where referral to a surgeon may mean several hours of travel. Training GPs in these communities to perform basic surgical procedures can have a huge impact on the ability of patients to get timely access to the help they need, prevent further deterioration of conditions and save lives.

Surgical skills for rural GPs

One response to this need has been the provision of our Minor Surgery for General Practitioners course, which has been conducted for the past six years by the Skills & Education Centre. Accredited by the Australian College of Rural & Remote Medicine and the Royal Australian College of General Practitioners, and targeted especially, but not exclusively, at remote and rural GPs, the course aims to update resuscitation and minor surgical procedure skills. Over two days, participants get an anatomical-based grounding and practical experience in injections and nerve blocks, urology and peripheral limb procedures, skin procedures, and punctures and airway management. Specific topics are wide-ranging and include ingrown toenails, haemorrhoids, biopsies, lumbar punctures, and ophthalmic foreign bodies just to name a few.

Skills & Education Centre Medical Director Donald Murphy is to be congratulated for overseeing a course that is practical, down-to-earth and relevant. In addition to Fellows from various College specialties including urology, general surgery and orthopaedics, there are anaesthetists, dermatologists, ophthalmologists, procedural general practitioners and anatomists on hand to take GPs through procedures, answer questions and network in a relaxed and informal atmosphere. GPs come away from the course not only competent, but confident to perform life-saving procedures. The premise of the course is that minor procedures are well within the capability of a well-trained GP with a good support network that includes fully trained surgeons.

Don tells the story of one participant who was driving home from the course to New South Wales and pulled over when she noticed a car crashed at the side of the road. The driver ▶

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“The premise of the course is that minor procedures are well within the capability of a well-trained GP with a good support network that includes fully trained surgeons.”

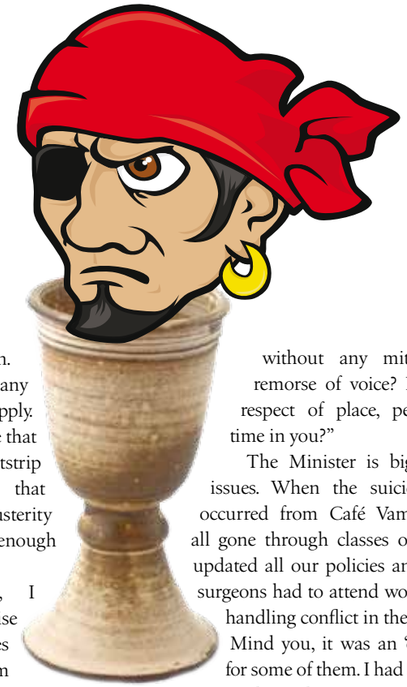
was seriously injured and unable to breathe. Using equipment and techniques learned earlier that day, she performed a cricothyroid puncture, established the airway and saved a life. An attending ambulance had the necessary equipment on board, but remarkably nobody else at the scene knew how to use it. This GP now had the necessary knowledge and, crucially, the confidence to do what she had to do. This is what this minor skills course is all about.

Don is currently in the process of submitting the course for additional accreditation by the College Education Board. There are also opportunities to further develop the course for outreach teaching, extending its influence to such areas as the Timor Project, and papers are in the process of compilation and publication.

As for the GP who performed the trepanation, the College was pleased to welcome him to the workshop earlier this year to talk about his experience and its relevance to participants, all of whom could be faced by such an emergency at any point in the future.

Poison’d Chalice

Is there no respect of place, persons, nor time in you?



Professor U.R.Kidding

Spring is in the air, summer is around the corner. This used to be a time to relish, but as a close confidant of hospital administrators, I approach it with a little trepidation (by ‘close confidant’ I mean the nearest person to blame!). It is of course the second quarter of the financial year. Budgets have long since been decided, projections finalised and now it is the time when the results start coming in. On top of that, the third quarter is sabotaged by the Christmas break that for elective surgery amounts to weeks – no option for remedies there. So the second quarter is crucial. It seems that everyone but me is thinking about the festive season and their holiday plans.

Well, not quite everyone; the Minister was not quite talking ‘Festive Greetings’ the other day. It was a special meeting of hospital chief executive officers and their directors of surgery. The thrill of being ‘summoned’ has disappeared. When the hot line from the CEO’s office goes off and the statement of “the Minister is wanting to see us” is made, it used to give me a shot of adrenaline. I wondered what we had done wrong or maybe he wanted to congratulate us! Oh to be so naive again. No, there are only two reasons for being summoned. If you are summoned alone, it is because you have done something wrong, and if you are summoned in a group, it is for a pep-talk.

As we dutifully followed the political adviser and traipsed into the meeting room, there was the Minister to greet us. “Good to see you again, seriously, kidding” Well that is my translation – actually he left out the commas and laughed at his little joke.

And so it was – a pep-talk on waiting list numbers – particularly long-waiting patients. The same discussion, but just a new version of waiting list initiatives. Of course, having the waiting list data checked, audited and cross-checked at least six times is a core requirement as well as having it signed off by everyone including the CEO, Chair of the Board and anyone else that could get roped in.

I was always aware that in any system demand could outstrip supply. I am now a convert to the doctrine that hospital demand will always outstrip any budget, no matter what that budget is. You do not need UK austerity measures to know there is not enough money going around...

As the Minister spoke, I daydreamed, and began to realise that blaming inadequate resources was, at least in part, a mechanism that enabled me to avoid thinking about the issue. As far as long-waiting patients are concerned, available resources is one factor, but the other is waiting list management. For some time I had a growing disquiet that the average waiting time for admitted patients was vastly less than the average waiting time of still waiting patients – and the gap was widening. Maybe this reflected good waiting list management – the more urgent patients were treated first, but maybe not. It was a question that I resolved to look into further...

And then at the end or what I hoped was the end of the discussion, it came out...

“And there is to be no David Jones behaviour!” I had been half asleep.

I knew about Davy Jones Locker. I was an addict of *Pirates of Caribbean*. Old sailors being absorbed into the woodwork of the Flying Dutchman. Pirates walking the plank, gold treasure to be found. It had really built on my literacy addiction to Treasure Island.

I shook my head again, the Minister was not into aquatics; this was a discussion about sexual harassment and behaviour in the hospital sector. He was talking about Kristy Fraser-Kirk and $37 million.

Malviolio’s words came to mind (Twelfth Night, II, Scene III). “My masters, are you mad? Or what are you? Have ye no wit, manners, nor honesty, but to gabble like tinkers at this time of night? Do ye make an alehouse of my lady’s house that ye squeak out your coziers’ catches without any mitigation or remorse of voice? Is there no respect of place, persons, nor time in you?”

The Minister is big on these issues. When the suicide tragedy occurred from Café Vamp we had all gone through classes on bullying, updated all our policies and even the surgeons had to attend workshops on handling conflict in the workplace. Mind you, it was an ‘eye-opener’ for some of them. I had been trying to work out how to get a few of the pushier surgeons to these for some time. Strange, it was not the older ‘crustier’ surgeons, but some of the ‘young turks’ who needed it most.

Now the issue was to have a really decent look at sexual harassment. The shock of the David Jones case was that the Board was also legally challenged for allegedly having turned a blind eye to it all and allegedly allowing a culture of harassment to be enshrined. From the Minister’s perspective the ramifications would reach everywhere. And they might. The health sector has launched more sexual innuendoes than most. Dr Kildare may have inspired a generation of aspiring doctors 50 years ago, but the *House of God* had been the mainstay for the last 20 years. *The Flying Doctors* was rapidly replaced by *E.R.* and *Grey’s Anatomy*. We even launched George Clooney as a superstar!

The Minister was really clear. All those end of year functions, all those public relations events had to be carefully reviewed. Immediately. Then the training on respectful work-places, harassment policies, full accountability by all management and governance structures.

I stumbled out of the Ministerial briefing. At least I knew I was safe, the only thing I now hold tight at these functions is my glass of red.

As an older and thus more traumatised surgeon, could I invite you to have a very safe and correct festive season.

Vice-President of AMA Victoria and Emergency Physician Dr Stephen Parnis welcomes the involvement of the College.

Time to act on rising violence in our EDs

Recent comment from the AMA on rising violence in emergency departments has spurred the College's Trauma Committee to speak out

The College's Trauma Committee is calling for radical action to help stem the rise of violence toward medical staff in hospitals, particularly in Emergency Departments.

The chair of the Committee, Mr Daryl Wall, said the Federal Health Department must fund research into the issue, which is believed to be widely under-reported, and that front-line staff should be offered training in both conflict resolution and self-defence.

As Director of Surgery at the Princess Alexandra Hospital in Brisbane, one of the busiest emergency departments in Australia, Mr Wall has witnessed the issue in his workplace.

He said both hospital security services needed to be improved, particularly late at night and that staff ratios should be increased in emergency departments to cut waiting times and the consequent frustration felt by patients.

Specific, dedicated research into the issue could also allow for a type of patient profiling so that medical and hospital staff could anticipate violence before it occurred and thus possibly prevent it, he said.

"Many hospitals do provide security, but it is not necessarily continuous and not specifically directed at the hours when alcohol and drug issues are often contributing factors to injury," Mr Wall said.

"Nurses and medical staff are devoted to their patients and are often self-sacrificing in that if they suffer physical and verbal assault, they rarely report it, in the mistaken belief that they could have somehow prevented it.

"Yet this problem is on the rise around the world now and it must be addressed. No medical professional should be expected to accept violence as part of their working day."

Mr Wall said he knew of medical staff suffering broken jaws, severe bruising, broken teeth and noses or others who had become the focus of murderous threats.

He said the violence was caused either by patients under the influence of alcohol or drugs, those suffering dementia or psychosis, members of their families and even enemies who had followed the injured patient into the hospital.

Aggressive patients

He said research into the types of patients likely to become aggressive was urgently needed.

"I think it is time for the development of a profiling tool or scoring system that could be used to screen for at-risk patients," he said.

"It is common practice for psychiatric patients to be admitted into separate ward areas and through the use of separate protocols and I think we may have to do the same with potentially aggressive patients because it has become patently clear that there is a growing percentage of people who for a variety of reasons cannot control their anger and behaviour in public settings."

Mr Wall said the issue of violence in the emergency departments of hospitals across Australia had come before the Trauma Committee and said the College felt bound to take on the issue given its distinguished history in advocating for social change to reduce preventable injury.

Yet he said that while it was often easier to stand up on public health issues such as the wearing of seat belts, helmets and blood-alcohol testing, it was now time to stand up for medical personnel.

He called on surgeons to encourage all hospital staff to report incidents of hospital-based violence so that a clearer picture of the dimensions of the problem could be better understood.

"Many doctors and nurses are exquisitely sensitive in response to violent events because they often take responsibility for anything that deviates from the standard clinical pathway.

"Often too they show great compassion for their patients and would rather not get the police involved. However, I think the days of such generosity may now be over."

Mr Wall said that if the issue of violence in hospitals was not addressed, poor staff morale could lead to higher hospital attrition rates.

He said the Trauma Committee was now working on the development of a Defence Kit for hospital staff to guide people on the reporting of violence, possible prevention strategies and the need for follow-up and counselling.

"We now see terrible violence on a Saturday night and Sunday morning, violence that didn't happen a few decades ago and we have to change in relation to that," he said.

"When health professionals go to the aid of an injured person now they must assume that person may be drug or alcohol affected until proven otherwise.

"They should assess the patient, bring an unconscious person around and then stand back to analyse the possible behaviour.

"All this is a distressing fact of modern life, but when you have nurses, doctors and ambulance officers being attacked while doing their job we have little choice, but to deal with it to protect ourselves and each other."

Vice-President of AMA Victoria and Emergency Physician Dr Stephen Parnis welcomed the involvement of the College in addressing the issue.

He said that while the AMA two years ago had developed a safety kit for GPs and their clinic staff, it was now time to tackle hospital-based violence.

He said the vast majority of staff who had worked in the public hospital system for more than a year would have stories of verbal or physical assault and said he too had been viciously threatened by a drug-affected patient.

More research needed

He particularly praised the College's call for dedicated and detailed research saying much of the problem was now only understood on the basis of anecdotal evidence.

He also said previous incidents of violence and aggression should now be listed on patient histories to forewarn hospital staff.

"We need as much information on this as we can get because the more we know, the better we could be in managing and preventing issues of violence and aggression," Dr Parnis said.

"We need extra funding to support that research, but we also need extra funding for the entire public hospital system to cut waiting times not only in emergency departments, but for elective surgery too which can often, if waiting times have blown out, end up as an emergency with all the associated frustration that goes along with that.

"We may even need to redesign some emergency departments to separate those patients affected by drugs or alcohol.

"I'd be more reluctant to support staff undertaking self-defence courses, however, because I'm not convinced it is the role of medical professionals to be restraining patients. I think if hospitals are provided with adequate security it shouldn't have to come to that."

The president of the Australian Psychological Society, Professor Bob Montgomery, said research and anecdotal evidence supported the view that aggressive behaviour had increased in the general community.

He said modern life, from congested traffic to the impatience caused by supposedly-instantaneous communications via technology, were clear stressors while a break-down in notions of authority and hierarchy over the past 50 years was also a factor.

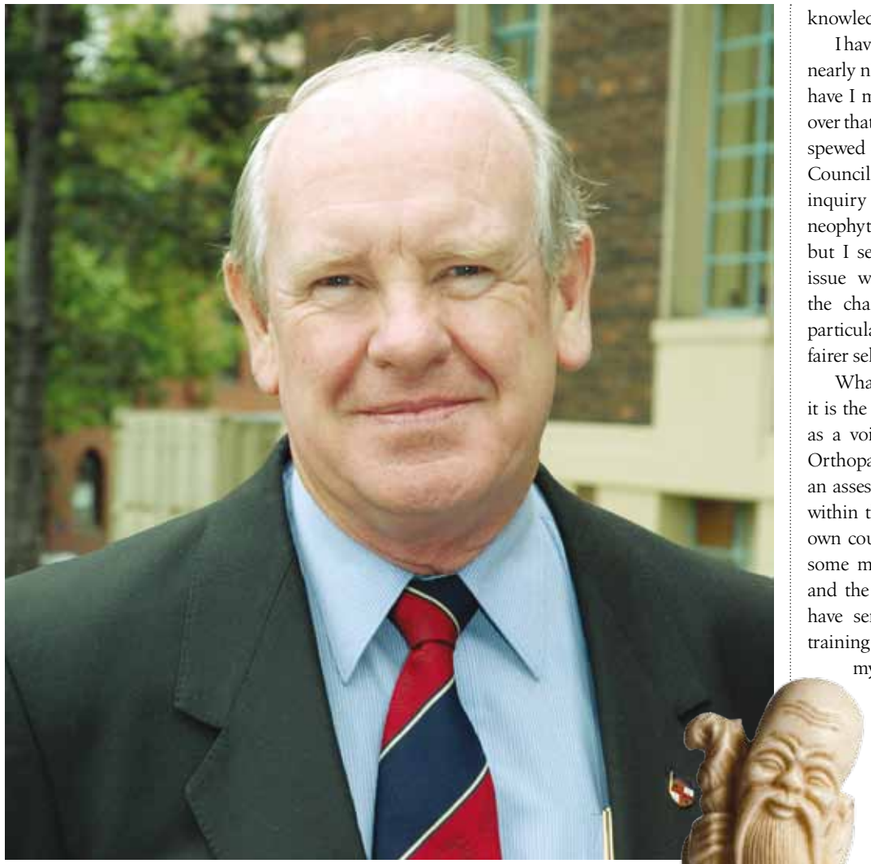
However, he believed one of the key drivers behind the rise in violent public behaviour was the message broadly disseminated through sport, film and technology that aggressive behaviour was acceptable if a person believed they were in the right.

"I think this repeated message is very important in relation to the behaviours we are seeing now and this is not just in relation to doctors and nurses, but teachers, managers and legal representatives," Professor Montgomery said.

"However, medical personnel are more likely to deal with people when alcohol or mood-altering drugs are added to the mix when people can lash out aggressively and feel they have the right to do so.

"I think in this case these problems are then exacerbated when people come into contact with complex or frustrating systems, when they feel vulnerable or when they are made to wait for long periods of time.

"So health funding does become an issue in this as well as the need to offer staff access to courses to teach them how to diffuse potentially violent situations."



I'm now here…

And now for my last say.

Glenn McCulloch
(aka IMA Newfellow)

Confucius is said to have been the first to say that a picture paints a thousand words, although Engelbert Humperdinck made a fortune out of the song. As promised last month here is the picture of the real Mr IMA Newfellow. I suspect that my few readers are a little disappointed to see that the author was not College CEO David Hillis after all.

As this series of articles draws to a close I need to make a few explanations as to who the various characters that I have used are based on. Who really are Mr Nit Picker, Mr Pot Stirrer and Professor Dead Certain? The first two are definitely me, but then they may also be in part based on every surgeon. Being a bit obsessive about getting things exactly right is a desirable trait in surgery. "I was pretty close to stopping the bleeding from that artery" does not have a comforting ring to it, does it?

There are not many 'shrinking violet' surgeons are there? We are all willing to stir the pot a bit – sometimes in jest with colleagues and patients, but sometimes as a response to the inadequacies of the health systems in our two countries. Pot stirrers are a welcome addition to the health debate.

But as for Professor Dead Certain – who is he? Could he be my old friend and current Councillor Guy Maddern (possibly former friend now)? Guy certainly knows what he thinks and I suspect he sometimes knows what I think before I even think it. Being certain about something is a highly desirable attribute for surgeons – provided it is based on knowledge and not on inadequate information.

I have been the neurosurgical Councillor for nearly nine years. Have I learned anything and have I made any observations on the College over that time (other than my trite observations spewed out in these articles)? When I joined Council in 2002 the hot issue was the ACCC inquiry into the College's processes. As a neophyte I understood little of the issues, but I see now that the College handled the issue well and benefited enormously from the changes that ensued. Trainees have in particular benefited by the more robust and fairer selection and assessment tools.

What is the hot issue in 2010? In my view it is the possible disintegration of the College as a voice for all of surgery. The Australian Orthopaedic Association has set in process an assessment of the benefits of them staying within the College structure or plotting their own course. Their grievance has, in my view, some merit. The Urological Society of ANZ and the Neurosurgical Society of Australasia have serious disagreements over aspects of training and assessment. Their complaints in my view are valid. This is not the place to dissect these issues, but my point is that there are three of the nine specialties who are questioning their role within the College.

We as a College can not and must not ignore these issues. If the College is to survive another 80 years as an umbrella organisation for all of surgery, it must stop micro-managing selection, training and discipling trainees. It must leave the specialties to decide whether IMGs are not comparable, partially comparable or substantially comparable to ANZ trained surgeons. It must devolve the majority of specialty functions to the specialties themselves. The College needs to be smaller and less bureaucratic and be truly an umbrella for all of surgery.

We as specialties must work with the College to a common reasonable goal. If we do disintegrate, then I believe that we will both flounder. Both the College and Specialty Societies have evolved significantly over the past 20 years to the benefit of all. It is important that we continue to show that capacity as we move forward. Too much is at stake.

Now I have been rather complaining in this article – not trite or superficial as is my tendency. Have I indeed been a curmudgeon? Now that's an idea! What about a complaining old surgeon writing a column each month – 'Curmudgeon's Corner'? Watch this space!

Newly qualified East Timorese Anaesthetic Nurses with course leaders Dr Brian Spain and Dr Eric Vreede

From L-R: Dr Eric Vreede, Dr Ronald Beck and Dr Glenn Guest.

Building anaesthetic services in Timor Leste

Dr Eric Vreede has been a huge influence in developing independent anaesthetist health care inTimor Leste, soon to deliver the first fully-qualified, locally-born anaesthetist, Dr Flavio De Araujo (Dr Edy)

For the first time since gaining Independence, Timor Leste is now in a position to provide anaesthesia in every hospital across the nation.

Through College support and coordination, AusAID funding and the tireless efforts of Dili-based anaesthetist Dr Eric Vreede, 21 nurse anaesthetists from Dili National Hospital and the five regional hospitals have now passed their formal one-year training course.

According to Dr Vreede, all 21 practitioners are now able to provide Ketamine, Spinal and General Anaesthesia (with or without intubation) in more than 90 per cent of cases as well as managing pre-operative assessment, resuscitation and emergencies.

The training has been provided through the College's international development project known as the Australia Timor Leste Assistance for Specialist Services (ATLASS) program.

To add to the significance of the milestone, Timor Leste's first fully-qualified, locally-born anaesthetist, Dr Flavio De Araujo (or Dr Edy as he is known) will soon return to Timor Leste after completing his Masters of Medicine Degree at the Fiji School of Medicine.

Dr Vreede, who has been in Timor Leste for almost seven years, acted as Dr Edy's mentor and described the success of his studies and the training of the nurses as being of great significance in the provision of quality care for the people of Timor Leste.

"Timor Leste currently has three anaesthetists, all of us (internationals) are based at the National Hospital in Dili, so to now have nurse anaesthetists across the country is a great achievement," he said.

"Over the 10 years the program and its predecessor have been running, the nurses chosen for training have spent one year based in Dili undertaking both formal classes and competency-based skills development working alongside us in theatre.

"They are all back working in their regional hospitals so that we are now in a position to offer an anaesthetic service in every hospital in Timor Leste, which is pretty remarkable given that only six years ago the only anaesthetic service provided was located in Dili.

"The nurses are very good at what they do, extremely diligent and committed, and provide a high quality service, which was the central aim of the training and the ATLASS program."

The courses, designed by Dr Vreede (and his anaesthetic colleagues from Australia), and endorsed by the Ministry of Health and the Institute for Health Sciences in Timor Leste, began in 2004 with the first nine nurse anaesthetists certified to practice in 2005. The courses would not have succeeded without the enormous support of a number of anaesthetists from Australia, particularly Dr Brian Spain and Dr Haydn Perndt who have been instrumental in the delivery of the training program.

Dr Vreede said the provision of an anaesthetic service particularly in regional areas was crucial given the determination of the national health authorities and international aid organisations to reduce the rate of maternal mortality in Timor Leste.

"One of the central pressing needs for anaesthesia in Timor Leste has long been the need to be able to provide caesarean sections to mothers with complications of pregnancy," he said.

"Maternal mortality is still quite high here so the more anaesthetists, the more caesarean sections that can be done and hopefully fewer women will die.

"But even broader than this, before there were anaesthetic services in regional hospitals, many sick people were told they had to travel to Dili for treatment but many people couldn't, either because they couldn't afford to travel or leave their homes for any extended period of time, so many just did not receive the care they needed.

"Now, to have qualified staff to support the doctors so they can provide the necessary care when and where people need it is a wonderful achievement."

Dr Vreede first arrived in Timor Leste in 2004 as an employee of the Ministry of Health before becoming the long term anaesthetist and Team Leader of the ATLASS program. Dr Vreede is also the head of the Anaesthesia Department at Dili National Hospital.

Clearly a man who relishes a challenge, before arriving there he spent three years establishing a Nurse Anaesthetist course in war-torn Sierra Leone in West Africa.

"I've always had a great interest in helping to provide anaesthesia and anaesthetic services in developing countries," he said.

"It's of great practical use in such countries, it can make a significant difference to the quality of health care provided to the people and is greatly rewarding."

Dr Vreede said that he hoped that some of the 700 Timorese doctors now in training in Cuba would choose to specialise in anaesthesia in coming years.

However, he said even with the provision of the nurse anaesthetists and the training of more doctors, Timor Leste still needs the specialist surgical team visits provided through the College.

"Timor Leste only has two nationals trained as general surgeons so it is still too early to think about specialisation," Dr Vreede said.

"It will probably take another 10 years before that becomes a realistic issue and until then the people of Timor Leste still need the services of the resident advisers (emergency physician, anaesthetist, and general surgeon), and the specialist teams.

"Funding for the program ends in June 2011 but we hope that AusAID will see the wisdom of extending that support because there is still much to be done."

Dr Vreede said he greatly enjoys his life in Timor Leste and said any sense of professional isolation was assuaged by his close contact with Australian and New Zealand surgeons and anaesthetists.

"Life's great here inTimor Leste ; the people, the culture the climate, the two-minute commute to work," he said.

"It can be professionally lonely at times but I enjoy working with the specialist teams when they visit, I go to conferences and consult with colleagues overseas to talk about cases and developments in the field so it rarely becomes a problem.

"I'd like to stay here for the next few years.

"Helping to design a nurse anaesthetist course and now having a certified practitioner in every hospital is an undoubted highlight of my time here.

"Then having Dr Edy back will feel like a significant moment not just on a personal level but in terms of Timor Leste incrementally moving to become self-sufficient in the provision of quality health care.

"I worked with Dr Edy during the first 18-months of his training, so his return will definitely feel like a closing of the loop."

The College's Timor Leste program lists the provision of nurse anaesthetists in every hospital as one of its most significant achievements.

Yet it does not stand in isolation. Since 2001, the program has also trained the country's first ophthalmologist, placed and supported Timorese surgical trainees in specialist training programs across the Asia-Pacific region and advanced the skills of more than 80 Timorese medical personnel through trauma and burns management courses.

More directly, visiting surgical teams funded under the program have conducted more than 8000 life-changing surgical procedures and treated and examined up to 42,500 sick and injured patients.

With Karen Murphy

Congratulations

to two NSW SET trainees who obtained the highest score for the May/June 2010 SET Surgical Science (Generic) Exam and the SET Clinical Examination.

Dr Prashanth Rao of NSW was awarded the Gordon Gordon-Taylor Medal for the SSE (Generic Paper), by Joseph Lizzio, Chair of the NSW Regional Committee.

Dr Christopher Lehane of NSW was awarded the Clinical Examination Prize for the highest score in the Clinical Examination, by Joseph Lizzio, Chair of the NSW Regional Committee.

Members of the Clinical Examination Committee wish to thank the following College Fellows who examined at the May 2010 Clinical Examination.

MELBOURNE	MELBOURNE	BRISBANE	SYDNEY
Stephen Salerno (Co-ordinator)	**Ian Michell (Co-ordinator)**	**Ben Anderson (Co-ordinator)**	**Bruce French (Co-ordinator)**
Perry Burstin	Ahmad Aly	Reza Adib	Nigel Ackroyd
Alvin Cham	Richard Brouwer	Christopher Bourke	Ulvi Budak
Yvonne Chow	Lindsay Castles	Michael Coroneos	Robert Claxton
Gavin Cottrell	Yee Chan	Shashank Desai	Michael Kern
Peter Grossberg	Wai-Ting Choi	Wallace Foster	Simone Matousek
Jeremy Grummet	Boon Hong	Andrew Jenkins	Graeme Mendelsohn
Susan Liew	Anthony Hyett	Mervyn Lander	Jamal Merei
David Macintosh	Robert Jones	Wingchi Lo	Irwin Mohan
Helen Maroulis	Geoffrey Kohn	Brent McMonagle	Suchitra Paramaesvaran
Adel Morsi	James Lee	Praga Pillay	Ronald Peach
Bruce Munro	Randal Leung	Phillip Scarlett	Robert Piper
Marinis Pirpiris	Richard Masters	Pillav Shah	Hermchander Rao
Noel Russell	Richard McMullin	Peter Sharwood	Adam Rapaport
Peter Scott	Timothy Pitt	Rodney Tracey	Brindha Shivalingam
Matthew Taylor	Wanda Stelmach	Marianne Vonau	Kethieswaran Thuraisingham
David Ying	Tom Sweeney	Robert Wainwright	

Fellows interested in becoming an examiner for the Clinical Examination please contact Lorraine Jennings +61 3 9249 1245 or lorraine.jennings@surgeons.org

What is involved?
Giving up your time on two mornings per year!
What are the benefits?
You help your College. You help your Trainees.
Do I get CPD points?
Yes at the rate of one point per hour.
Do I get paid?
Sadly not, but travel and accommodation are reimbursed by the College.
Can anyone do the job?
As long as you have the FRACS you're welcome!

SYDNEY	NEWCASTLE – NSW
Nazih Assaad (Co-ordinator)	**Geoffrey Workman (Co-ordinator)**
Sulman Ahmed	Peter Chong
Richard Arnot	Philip Colman
Lionel Chang	Stephen Deane
Pierre Chapuis	Robert Eisenberg
Dave Jayker	Munish Heer
Darren Gold	Abraham Isaacs
Nabeel Ibrahim	Robert Kuru
Anthony Jacobson	Mark Lynn
Richard Lee	Peter Martin
Reginald Lord	Mervyn McCallum
Santoshi Nagaonkar	Andrew Myers
Thomas Reeve	David Nicholson
Marlene Soma	Diaa Samuel
Colin Summerhays	Taranpreet Singh
Con Vasili	Thyaparan Thiruchelvam
Heidi Wong	Timothy Wright

AUCKLAND NZ	DUNEDIN NZ
Richard Wong She (Co-ordinator)	**Ross Pettigrew (Co-ordinator)**
Zahoor Ahmad	Nigel Ackroyd
Venkat Balakrishnan	Ulvi Budak
Ali Bayan	Robert Claxton
Murray Beagley	Michael Kern
Colin Brown	Simone Matousek
Jonathan Burge	Graeme Mendelsohn
Murray Cox	Jamal Merei
Sivananthan Govender	Irwin Mohan
Alastair Hadlow	Suchitra Paramaesvaran
Iain Kelman	Ronald Peach
Anne Kolbe	Robert Piper
Stanley Loo	Hermchander Rao
Cary Mellow	Adam Rapaport
Indran Ramanathan	Brindha Shivalingam
Dev Tandon	Kethieswaran Thuraisingham
Michael Woodfield	

Brian Smith Memorial Award 2011 – in association with The Cabrini Clinical Education & Research Unit

Applications are invited for the Award for the year 2011

An award of $35,000 is available to facilitate research, including associated travel by a practitioner actively pursuing professional development. As Brian Smith's main surgical interests were disease of the colon and rectum, the Committee of the Brian Smith Memorial Award will give preference to practitioners with a special interest in the applied anatomy, physiology or pathology of the colon or rectum.

Your application should include the following:
> Contact details
> A copy of you curriculum vitae
>An explanation of how you would apply the award

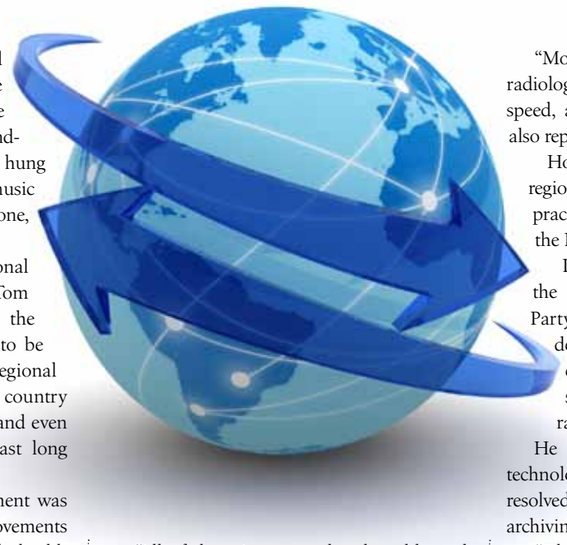
Applications to the Brian Smith Memorial Foundation, ANZ Trustees, GPO Box 389, Melbourne, Victoria 3001 are to be received by 18 December 2010.

Successful applicants will be notified as soon as a decision has been made.

For further information 1800 808 910

The National Broadband Network and you

There is a lot up in the air about how the Government's National Broadband Network will change our working lives



The new focus on regional Australia which lies at the heart of the deal between the Gillard Government and key independent MPs following the election of a hung parliament may have sounded like music to the ears of rural surgeons, but no-one, it seems, is dancing yet.

The chairman of the Divisional Group of Rural Surgeons, Dr Tom Bowles, cautiously welcomed the development, but said it remained to be seen if funding and support for regional communities would flow across the country – not just into the key electorates – and even whether the political deal would last long enough to make an impact.

However, he said if the commitment was genuine and long-lasting, key improvements could be made to hospital and health infrastructure, staffing and equipment with greater connectivity provided through the national broadband network.

"This deal may or may not last, but while it does we will be pushing for as much attention as we can get," Dr Bowles said.

"As a starting point we would seek to make the issues relating to a lack of rural surgeons a primary focus."

"Federal funding bodies need to understand that people who work in country areas do it for the lifestyle not the money, but they will not make that choice if there are inadequate staffing levels to provide relief, a reasonable workload and access to other necessary medical expertise.

Dr Bowles listed on-going funding for the Rural Surgical Training Program as crucial to providing sufficient surgeons for country areas as well as government support and funding for a register listing where and which surgical specialties may be needed in the future to guide the choices of trainees.

"We are doing our best to win the hearts and souls of surgical trainees to get them back to work in rural areas after their rotations, but again, you won't get them back without the anaesthetists and support staff.

"All of these issues need to be addressed – as well as pushing for improvements in indigenous health – and if this political deal shines a spotlight on these areas of need, that will be a very positive development."

Great impact in rural areas

Yet according to Dr Bowles, it is the National Broadband Network (NBN), another key result of the federal election, which could have the greatest impact on the working lives of rural surgeons.

Now being rolled out across seven sites around Australia from Tasmania to Townsville, the NBN has the potential to alter one of the fundamental issues confronting regional surgeons, which has long been a sense of professional isolation.

"The NBN is one of the really positive things to have come out of the election for it has the potential to make a huge difference in terms of imaging, diagnostics and collaboration," Dr Bowles said.

"To be able to have live, high-speed discussions with colleagues would be a huge improvement as well as having the capacity to use it inter-operatively in terms of having someone look over your shoulder in theatre during complex cases.

"Most regional hospitals don't have radiology at night so to have access to high-speed, accurate, immediate reporting would also represent a huge improvement."

However, much like the new focus on regional Australia, little is known about the practical details of the eventual workings of the NBN.

Dr Bernard Bourke, the Chairman of the College's Digital Imaging Working Party, said the impact of the NBN would depend not only on its speed, but connectivity between medical and surgical practices, hospitals and radiology and diagnostic centres.

He said there were still significant technological issues to be understood and resolved including matters relating to privacy, archiving and software compatibility.

"The pie-in-the-sky dream is to have all the information and images we need available at a click of the button via fast, easy-to-access internet, but achieving that is going to be an extremely complex endeavour," Dr Bourke said.

"If – and it's a big if – the NBN works as it has been described as working, it will have a tremendous impact on the working lives of surgeons through immediate access to imaging (in our rooms, on the wards and in the operating theatre), remote operating, tele-consultations and robotics.

"Yet the devil is in the detail and we don't have that yet.

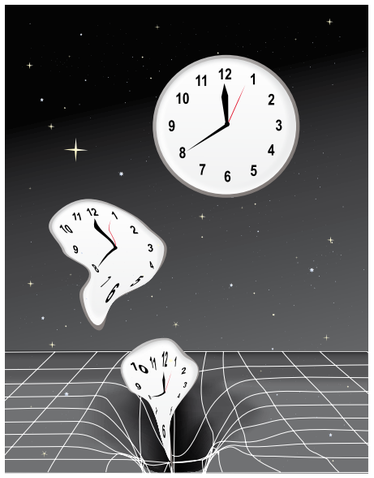
"It seems to me at this early stage that there is a greater focus on linking households rather than public services, but I think it would be of greater benefit to the country to initially connect doctors, hospitals and surgeons rather than allowing for faster computer games."

More than 1,100 kilometres of backbone optic fibre have now been laid as part of the initial roll-out of the NBN, which is expected to provide broadband speeds of 100 megabits per second to 93 per cent of Australian premises. It is expected to take up to eight years to construct.

With Karen Murphy

Let's do the Time warp

Time went much slower when we were younger and carefree.



Dr Ina Training

The days seem to move in fast forward. This is one thing I have learned. As you get older, everything moves faster, and you're trying to cram more and more into less and less. I've read somewhere that it's because the proportions of time relative to your lifespan are smaller as you get older. When you're three years old, 15 minutes seems like a very long time and a whole day is 1000th of your life. And when you're 60, it's one 20,000th. That is to say, it goes a hell of a lot faster.

I have a different theory. Time is marked by fun things. The fun or happiness in our lives provides accents or milestones to our existence, and the distance between fun drags out and gets slower. As you get older, you have less fun things and more responsibility. Hence, with the vastly reduced episodes of fun to highlight your life, time speeds up and you have less drag.

For example, when I was a kid, I would get home from school, have a glass of milk and play on the street until dusk. The afternoon would last ages, but be done all too quickly, so our mother would be calling us in from the dark. While she was cooking dinner, we would sit and do our homework. That half an hour would drag on like centuries. Then, when dinner came we had fun playing with our food and teasing each other, giggling and playing. Then we would play in our bedrooms, play in the bath splashing water everywhere, until our parents set us right and sent us to bed. Contrary to the old saying, I don't think time went quickly when you were having fun. It seemed that, when you were having fun, you weren't aware of the passage of time at all.

Now it feels like you get home from work, cook dinner, sit down and read some papers or the ANZ Journal of Surgery while you eat, and BANG it's midnight already. You look up, blinking at the clock and think, "there must have been a power outage and it's reset to 12.00 am". But no, there is nothing wrong with the clock. You are constantly aware of how quickly time moves, how fleeting she passes. Where did the night go? Where did the day go for that matter? Which reminds me, I really do have to register for the next Time Management Workshop.

I can't remember the last time I did something that wasn't work or study-related. I'm really looking forward to doing something fun at my next holiday, but can't think of anything. I'm not going bungee jumping, because I'm far too attached to my retinas. And I don't think I'll try sky-diving either, jumping out of a perfectly working aeroplane does not seem either sensible, or fun. Being responsible has warped my memory of what fun things are like, and I'm scared that I have forgotten how to do it. Does anyone know any good self-help 'How to' books? Like 'How to have fun for dummies'? Or how about 'How to have fun for people too responsible to have fun'?

This brings me to a new point. Are there any good suggestions for how surgeons can have fun? After all, as important staid pillars of the community, there are certain expectations to consider and there is a need to avoid what would be considered scandalous behaviour. Kind of like the married politician from NSW caught frequenting the gay night club. I think they made him quit his office over that. Why? I don't think there was any evidence it was impairing him from doing his job.

How do we get our kicks, without looking 'naughty'? I'm not so worried about what our patients think. I'm sure that the majority would love to know that we can let our hair down and drink a bottle of wine by ourselves - when we're not on call, of course! But imagine what would happen if the media caught one of us being human and splashed it all over the tabloids, similar to the politician? My partner calls it the 'Today Tonight Test'. Don't do anything you can't justify if it were shown on Today Tonight.

What I think would be worse, far worse than our patients or the media knowing our secret fun activities, is ... IMAGINE IF OUR COLLEAGUES FOUND OUT! For example, what if you like the attention of lap dancers in a strip club? Or dressing up in women's clothes (which is only embarrassing if you're a man). What if your secret passion is drawing human anatomy? Well, that's not embarrassing. But what if you like drawing the human anatomy wrong? Heaven forbid.

Life was so much simpler when I was a kid, and we didn't have to worry about how to enjoy life. We just did. We didn't have to worry about what others would think of our style of fun. And we did it without hurting stray puppies and other people. Except maybe mum, who had to clean up the bathroom after, but it was after all, only water. I guess it doesn't matter what you find fun, as long as it's safe and not hurting anyone else, you should get yourself out there and enjoy it. After all, you only live once, and if it makes life last longer (or at least seem like it), it's worth it. And as Dr Seuss says, "If you never did, you should. These things are fun, and fun is good."

Take some time out for simple pleasures this Christmas. Do something that you enjoy, preferably with those you care about, and remember what is important to you. We work so hard trying to help strangers and better humanity that we often forget to look after ourselves. Have fun. Even if you have to make a little of that fun at work.

Merry Christmas and have a fantastic holiday season.

President Ian Civil, Dr David Hamilton and Professor David Watters.

President visits PNG Symposium

The President found much interest on his recent trip to Papua New Guinea

College President Ian Civil attended the 46th Annual Medical Symposium held in Papua New Guinea in late August. The annual meeting is held by the Medical Society of Papua New Guinea (PNG) and this year's theme was 'Lifestyle Related Diseases and Cancers'.

The symposium was opened by Prime Minister of PNG, Grand Chief Sir Michael Somare. The Prime Minister also launched Professor David Watters' latest book Stitches in Time: Two Centuries of Surgery in Papua New Guinea. The book is a history of surgery in PNG, from 1800 until recent times, including the period in which Professor Watters played a significant part.

"This book and its 780 pages took me more than 10 years to write. Its one simple message is that the inhabitants of PNG who, in the 19th century, were uneducated and living as what Europeans then called 'savages', embraced change and became subspecialist surgeons within 100 years of contact and in only one generation of educational opportunity," Professor Watters said.

The book includes the biographical vignettes of some 200 missionaries, doctors and surgeons. Its final section reviews the Provinces individually, moving from building the first hospitals, staffing them with medical officers and surgeons, to now, when the first national surgeons returned to practise their skills.

"By 2010, 70 general surgeons had been trained, with a surgeon posted to every Province hospital. Fifteen general surgeons had become subspecialists and in addition there were 11 ophthalmologists, nine ENT surgeons and two specialists in OMS. The book covers the evolution of surgery and surgical training in Papua New Guinea."

President Ian Civil was a guest speaker at the symposium and talked about further College support for surgical trainees in the region. He said the gathering of around 300 doctors was very well run, particularly considering Wewak is only a small town.

"Many visitors stayed in homestays or at missions, or stayed with friends, relatives or people they knew there. It was quite a big deal for a small town and they coped remarkably well."

He also noted that the type of presentations at the symposium differed to those given at such events in Australia and New Zealand.

"A talk given by one of the physicians was on 'Non-communicable diseases are here to stay', which is almost the reverse of what we see here.

"Our work here is about non-communicable disease, about cancer and injury, about degenerative diseases etc; only occasionally do we hear from people reminding us that communicable diseases can never be ignored."

It's is also noticeable that as the population of PNG gets older, and become more westernised, things such as heart, cardiovascular and degenerative diseases are becoming more important.

"I thought that was a fascinating development," Mr Civil said.

Selection for surgical education and training

Trainees are selected from the beginning of their training directly into one of the nine specialty training programs.

Simon Williams,
Chair, Board of Surgical Education and Training

In 2011, the College will conduct the fifth selection for the Surgical Education and Training (SET) program. Selection is an evolving process and each year undergoes further review. The aim is to ensure that the selection process is merit-based, free of bias and, to the greatest possible extent, quantifiable. Selection must comply with Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) accreditation requirements and the Brennan Principles. The Brennan Principles are available on the Australian Government website at www.health.gov.au

Selection into surgical training is a competitive process. Trainees are selected from the beginning of their training directly into one of the nine specialty training programs. The earliest point at which application can be made for the first year of training (SET1) is during Post Graduate Year (PGY) 2, with training for successful applicants beginning in PGY3. The number of trainees selected into each specialty each year is based on the number of posts vacated in that specialty at the conclusion of the relevant training year.

Selection is conducted in accordance with the Selection into Surgical Education and Training policy, and each specialty uses as a minimum three selection tools: a curriculum vitae, referee reports and an interview.

A detailed list of the weighting assigned to each tool for each specialty is made available on the College website in December, prior to the opening of selection in January of each year.

There are two stages of the selection process that must be completed before a doctor can be assessed for suitability for training: registration and application.

Registration

Doctors wishing to undertake training for a surgical career must first register for selection. Registration is conducted online through the College website for all 13 programs and it is at the registration stage of the selection process that the Generic Eligibility Criteria are assessed.

The Generic Eligibility Criteria remain unchanged for the 2011 selection process. Registrants must have permanent residency or citizenship of Australia or New Zealand and General (unconditional) registration in Australia or General scope or restricted general scope registration in the relevant specialty in New Zealand.

These requirements must be met at the time of registration for an applicant to be eligible to continue on to submit an application.

Application

Application is conducted online through either the College website or the Specialty Society or Association websites. In 2011, applications can be lodged directly though the College website for the following specialties:

> Cardiothoracic Surgery
> General Surgery (New Zealand)
> Otolaryngology, Head and Neck Surgery (New Zealand)
> Paediatric Surgery
> Plastic and Reconstructive Surgery (New Zealand)
> Vascular Surgery

Applicants may apply for selection into SET if they can demonstrate, at the time of submitting their application that they have completed, or will complete prior to the start of the next training year, all the mandatory requirements of the specialty to which they are applying. The Specialty Specific Selection Criteria and mandatory requirements are made available on the College website prior to the opening of selection in January each year.

Where it is indicated that these requirements must be completed prior to the start of the next year of training, and an applicant does not fulfil the requirements, any offers to the training program that may have been made to the applicant will be withdrawn.

Once an application is received, it is assessed to determine if the minimum specialty specific criteria has been met. The CV is then scored for eligible applicants, based on published guidelines for scoreable achievements, and referee reports are collected.

Referee reports

Applicants must provide current contact details, including a valid email address for each of the referees listed on the online application form. It is the responsibility of the applicant to advise each of the listed referees that they may be contacted by the College during the referee reporting process. Specialty Specific Selection Criteria also apply to the referee requirements.

For all specialty programs except orthopaedic surgery in Australia and New Zealand, a single, online system is used to capture referee report information for scoring. The Online Referee Reporting process occurs over a period of five weeks, commencing in April. Each referee is sent an initial email from the College that includes information regarding the process and a link to one or more online referee report/s. Reminder emails are sent weekly from the College during the process to those referees who are yet to submit their reports. During the final weeks of the process, referees yet to submit forms will also be contacted by telephone.

The referee reporting stage is a significant part of the selection process. Following this stage the referee reporting score is combined with the score for the application (Curriculum Vitae) to determine those applicants who meet the minimum criteria for progression to interview.

Interviews

The interviews are conducted in June/July of each year and successful applicants who are invited to interview receive at least two weeks notice of the interview date.

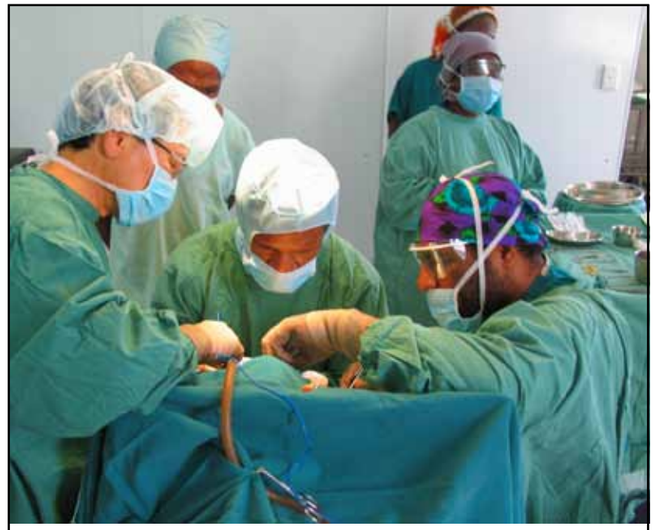
The format of the semi-structured interviews varies slightly between the specialties. However, the selection principles outline that interview panels will consist of a minimum of two people and a maximum of four with the aim of having at least four interview stations by 2012.

Offers

Announcement of offers occurs separately in Australia and New Zealand due to the difference in hospital year starting dates. Offers for the New Zealand programs are made at the start of July and offers for the Australian and bi-national programs are made in mid-July.

While selection for the 2011 training year has only just been completed, preparations for next year's round have already begun. Information will be published by December with advertisements placed in major papers in January. If you know anyone intending to apply in 2011 for the 2012 intake, please encourage them to check the College website for further details.

For information about the Selection Interviewer Training workshop, please contact your specialty or call +61 3 9276 7441



The Royal Australasian College of Surgeons invites nominations of worthy individuals for a

SURGEONS INTERNATIONAL AWARD

The Award provides for doctors, nurses or other health professionals from developing communities to undertake short term visits, usually of 4-6 weeks duration, to one or more Australian hospitals to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's country.

The Award may cover a return economy class airfare, necessary accommodation costs and living expenses for the recipient. The value of the award varies up to a total amount of AU $12,000, depending on the requirements of the candidate's programme.

More than one award can be made in any one year.

NOMINATION CRITERIA

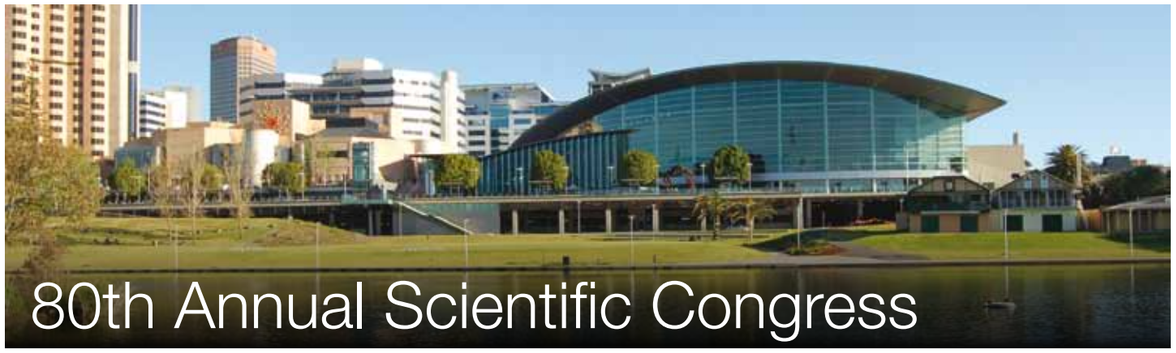
> Surgeons participating in the RACS International Development Program are encouraged to nominate worthy individuals they have identified while undertaking international development activities.
> Surgeons who nominate worthy individuals with whom they have had contact must be willing to accept the responsibility for arranging a suitable program and acting as a personal host to the award recipient.

NOMINATIONS MUST INCLUDE

> Personal and professional information concerning the nominee;
> Objectives of the proposed visit;
> Anticipated benefits to the nominee and their home country;
> Names of the International Development Program team members responsible for organising the visit (including accommodation, training program and travel within Australia);
> An outline of the proposed training program and activities; and
> Letters of recommendation from the nominee's hospital and/or Health Department with an indication of the local importance of any upskilling resulting from the Award.

FORWARD NOMINATIONS TO:

International Scholarships Officer
Royal Australasian College of Surgeons
College of Surgeons' Gardens
250 – 290 Spring Street, East Melbourne VIC 3002
E: international.scholarships@surgeons.org
T: +61 3 9249 1211 F: +61 3 9276 7431



80th Annual Scientific Congress

Adelaide Conference Centre, Monday 2 May to Friday 6 May

Suren Krishnan (right), Congress Convener
Tom Wilson (left), Congress Scientific Convener

There has been two years of planning by Adelaide surgeons, and now Adelaide is ready to host an outstanding Annual Scientific Congress – the 80th. We not only invite you to attend the conference, but also to come early or stay late and see more of what Adelaide and South Australia have to offer – cool nights, clear lustrous days, fall colours that invite pedestrian or pedalling pursuits. Life is not all about surgery, but balance. Adelaide's Mediterranean climate can be trying in summer and cool in winter, but will be perfect for the autumn congress.

The College's 80th Scientific Congress will be staged at the Adelaide Conference Centre, situated between North Terrace and the Torrens. This beautiful city will be at its most picturesque in May – the Botanic Gardens, the Adelaide Hills and the towns of Hahndorf, Stirling and Aldgate or further afield to McLaren Vale, the Barossa or the cooler upper Eden Valley are all within easy reach of Adelaide.

The ASC is also about balance – it presents within its four days of programs the opportunity to broaden your surgical perspective; it combines specialty-specific content with national and international speakers, combined sessions allowing discussion between specialty surgeons and plenary programs that address generic surgical matters – governance, standards and education.

Under the same roof you can catch up on the latest research in other areas such as surgical education, transplantation or the medico-legal landscape. The ASC offers balance, but also a broader horizon. There is an exciting Associates program and the section and Congress dinners will emphasise the best that Adelaide dining has to offer.

Masterclass program

The masterclass program began in 2005 with a single breakfast session. In Adelaide, 27 masterclasses are available across the specialty spectrum. Masterclasses are a didactic forum, deliberately so, and the content is more interactive. They present a 'how I do it' from surgical leaders. You can book for the masterclass program on the registration form in your copy of the provisional program.

Plenary program – Tuesday 3 May

The President, Ian Civil will open and chair the first session of the Congress – 'The interface between surgery and government'. The opening lecture will be the British Journal of Surgery Lecture delivered by Lord Ara Darzi, Professor of Surgery at Imperial College, London. His lecture is titled 'Innovation and the interface between surgery and government', an area in which he is very well qualified to speak.

The interaction between surgery, the College and government can be difficult. But we must acknowledge the government ultimately pays for much of the surgery that we do, and therefore must also play a supervisory role, particularly in the financial area. Dr Tony Webber, Director of the Professional Services Review board will discuss the role of his department in this fraught area. The final speaker is one of Australia's iconic surgeons – Professor David David, head of the renowned Australian Craniofacial Unit. David has experienced success in negotiating with government and influencing government policy and he will address how this can be achieved.

Trauma surgery

The theme of the 2011 Annual Scientific Congress is Unity Through Diversity. This concept is epitomised by the Trauma program convened by Rob Atkinson. Rob has provided the following information regarding his program:

Trauma is a truly collegiate activity in a meeting of all the specialties. So, those who touch on trauma with their daily commitments in public and private, remote or rural or any other opportunity to be outside one's comfort zone. This can include outreach and certainly military surgery, where if you are the available surgeon you will need to know what you do not know and where to go to get support and information required for best practise. The challenge is to touch on these areas and stimulate thought, enhance skills, look at potential knowledge gaps and where to go to fill the gaps.

The trauma surgery program will cover high level to low level, looking at systems of how best to deliver care. It also acknowledges the greatest killer of our young, road trauma, and looks at all aspects of prevention for definitive treatment that affect our lives, potentially as patients as well as surgical care givers.

We have distinguished Australian and New Zealand contributors, but two overseas guests will bring an international flavour with their expertise from London; Karim Brohi, a well-known, talented and respected vascular surgeon in partnership with Keith Willet, an orthopaedic surgeon from Oxford with an international reputation in trauma and planning.

Please bring your questions along to challenge and expand the frontiers of trauma surgery knowledge.

The trauma surgery program extends across the entire four days of the meeting, with the trauma section dinner on Wednesday evening.

asc.surgeons.org

FELLOWSHIP SURVEY 2010

Have you had your say yet?

Mr Graeme Campbell,
Chair, Fellowship Services Committee

Fellows have the opportunity to shape the direction of the College, and provide feedback on the services and activities currently offered by participating in the 2010 Fellowship Survey. The survey will assist with identifying areas for improvement, College strengths and the potential path Fellows wish the College to take in the coming years.

All active and retired Fellows received an email invitation to participate in the survey in late October.

The College last gauged the views of the Fellowship in 2006. Almost 60 per cent of the Fellowship participated in the 2006 Fellowship Survey and provided valuable feedback on areas including communication, publications, professional development, member benefits and the College name.

We recognise that Fellows may at times feel oversurveyed, however it is essential to our performance as a service organisation to receive structured feedback on how the College is of 'real benefit' to the Fellowship.

Results from the 2010 Fellowship Survey will be made available on the College website and in *Surgical News*.

Fellows' feedback is essential and contributes to the ongoing success of the College. If you haven't already done so, please take a few minutes to complete this important survey and we thank you for your assistance in identifying how best our College can work for all Fellows.

For more information and how to access to the survey, please contact Kylie Mahoney, Senior Project Officer, at email fellowship.survey@surgeons.org or telephone +61 3 9249 1284.

A gathering at the Melbourne office of the College to raise money for a new surgery prize was a fitting celebration of a respected surgeon.

Durham Smith, Douglas Stephens and College President Ian Civil

Julian Smith and Robert Fowler

Tony Mirams, John Tucker and John Masterton

Marie Harkness and Douglas Stephens

Douglas Stephens and Durham Smith

Douglas Stephens honoured by family, friends and colleagues

Kingsley Faulkner
Chair, Foundation for Surgery

More than 160 people gathered at the College's Melbourne building on the evening of Monday 25 October to honour the life and work of Douglas Stephens and to support the prize in Paediatric Surgery that will bear his name.

Family, friends and former colleagues were told of Douglas' great passions which, in addition to his clinical work and pioneering surgical research, include family, fishing, golf and painting. Many of Douglas' watercolours were on sale at the event, with proceeds going to the Douglas Stephens Paediatric Surgery Research Prize.

To be awarded for original research by a Paediatric Surgery Trainee or a Paediatric Surgeon within 10 years of obtaining a Fellowship of the College, the prize will enable the recipient to undertake further research or facilitate overseas travel for the purpose of study or research.

Many of those attending Monday's function have stated their belief that it will be the world's most prestigious prize in the field of Paediatric Surgery.

Douglas was his unassuming self and admitted to being embarrassed by "all this fuss". As former College President Durham Smith observed, this was entirely in keeping with the man who, over the decades they had known each other, had never once mentioned his involvement in WWII nor the fact that at El Eisa in 1942 he had been awarded a Distinguished Service Order in the field for exceptional bravery attending wounded under heavy enemy fire.

Douglas Stephens graduated in Medicine from the University of Melbourne in 1936. On completing Residences at the Royal Melbourne and Royal Children's Hospitals, he served with great distinction in a Forward Operating Team in the AIF, 6th Division, 2/3 Field Ambulance in the Middle East, the siege of Tobruk and in the South West Pacific.

After the war Douglas returned to the Royal Children's, but his enquiring mind was recognised by the award of a Nuffield Research Fellowship at the Hospital for Sick Children in London. It was here that he began his enduring study into the area of major congenital abnormalities affecting the quality of life of children.

On his return to Australia in 1950 he was appointed as a Consultant Surgeon at the Royal Children's, combining research with clinical practice. As Director of Surgical Research he became recognised as the master of patho-embryology – the study of abnormalities in the foetus and newborn. His work led to major advances in the treatment of bowel, urinary and genital organ abnormalities.

In the 1970s, remarkably, every practicing adult urologist in Victoria had sought and obtained an appointment under Douglas Stephens' leadership, such was his reputation for originality. At the age of 61, his international reputation was further recognised when he was appointed Chair in Paediatrics and Surgery at Northwestern University and the Children's Hospital at Chicago. There he trained another generation of surgeons. As recently as 1996, Douglas was publishing monumental works on the subject of paediatric surgery.

It was a wonderful evening and a fitting tribute to a man, who in his 98th year, continues to inspire with his sharp mind, gentle wit and unquenchable thirst for life.

Readers wishing to support the Douglas Stephens Paediatric Surgery Research Prize or enquire about artwork still available for purchase should contact the Foundation for Surgery Manager, Kay Blandthorn, on (03) 9249 1110 or at foundation@surgeons.org Donations are tax deductible.

Are you a flying surgeon?

Have you ever thought of combining your surgical career with your love of flying?
Do you already provide a flying outreach service?

- I am trying to identify surgeons who have, or are interested in obtaining, a pilot's licence.
- The aim will be improving outreach services in Australia and education of remote practitioners through information sharing and collaboration.
- The initial proposal is to establish an on line chat group and organise an annual conference.

If you are interested in pursuing this concept then please contact Neil Meulman FRACS PPL. neilme@vic.chariot.net.au

ASERNIP-S REVIEW:

Autologous fat transfer for breast augmentation

This topic was the subject of a poster presentation at the Health Technology Assessment International (HTAi) annual meeting in Dublin, Ireland (6-9 June, 2010)

Guy Maddern
ASERNIP-S Surgical Director

Female breast augmentation is a commonly requested surgical procedure for both cosmetic and reconstructive indications. From 2007 to 2008, a total of 8,405 procedures were carried out in Australia, 7,753 of which were cosmetic procedures and 285 were reconstructive procedures following unilateral (n=208) or bilateral (n=77) mastectomy.

Cosmetic breast enhancement surgery involves the insertion of an implant behind the breast tissue, commonly prefilled silicone gel filled prostheses or silicone shells, which are filled with saline at the time of surgery. The number of augmentation procedures for cosmetic indications in Australia has increased by 60 per cent from 2000 to 2007.

Reconstructive mammaplasty is performed to restore body symmetry and achieve the closest to normal breast contour possible, without compromising cancer treatment. This surgery may involve the use of autologous tissue flaps taken from a donor site to reconstruct the breast or the use of a tissue expander to create a pocket to accommodate an implant.

An update of a review by ASERNIP-S has recently been undertaken; the aim of this review was to assess the safety and efficacy of autologous fat transfer, compared with conventional cosmetic and reconstructive breast augmentation procedures.

Concerns regarding the efficacy of silicone breast implants motivated the search for alternative transplant materials. Autologous fat transfer was described by Bircoll et al. (1987) and involved the collection of fat using standard liposuction techniques. The fat was then mixed with insulin and reinjected. Fat was injected into multiple submammary pockets in the breast in very small quantities to minimise the risk of absorption or necrosis.

The advantages of autologous fat transfer for breast augmentation include avoiding large incision scars and the use of prostheses and their associated complications, as well as providing a more realistic breast feel.

A representation of the female figure. Image provided courtesy of Mr Randall Sach, surgeon-artist.

The original review was undertaken by ASERNIP-S in February, 2002. At this time there was a lack of evidence regarding patient benefit from the procedure, particularly in regards to the obscurement of carcinoma. Since then it has become evident that it may be possible to distinguish between the calcifications sometimes caused by autologous fat transfer and actual early stage breast cancer, potentially making autologous fat transfer a viable technique for breast augmentation for both cosmetic and reconstructive indications.

Review update

The recent review involved a literature search that identified 35 studies for inclusion, including a total of 3,276 participants. The overall quality of the available literature was considered to be poor, which made the findings of the review less reliable.

Fat necrosis, calcification and cysts were the most common complications associated with autologous fat transfer; however, these complications only occurred in a small proportion of patients. There was no data linking the presence of these complications with long-term mammographic and cancer-related outcomes.

Overall, autologous fat transfer for cosmetic and reconstructive breast augmentation is considered to be at least as safe as the mentioned procedures. It is important to note that safety data examining the effect of microcalcifications following autologous fat transfer on subsequent breast cancer detection were not specifically reported in the studies included in the review. This means safety in regards to this outcome cannot be determined.

Patient satisfaction following autologous fat transfer was high. The main complaint associated with the procedure was the limited breast volume increase. Where patients desire a moderate to large increase in breast volume, the use of autologous fat transfer in addition to prostheses or autologous tissue transfer is feasible.

Results suggest that autologous fat transfer can be safely and effectively used in conjunction with other augmentative procedures. Fat reabsorption occurred following autologous fat transfer to varying degrees, usually in the short-term (12- month) follow-up period. As a result, additional fat transfer procedures were often necessary.

Due to the variability of outcomes used between the studies, it was not possible to compare efficacy across the different procedures. However, autologous fat transfer may be considered less efficacious due to being unable to achieve a volume increase comparable to that of prostheses or autologous tissue augmentation.

In order to evaluate the safety and efficacy of autologous fat transfer, controlled trials particularly assessing the effects of microcalcifications on immediate and long-term breast cancer detection, need to be conducted.

Studies to determine the maximum breast volume increase achievable by autologous fat transfer would also be useful in order to define who would benefit most from the procedure, as well as which breast indications should be treated using autologous fat transfer.

For women, reconstruction following breast cancer or disease is believed to provide a sense of overcoming the disease. Research shows that breast cancer accounts for the highest prevalence of malignant disease in women from industrialised countries.

In Australia in 2006, 12,614 women were diagnosed with breast cancer, accounting for 28 per cent of all new cancer cases that year. From 2007 to 2008, 5,187 hospitalisations (4.9 per cent of all breast cancer-related hospitalisations) took place for the performance of simple mastectomy.

The complete review was funded by the South Australian Department of Health and is available through the ASERNIP-S website: www.surgeons.org/asernip-s

Alternatively, for further information please contact Professor Guy Maddern or Mrs Deanne Forel at ASERNIP-S, +61 8 8363 7513, asernips@surgeons.org

Success for surgery careers among Indigenous medical students

Involvement by the Indigenous Health Committee at the latest symposium of the Australian Indigenous Doctors' Association has been well-received

The team celebrate a successful day.

Kelvin Kong
Chair, Indigenous Health Committee

"Good advice on why and how to become a surgeon", "passionate and enthusiastic presenters" and "very informative and entertaining" are just some of the encouraging comments made by participants in the College's recent Surgical Career Workshop.

Held during the symposium of the Australian Indigenous Doctors' Association (AIDA) in Launceston, the workshop was attended by 25 Indigenous doctors and medical students, along with AIDA staff and patron Dr Lowitja O'Donoghue - a much respected and admired Aboriginal stateswoman.

Facilitated by AIDA's representative to the Indigenous Health Committee (IHC), Dr Nino Scuderi, workshop participants heard presentations by local surgeons Mr Hung Nugyen (General Surgery) and Mr Stephen Brough (Urology) and Trainee Eric Daniel (Urology). The presentations tackled fundamental questions such as "how did you decide you wanted to be a surgeon?" and "can you have a life and be a surgeon?" The speakers also offered practical advice and tips on what to do to increase the chances of getting into a surgical training.

Drawing on personal experience and delivered with candour and good humour, the presenters spoke on how they managed their work/life balance, balancing the demands of training with family obligations and also offered thoughts on issues facing women as surgeons. Participants were left with the messages "enjoy your medical training" and "don't be discouraged if you fail to get in to SET the first time - see it as an opportunity to spend time broadening your experience and skills".

The RACS Mobile Surgical Simulation Unit added an exciting and interactive dimension to the College's presence at the symposium. Its use was made possible by a generous donation from the Foundation for Surgery. The steady stream of visitors to the bus, eager to test their laparoscopic skills or just to check out what it was all about, kept the unit's staff busy.

This positive response reinforced how valuable a resource the surgical simulator is for promoting surgery as a career. One student remarked, "it gives you a glimpse of the tools and expertise needed [for surgery]", and another commented, "the mobile unit was fantastic and further inspired me to consider and pursue a surgical career". Having the unit on site to support the workshop was a bonus and contributed to its success.

This year the symposium attracted more than 200 Indigenous and non-Indigenous people from across Australia and New Zealand. This reflects the growing numbers of Aboriginal and Torres Strait Islander (ATSI) people entering the medical profession as practitioners, researchers and educators, as well the trend by non-Indigenous organisations and individuals to work in partnership with ATSI communities.

The symposium program, based on the theme of 'Education for Strong Health and Culture', provided several glimpses of ATSI innovation in education, learning, leadership and culture and achievements of the ATSI medical community. In addition to presentations by AIDA's student and graduate members, Rupert Peter and Toby Ginger spoke of the role of the Ngangkari (traditional healers) in Aboriginal health and well being, and Mick Gooda, Social Justice Commissioner, outlined his agenda for Indigenous reconciliation and closing the gap for his term of office.

The positive feedback we received about the workshop suggests it was a success. The engagement with surgeons and trainees, the presenters and access to the surgical simulator were aspects considered of most value. The success of this workshop however, extends beyond the benefits to those who participated in it on the day.

The College's presence at the symposium and the commitment of resources to promoting surgery as career, did much to enhance its profile and standing with AIDA and within the wider ATSI medical community. This puts the College in good steed as it works toward achieving strategic objectives on Indigenous health and contributing to better outcomes for our Indigenous communities.

The surgical career workshop is just one of the activities of the program to promote surgery as a career in Australian Indigenous communities. The challenge remains to convert the interest we witnessed in Launceston into successful applications for specialist training and ultimately delivery of more Australian Indigenous surgeons.

The IHC is working with Te ORA, the Māori Medical Practitioners Association and a co-opted member on the committee, to develop a similar program for Aoetora/New Zealand.

The workshop received great support and encouragement from various sections of the College who helped to ensure its success. The IHC takes this opportunity to acknowledge all who contributed to the planning and success of our workshop.

We are grateful to the Foundation for Surgery for sponsoring the mobile surgical unit's trip to Launceston, and especially thank Meryl Altree and Nick Marlow for the many hours spent on the road driving the unit from Sydney and back. We extend our appreciation to Hung Nguyen, Stephen Brough and Eric Daniel for their very lively and well-considered presentations, and for giving up their Sunday morning to meet with the students. We also acknowledge the assistance provided by RACSTA and Dianne Cornish from the Tasmanian Regional Office in helping us secure workshop presenters.

Finally, we congratulate the Board and staff of AIDA on the success of the symposium and thank them for the opportunity to participate in the symposium in this way.

Fellows seeking further information about the College Indigenous health projects or wishing to support them through philanthropic donations are welcome to contact the IHC secretariat by emailing indigenoushealth@surgeons.org

Fellows respond without fault

Christchurch earthquake forced urgent changes to examination preparations

Spencer Beasley
Chair, Court of Examiners

At about 4.30 am on 4 September, a magnitude 7.1 earthquake hit Christchurch. The epicentre related to a previously unrecognised fault line close to the city. Two closely-spaced initial earthquakes lasted about 30 seconds and caused substantial damage to property and infrastructure: the city lost its power supply and large parts of the city remained without water for several days. Worse than that, it may take months before the sewage system to some eastern suburbs is fully repaired.

It was not until several hours after the quake, once daylight arrived, that the full extent of the damage caused to the city was realised. About 80,000 buildings were damaged, and 4,000 of these have been destroyed or condemned. Even a month after the quake, several streets in the central city remain closed or access is restricted. Along parts of the fault line, the ground moved by four metres. Amazingly, no one was killed, thanks in part to the time at which the earthquake struck, and in part to the strict New Zealand Earthquake Building Codes.

As often happens, natural disasters such as this bring out the best in people. Certainly in Christchurch, the effect has been to pull the community together, and there have been many examples of extraordinary acts of kindness and generosity as people have responded to those in need around them. And it has not just been in Christchurch that this has occurred: offers of help and support have come from far and wide.

Our College was also affected by this earthquake. It happened just three weeks before the Fellowship Examination was to be held in Christchurch. Preparations for the examination were already well-advanced. The college waited several days for a full and careful assessment of the situation in Christchurch, with daily discussion between college staff, local examination organisers, the CEO of Christchurch Hospital and senior examiners.

At the same time, behind the scenes, other options were being explored to relocate the exam. Throughout, it was agreed that every effort would be made to continue with the examinations, even if it meant changing the venue. Two weeks out from the exam and with almost hourly after-shocks still occurring in Christchurch, the difficult decision was made to change the venue, for the safety of those involved and for the integrity of the examination. A number of centres offered to help out, but it was Sydney (which had been the exam venue in May 2010) that ultimately took on the responsibility for hosting these examinations.

What happened next was outstanding and of great credit to Fellows (especially the senior examiners and local co-ordinators), College staff and candidates. The Fellowship examination was relocated and reorganised in just two weeks, an admirable achievement given all the logistical complexities of the examination, including organising hospitals and other venues, identifying new local co-ordinators, revising travel and accommodation arrangements, and finding and organising over 240 patients for the clinical vivas.

Photo courtesy J Begg, GNS Science, New Zealand

An illustration of how much the earth has moved in the area.

The Examinations Department, assisted by College staff in Wellington (who had been significantly involved in the organisation of the Christchurch examination) collaborated to make the new arrangements. The support and co-operation provided by Fellows, at short notice and within such a tight time frame, was impressive. It ensured that the exam ran smoothly and without a hitch. Candidates were offered the opportunity to defer if they wished, but only one out of 116 took up this offer. The examination was conducted efficiently and in good spirit and its success is a credit to those involved.

As Chairman of the Court, I would like to acknowledge this huge effort put in by so many Fellows and College staff – and others. This extra work was done with extraordinary commitment and without complaint.

It is appropriate that all Fellows be aware of the effort put in by many of their colleagues to hold these examinations in a new venue. But also, Fellows may wish to spare a thought for those in Christchurch who have suffered losses in the earthquake. We all hope that the after-shocks will settle down soon (at the time of writing this, a further 5.0 magnitude quake struck Christchurch, another of more than 1,700 after-shocks) and wish the people of Christchurch well as they re-build their fine city. It is certainly the intention of the College to hold another fellowship examination in Christchurch as soon as possible.

Preparation for Practice workshop

Jason Chuen,
Convenor of Workshop, Deputy Chair, YF Committee
Michael Law and Nicole Yap
Co-convenors

It's an intimidating challenge for new Fellows to set up a practice as a fully-fledged surgeon; we've all been there. As convenors, we had to think long and hard about the important 'going private' issues to cover in the workshop.

You've got your FRACS, now what?

We felt that many young surgeons forget that when you 'go private'; you are on your own. Such things as annual leave, regular patient exposure, a take-home salary plus a myriad of other details have to be taken into consideration when setting up a practice.

Drawing from our own experiences, we invited a range of experts to address many aspects of running a small business such as financial management and accounting concepts, medical marketing, setting up an office and managing staff.

In addition, participants heard from their peers. Our special thanks go to Richard Pope, an orthopaedic surgeon from Adelaide, who shared his experience of clinical models of private practice. Richard stressed the importance of the 'KISS principle' (Keep It Short and Simple) and his interactive session was well received.

Sean Mackay, a general surgeon, shared his experiences of doing research and being involved in academic training. Sean also encouraged the participants to consider doing a period of dedicated research as it complements the clinical training.

Wendy Bissinger, a GP, shared her insights about the needs of GPs and how they operate. Wendy also provided invaluable tips for surgeons wanting to build their referral base.

Michael Grigg, a vascular surgeon and College Councillor, discussed some of the pitfalls associated with medical industry interactions and how this related to our Code of Conduct. With examples and scenarios, Michael also shared his own experiences of being on College committees and encouraged the participants to become involved at some point, as the College is essentially your College!

The planning for our two-day 'Preparation for Practice' workshop was well underway when we realised that it was 'accidentally' scheduled on the AFL Grand Final weekend. Everyone thought we were mad; maybe even the 40 participants who attended the workshop! However, we pulled it off and would like to sincerely thank everyone who helped to make this weekend so successful. We hope that everyone gained something from the workshop to help them set up a private practice.

What's next?

Part of the Younger Fellows Committee focus is to help members develop their practice and careers. We are in the process of developing a three year strategic plan for the delivery of these types of workshops across Australia and New Zealand. If you are interested in attending or helping convene a workshop please send your expression of interest to the Younger Fellows Secretariat, Younger.Fellows@surgeons.org For more information about the Preparation for Practice workshops please contact your regional offices or the Younger Fellows Secretariat Younger.Fellows@surgeons.org or call +61 3 9249 1122

Is there life after surgery?

Giving up the tools can be difficult after a 70+ hour week. One surgeon has found various studies and projects to keep himself occupied.

Hilton Morrish Selvey
FRACS, FRCS

On my final retirement I pondered this question. Did I want to be one of those surgeons who haunt surgical meetings with feelings of irrelevance, where young surgeons read papers about operations and techniques that are way above their heads?

No, I did not, it would be better to go gracefully. There had to be life after surgery and I had to find it.

It was difficult at first and I had frequent dreams about operating where I could never actually get organised. There was always some impediment, I couldn't find the operating theatre, I couldn't find the change rooms, there was no anaesthetist – endless variations of this theme disturbed my sleep. Fortunately those dreams are now rare, as my mind has become occupied with other pursuits.

Butterflies for instance; they flit about our property and I can identify each species at a glance. I have studied each species, raised them from the egg and watched them emerge from their pupae and fly away without a backward glance or a word of thanks. The butterfly has a struggle to emerge and to find a place to rest while its wings unscramble, expand and gradually harden and become ready for flight. During this period it will readily climb onto a finger where it is content to remain until ready to go.

My studies revealed at least one process previously unknown; exactly how the larvae of the Papillionidae family construct the silk sling which will support the pupa, while the larva breaks down and reassembles itself as a butterfly. I prefer these studies to having to start the day with a 7am ward round, a full morning consultation and a long afternoon operating session!

There is more – swimming for example. I enter two 1km ocean races every year, events organised by USM Events, one in Mooloolaba and the other at Noosa. One can enter in one's age group; I always win mine, the 80+ group, as I am the only competitor. Training has to be continuous, in the ocean when it becomes warm enough, and in the heated water of a public pool in the winter. I splash up and down my lane being outpaced very easily by all the others also enjoying the pool.

"I enter two 1km ocean races every year … one can enter in one's age group; I always win mine, the 80+ group, as I am the only competitor."

Cycling is another pursuit to keep fit and slim. But after suffering four broken ribs when I was knocked off my bike by a hit and run driver, I am no longer such a keen cyclist.

Aeroplanes have always been a passion and since I retired I have built two. I also built a motor car, a replica of the MG TF. These projects took years; the last, the second aeroplane, took three years, six months and two days from the day the kit arrived to its first flight. The paperwork weighed 17kg! This aeroplane, was an all metal, low wing, two seater monoplane, with side by side seating. It was a very fast, beautiful aircraft, which my wife and I flew all round Australia. I even taught her to fly, but she refused to learn to take off or land. I asked her what she would do if I had a heart attack. "Crash", was her reply.

But trying to grow old gracefully has other problems. When I needed attention from a plastic surgeon, I discovered that my erstwhile colleagues have also retired, so I am a stranger to the current generation.

It would seem prudent for all surgeons to develop interests outside surgery long before retirement rears its ugly head. My views are not isolated; I note that a plastic surgeon wrote recently about replacing surgery with sculpting. Another races his ocean going yacht, but nevertheless the message bears repeating.

For more information about 2011 Building towards Retirement workshop, please contact +61 39276 7473

2010 professional development workshops

The year is coming to an end but professional development opportunities go on! We'd like to invite you to attend the following workshops that support you to strengthen your abilities in arenas such as communication, business, leadership and management.

Process Communication Model (PCM)
17-19 November 2010, Brisbane

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.
Proudly supported by the Dept of Health and Ageing

Occupational Medicine: getting patients back to work
19 November 2010, Wollongong

Surgeons have an important role to play in assisting patients to successfully return to work. An understanding of a patient's working environment is vital in order for surgeons to advise on restrictions and alternatives to their work practices. Knowing more about workplaces can also help to improve communication between all stakeholders involved in the return to work process. This whole day course in factory setting is a very efficient way for you to see many commonly performed jobs which is of significant benefit in case assessment and providing return to work advice.

Writing Reports for Court
20 November 2010, Sydney

This important half day workshop offers skills-based training in preparing medical reports for use in legal matters, focusing on the fundamentals of an excellent medico legal report. Gain valuable individualised feedback on your own medico legal reports as well as an understanding of the lawyer/expert relationship, advocate perspective and surgical perspective on form and content.

Leadership in a Climate of Change
19-21 November 2010, Melbourne

This 2½ day workshop aims to develop your understanding of how to be an effective leader in the 21st century. It focuses on leadership styles, establishing and maintaining effective working relationships, managing the performance of others and managing issues effectively in a vibrant work environment. You will complete an online behavioural inventory called the DiSC profile that will generate a specialised report on your leadership attributes which is the basis for interactive debrief session. Behavioural preferences for a range of leadership styles are explored and you'll be offered challenging insights about your leadership attributes. *NB: This workshop is stand alone or one of three entry points for the Advanced Diploma of Management*

Further Information: 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.

professional development workshops

DATES: JAN-MAY 2011

NSW
12 February, Sydney
Supervisors and Trainers for SET (SAT SET)
18-20 February, Sydney
Providing Strategic Direction

QLD
26 February, Brisbane
Supervisors and Trainers for SET (SAT SET)
31 March – 2 April, Gold Coast
Surgical Teachers Course
27-29 May, Brisbane
Sustaining Your Business

SA
29 April – 1 May, Adelaide
Younger Fellows Forum
2 May, Adelaide (pre ASC)
Keeping Trainees on Track (KTOT)
2 May, Adelaide (pre ASC)
Occupational Medicine,
2 May, Adelaide (pre ASC)
Polishing Presentation Skills
2 May, Adelaide (pre ASC)
Practice Made Perfect
2 May, Adelaide (pre ASC)
Supervisors and Trainers for SET (SAT SET

VIC
12 March, Melbourne
Communication Skills for Cancer Clinicians
TBA, Melbourne
Keeping Trainees on Track (KTOT) (Facilitator)
18 March, Melbourne
Occupational Medicine
5 April, Melbourne
Supervisors and Trainers for SET (SAT SET)

WA
23 March, Perth
Supervisors and Trainers for SET (SAT SET)

NZ
17 February, Auckland
Supervisors and Trainers for SET (SAT SET)

Taking on Cleveland

Dr Adele Burgess gained valuable experience and worked with important mentors in her time at the Cleveland Clinic in the United States

It has its own police force, two jets fitted out as hospitals, employs more than 1,700 salaried medical staff representing 120 specialties and sub-specialities, is spread across 41 buildings over 57 hectares and has almost one million patient visits per year.

It is the Cleveland Clinic, one of the largest private medical and tertiary referral centres in the world and a globally recognised leader in colorectal surgery and surgical innovation.

Little wonder then, that colorectal surgeon Dr Adele Burgess was honoured to have been awarded a Fellowship to work and study there while also delighted to receive the Murray and Unity Pheils Travel Fellowship to help get her there.

Now back in Melbourne after the conclusion of her Fellowship year, which began in July 2009, Dr Burgess described her time in the US as an invaluable experience.

"Patients come from all over the world to the Cleveland Clinic so I had the opportunity to see some amazing pathology, some of the most difficult and bizarre cases that we would rarely, if ever, see here in Australia," she said.

"The colorectal surgeons at Cleveland Clinic perform more than 5,000 surgical procedures annually, including an average of 500 laparoscopic intestinal resections, 260 operations to treat Crohn's disease and 170 ileal pouch-anal anastomosis surgeries.

"I worked harder than I have ever worked in my life, but it was hugely rewarding not only for the variety of cases, but the opportunity to work with some of the leading colorectal surgeons in the world such as my supervisor Dr Victor Fazio who was chair of the Digestive Diseases Institute at the Clinic.

"Australian colorectal surgeons have developed close links with the Cleveland Clinic over the past 30 years, with many of the surgeons who trained me having trained there so there is a strong tradition of us going there to learn as much as we can.

"It was also interesting to see and experience a different medical system, in this case a privatised system, and compare how well we do, and the amazing things we can achieve in a public system."

Left: Big police cars in Cleveland; Right: Adele with her family.

Now working at the Austin Hospital and the Epworth and Warringal Private Hospitals, Dr Burgess said the skills and knowledge she had gained would be of significant benefit to Australian patients.

She listed those skills as complex re-operative surgery and clinical decision making in relation to the complex abdomen, laparoscopic colon resections and j-pouch creation for inflammatory bowel disease.

Of particular interest to her, however, were the skills learnt for the treatment of complex pelvic floor problems from world leader in the field, Dr Tracy Hull.

"Pelvic floor issues have never really received the attention they deserve not only because a lot of patients don't like to talk about issues relating to incontinence, but because there has always been an element of acceptance associated in living with such matters," she said.

"These problems affect two distinct types of patients: women who have suffered injury through childbirth; and the people suffering incontinence as they age.

"With an aging population, however, and with people staying healthier for longer I think there will be less acceptance of this in coming years, with more people expecting answers and treatment and there are certainly some conditions that are surgically rectifiable.

"I feel very grateful to have had the opportunity to study under Dr Hull and perhaps now be in a position to help people with such conditions and to let people know they do not have to suffer needlessly."

While in the US, Dr Burgess co-wrote a chapter on pelvic floor problems and continence surgery with Dr Hull, conducted research into the use of chemotherapy after resection of rectal cancer and investigated the outcomes of patients with Familial Adenomatous Polyposis who develop desmoids tumours to determine optimal treatment options.

"The Cleveland Clinic houses the largest institutional registries for inherited colon cancer in the US and the second largest in the world," she said.

"It is an invaluable resource and the research I conducted formed the basis of a poster presented to the American Colorectal Surgical Society meeting in Minneapolis held during my Fellowship year."

Dr Burgess said other highlights of the year had been the chance to travel with her new baby and husband, to experience a different climate and to work within an environment dedicated to surgical innovation.

"I found it exciting to be working alongside such international experts who are as passionate about colorectal surgery as I am because it's not really a subject very many people are passionate about," she laughed.

The Murray and Unity Pheils Travel Scholarship carries a value of $10,000 and is designed to assist a trainee or Fellow of the College wishing to travel overseas to obtain further training and surgical skills. It was established following a generous donation by the late Professor Murray Pheils.

With Karen Murphy

Is creativity worth fostering?

The Creative Doctors Network provide an outlet for all types of doctors seeking inspiration to push their talent further

Fellow Dr Neil Thomson at the Creative Doctors Festival.

Dr Tony Chu,
President AMA (NSW) Creative Doctors Network (CDN)

As a doctor-actor-filmmaker, I read with interest the article in the *Sydney Morning Herald* (SMH) written by Julie Robotham (Health Editor), of 7 August 2010). Its headline was: "Stressed out surgeons or tomorrow's easy riders".

In brief, it was a commentary on a survey of medical students that revealed the "chasm between the disciplines they deem most prestigious and those they believe support a life beyond doctoring."

The article itself was mildly stimulating with various pro and con comments from the study's leader, a university Dean and a med student (third year). However, the ensuing letters to the editor over the next two days proved mightily entertaining with criticisms on the choice of medicine for lifestyle reasons; long work hours; what defines a doctor and on-call work for hospital specialists.

Having recently compared notes with medical students, I was also stirred to write something informative but not inflammatory. In addition, I was hoping to indirectly shed light on our Creative Doctors Network (CDN).

An extract from my letter is as follows.

"Recognition of this critical dilemma of a proper work life-balance saw the recent creation of a Creative Doctors Network in Sydney. Its simple mantra is to nurture creativity within the medical profession.

Supported by NSW AMA, the network meets quarterly. At the recent '20/20 Vision' Film Night, doctors and students showcased their entertaining and inspiring films. In the Q & A that followed, senior doctors spoke about desperately trying to revive their creative passions, brutally suppressed by the long years in study, ongoing training and work commitments. Whereupon hearing this, medical students replied they would not let this happen to them. They strongly believe they can continue their artistic pursuits in parallel with medicine ..."

Regrettably, this letter was not published by *SMH*. But it was still a win. The *Herald* wrote back they were fascinated our group existed and will be sending a journalist to our next Creative Doctors Event. Many different types of medical practitioner are represented within the network, so if you haven't already, it's time to check us out.

For the latest CDN news, events, competitions and networking opportunities, email: tonycdn@gmail.com {Next event is Thursday 3 Feb 2011}. It will be a Readings Night for poetry, short stories, novels, etc.

Missing data equals missed opportunity

Surgical mortality case forms should be completed as accurately as possible

Guy Maddern
Chair, ANZASM Steering Committee

State-based surgical mortality audits are now part of the clinical landscape and across the country surgeons generally have been very supportive of this College project.

Each state produces its own annual report, and the Australian & New Zealand Audit of Surgical Mortality (ANZASM) is now in a position to produce a national report based on the combined state data. The national database now contains several thousand cases, and clearly this gives an opportunity to analyse mortality trends and potentially identify areas for improving patient care Australia-wide.

One of the recurring problems encountered when analysing the results is a significant amount of missing data. Surgeons are aware that the strength of any form of clinical research is highly dependent on adequate follow-up of patients to obtain as complete a dataset as possible. All too often this has been an issue in clinical research papers which can minimise the strength of conclusions that can be drawn from a potentially useful research project.

It is therefore important that surgeons are encouraged to complete mortality case forms in as much detail as possible. The recent introduction of the Fellows Interface that allows surgeons to complete case forms electronically will hopefully encourage Fellows in this regard. Unfortunately many cases require a more detailed case note review, simply because of a lack of adequate information about what may have been a relatively straightforward case.

As an example, an assessor was recently given a case form, which stated that "the patient had a complicated intraoperative course, and died three days later in the Intensive Care Unit, after the family agreed to withdraw all treatment." Faced with this sort of statement, an assessor can hardly come to any conclusion without having to ask for a review of the case notes, which can become a time-consuming and lengthy process.

Unfortunately key questions, such as the use of intensive care or high dependency beds, decisions regarding deep vein thrombosis prophylaxis and the presence or absence of consultants in theatre, are often answered poorly. Ultimately such missing data may result in criticism of the audit's accuracy, and may weaken the argument that surgeons, as a professional group, are capable of engaging in a robust peer-review process.

Feedback is an essential part of any peer review process, both to surgeons, in the form of comments from assessors and from surgeons, with any comments regarding various aspects of the audit.

Recently all participating South Australian Fellows were given the opportunity to anonymously provide the South Australian Audit of Perioperative Mortality with their feedback. There was a greater than 20 per cent return rate for the survey, which asked surgeons to rate the value of the 2009 annual report, comments from assessors and the case note review booklet. Surgeons were also asked to identify opportunities for improvement.

Survey results showed that more than 80 per cent of respondents agreed or strongly agreed that the annual report was informative and useful. Three per cent of respondents disagreed, while 17 per cent were neutral. There were suggestions for future annual reports to have more of a focus on analysing data relative to surgical specialty and including a comparison of survival versus mortality.

Surgeons were also asked whether they found the case note review booklet a useful tool. The majority of surgeons (70 per cent) stated that they found the booklet to be a valid method of improving surgical care, with only three per cent of respondents disagreeing.

Fellows were also asked if they found the assessor's feedback comments in the peer review process valuable. Of the 66 per cent of responses affirming the process was valuable, 45 per cent agreed and 21 per cent strongly agreed. There were no responses indicating that the surgeon disagreed or strongly disagreed about the value of the feedback process.

The National Surgical Mortality Audit, which is managed by the Royal Australasian College of Surgeons, is an important part of clinical governance for surgeons in Australia. It is our responsibility to ensure that we have a rigorous process in place. To maintain the credibility of the audit all surgeons are encouraged to complete their mortality case forms as accurately as possible to improve the standard of the process into the future.

Authored by the SAAPM team

2011 Scholarship and Grant Recipients

The Board of Surgical Research thanks all applicants and congratulates the following successful recipients

Dr Cathy Ferguson
Chair, Board of Surgical Research

Research scholarship & fellowship recipients

The College wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding many of the following scholarships and grants.

Where indicated *, scholarship recipients must procure 25 per cent of their scholarship from either their research department or by external award or donation.

John Mitchell Crouch Fellowship

Associate Professor David Little
David Little is a paediatric orthopaedic surgeon at the Children's hospital at Westmead, Queensland, and he proposes to use the JMC fellowship funds to continue the area in his current research with the broadest impact due to its high translational value to many areas of clinical need in orthopaedics, which is the cellular contribution to bone repair. The advanced understanding and mature model systems in his laboratory have led to the world-first finding that muscle satellite cells contribute to fracture repair in open fractures – radically changing the paradigm that the muscle's role in bone repair was a purely vascular one.
Fellowship value – $150,000

Surgeon Scientist Scholarship*

Mr Charles Pilgrim
Specialty: General
Topic: Predicting chemo-induced hepatic injury on clinical, genetic and imaging
Supervisor: Associate Professor Michael Michael
Scholarship value – $70,000

Eric Bishop Scholarship*

Dr Nathaniel Chiang
Specialty: Neurosurgery
Topic: Tissue oxygenation and wound healing in vascular surgery
Supervisor: Professor Jamie Sleigh
Scholarship value – $60,000

Raelene Boyle Scholarship – Sponsored by Sporting Chance Cancer Foundation*

Dr Teck Sing Woon
Specialty: General
Topic: Interactions of prostate cancer with the immune system
Supervisor: Associate Professor Ian Davis
Scholarship value – $60,000

Paul Mackay Bolton Scholarship for Cancer Research*

Dr Adam Frankel
Specialty: General
Topic: Genome-wide analysis of oesophageal cancer: towards biomarkers of response and outcomes of therapy.
Supervisor: Associate Professor Andrew Barbour
Scholarship value – $60,000

WG Norman Research Fellowship*

Dr Alexander Cameron
Specialty: Plastic and Reconstructive
Topic: The role of flightless1 in human scar formation and implications for potential novel therapeutic techniques
Supervisor: Associate Professor Peter Anderson
Scholarship value – $60,000

Sir Roy McCaughey Surgical Research Fellowship*

Dr Johnny Ho Yin Wong
Specialty: Neurosurgery
Topic: Inhibition of Aquaporin -4 in the development of post traumatic syringomyelia
Supervisor: Professor Marcus Stoodley
Fellowship value – $60,000

Foundation for Surgery Reg Worcester Research Fellowship*

Dr Kieran Rowe
Specialty: General
Topic: Enhancement of adipose tissue engineering by mechanical forces
Supervisor: Dr Keren Abberton
Fellowship value – $60,000

Foundation for Surgery John Loewenthal Research Fellowship*

Dr Adrian Low
Specialty: Orthopaedic
Topic: Augmenting biology of healing at the bone-tendon interface
Supervisor: Professor Bill Walsh
Scholarship value – $60,000

Foundation for Surgery Catherine Marie Enright Kelly Scholarship*

Dr Matthew Hong
Specialty: Urology
Topic: Biomarkers in prostate cancer: utility in detection and prognostication
Supervisor: Associate Professor Chris Hovens
Scholarship value – $60,000

Foundation for Surgery New Zealand Research Fellowship*

Dr Deborah Wright
Specialty: General
Topic: Prognostic Modelling of colorectal cancer using multiple data sources
Supervisor: Associate Professor Cristin Print
Scholarship value – $60,000

Foundation for Surgery Research Scholarship*

Dr Henry To
Specialty: General
Topic: A genetic study of Barrett's oesophagus and oesophageal adenocarcinoma using NGS
Supervisor: Associate Professor Wayne Phillips
Scholarship value – $60,000

Foundation for Surgery Research Scholarship*

Dr Simon Liubinas
Specialty: Neurosurgery
Topic: Molecular and radiological features predisposing to brain tumour associated epilepsy
Supervisor: Professor Terrence O'Brien
Scholarship value – $60,000

Foundation for Surgery Research Scholarship*

Dr David Westwood
Specialty: General
Topic: Role of pro-gastrin derived peptides on colorectal cancer development
Supervisor: Professor Graham Baldwin
Scholarship value – $60,000

Foundation for Surgery Research Scholarship*

Mr Sameer Memon
Specialty: General
Topic: Investigation of response to neoadjuvant treatment in rectal cancer
Supervisor: Associate Professor Alexander Heriot
Scholarship value – $60,000

Foundation for Surgery Research Fellowship*

Mr Paul Burton
Specialty: General
Topic: Mechanics of satiety and appetite control
Supervisor: Professor Paul O'Brien
Scholarship value – $60,000

Travel Scholarship, Fellowship and Grant Recipients

Fellowship in Surgical Education

Dr Emma Igras
Specialty: General
Scholarship value – $50,000

Margorie Hooper Scholarship

Dr Gregory Rice
Specialty: Cardiothoracic
Scholarship value – $65,000

Murray and Unity Pheils Travel Fellowship

Mr Eugene Ong
Specialty: General
Fellowship value -$10,000

Lumley Exchange Fellowship

Dr Regent Lee
Specialty: Vascular
Fellowship value – $60,000

Morgan Travelling Scholarship

Dr Benjamin Dixon
Specialty: Otolaryngology
Scholarship value – $10,000

Hugh Johnston Travel Grants

Dr Benjamin Wei
Specialty: Otolaryngology
Grant value – $10,000

Dr Catherine Sinclair
Specialty: Otolaryngology
Grant Value – $10,000

Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship

Associate Professor Peter Anderson
Specialty: Plastic and Reconstructive
Grant value – $8,000

Ramsay Fellowships for Provincial Surgeons – 2010

Mr Elamurugan Arumugam
Fellowship value – $5,000
Professor Jonathan Golledge
Fellowship value – $2,500
Mr Perry Turner
Fellowship value – $5,000
Dr Abdullah Shamimudeen
Fellowship value – $5,000

Other Scholarships

The following lists external awards that Fellows and Trainees of the College have been successful in attracting from other organisations.

The Garnett Passe & Rodney Williams Memorial Foundation

Dr David Rowe – Victoria
Specialty: Otolaryngology Head and Neck Surgery
Project title: Preventing delayed hearing loss in cochlear implant surgery by reducing intracochlear fibrosis
Gross value of award – $210,000 over three years

The Garnett Passe & Rodney Williams Memorial Foundation

Dr Joshua Jervis-Bardy – South Australia
Specialty: Otolaryngology Head and Neck Surgery
Project title: The role of nitric oxide in the pathophysiology of staphylococcus aureus biofilm formation in chronic rhinosinusitis
Gross value of award – $210,000 over three years

The Garnett Passe & Rodney Williams Memorial Foundation

Dr Tristan Allsopp
Specialty: Otolaryngology Head and Neck Surgery
Project title: Development of a topical macrolide solution for the treatment of chronic rhinosinusitis
Gross value of award – $70,000 over one year

NSA Research Scholarship

Dr Iwan Bennett
Specialty: Neurosurgery
Project title: The role of the Fat4 tumour suppressor gene in malignant gliomas
Gross value of award – $35,000

Synthes-NSA Research Scholarship

Dr Rumal Jayalath
Specialty: Neurosurgery
Project title: Targeting the G2 phase checkpoint in glioblastoma to improve the efficacy of current therapy
Gross value of award – $35,000

NSA Research Scholarship

Dr Johnny Wong
Specialty: Neurosurgery
Project title: Investigating the role of aquaporin-4 in the development of post-traumatic syringomyelia
Gross value of award – $15,000 (top up)

NSA Research Scholarship

Dr Jin Wee Tee
Specialty: Neurosurgery
Project title: Predictors of functional outcome of patients with traumatic spine fractures
Gross value of award – $20,000

Synthes-NSA Research Grant

Dr Katherine Holland
Specialty: Neurosurgery
Project title: Clinical and molecular factors determining recurrence and survival in glioblastoma multiforme
Gross value of award – $35,000

Medtronic-NSA Research Grant

Dr Andrew Davidson
Specialty: Neurosurgery
Project title: Molecular imaging of vascular targets in an animal model of brain AVM primed with focused ultrasound
Gross value of award – $35,000

National Health Medical Research Council Biomedical Scholarship

Dr Michael Wagels
Specialty: Plastic and Reconstructive Surgery
Project title: Free muscle flap vascularity and neovascularisation – implications for future surgery and trauma management
Gross value of award – $80,000

Preliminary Notice: Applications for 2012 scholarships will open in March 2011

The College finances and budget 2011

A report from the Treasurer

Mike Hollands
Treasurer

The College Budget for 2011 was approved at the October meeting of Council. I thought it might be interesting for fellows to understand the budget process and where your subscriptions and Trainees fees are spent.

The process starts with a budget strategy meeting to identify strategic initiatives for 2011. These initiatives form the key components of the budget, which determines the resource allocation to fund the activities of the College for the 2011 year.

Key attributes incorporated in the budget strategy review and the budget processes were to:

> Identify new key activities to commence in 2011 year in line with the Strategic Plan 2010-2015.
> Consider a College-wide perspective to ensure all activities are included.
> Ensure minimal cross subsidisation between areas of activity wherever possible and cross subsidies must be made apparent to Council.
> Undertake College Projects only if they fully cover all costs and only those deemed by Council to be strategically important will be allowed a "College contribution".
> An allocation of 50% of surpluses on completed projects should be placed in the Foundation for Surgery for ongoing commitment to International Projects and Surgical Research.
> Staff salary levels to be aligned as a minimum to the 25th percentile of the general market in accordance with College remuneration policy.
> Subscription fees to be increased by CPI to ensure the College operational activities achieve the agreed operating surplus.
> All other College fees subject to increase by CPI.
> Review of all NZD denominated fees to be charged at AUD equivalent to consider parity in fee structure between the jurisdictions.
> Determine Examination and Training fees and ensure all related activities are self funding.
> Ensure all College infrastructure usage, including offices, is maximised for the benefit of all Trainees and Fellows.
> Trainee activities – aim is to ensure that all educational expenditure is fully funded from Trainees' fees.
> Fellow related activities – aim to ensure all expenditure is fully funded from annual subscriptions.
> Initiate a process of transferring sufficient funds into the Foundation for Surgery to enable it to fully fund surgical scholarships without using operating funds.

The College operating activities continue to maintain a positive financial position and in 2011 will achieve an operating budget surplus. The strategic surplus for core operational activities of 2% has been omitted from this budget. This will enable the College to still achieve a modest surplus for 2011, while providing significant funding investment for Education and other key initiatives including a comprehensive review of the College's core operating and information technology systems and functionality being delivered under Project Refresh. During 2011 management will endeavour to recover the 2% surplus through efficiency gains and cost saving measures.

The surplus excludes any returns from the investment reserve or Foundation for Surgery, some of which are distributed as research grants and scholarships, as Council continues its policy of not relying on investment returns to fund core operational activities.

The 2011 Budget continues the ongoing investment in services to Fellows as well as educational and research activities.

College activities in 2010

During the current year there has been considerable activity across the College operations including:

> Detailed post implementation review and ongoing administration of the Surgical Education and Training (SET) program in conjunction with Specialist Societies and Associations.
> Continued review of the International Medical Graduates (IMG) assessment process, with the emphasis on the development and availability of support programs for the successful transition of IMGs into the surgical workforce.
> The College manages a diverse number of research, aid and audit projects with a total life contract value in excess of $50.8 million. Project activities are funded by external agencies and funding providers with a minimal funding contribution of $43k to September (2009 – $136k) from the College.
> Enhanced use of simulation including the development of a simulation course – Training in Professional Skills and the ongoing development of the Surgical Simulation Project.
> Continued development and expansion of courses and workshops for Surgical Trainees and Continuing Professional Development for Fellows.
> Review of the College Code of Conduct, Infection Control guidelines and development of other standards papers.
> Launch of the 2010-2012 CPD Program and promotion of online data capture.
> Provide continuing support to the Trainee Association.
> Commencement of significant investment in core operating and information technology systems under "Project Refresh" including implementation of a new Learning Management System to provide a better platform for the College's educational resources and improved web presence.
> Further development of online library and information services.
> Ongoing management of existing and new projects with the Commonwealth Government including Specialist Training Program, Surgical Simulation Skills Program, Pacific Island Project – Phase III, Papua New Guinea HECS II, ATLASS, Surgical Morbidity and Mortality Audits and ASERNIP-S related projects.
> Successful pilot rollout of Electronic Trainee Logbooks to General Surgery, Cardiothoracic Surgery and Neurosurgery.

Total College Budget – 2011 (2010 Budget Comparison)

	Budget 2010 $'000's	Budget 2011 $000's	Increase / (Decrease) %
Revenue	42,504	43,479	2.3% ↑
Expenditure	39,995	42,204	5.5% ↑
Total Surplus	2,509	1,275	(49.2%) ↓

College budget in 2011

The budget for 2011, reviewed and approved by Council, included the following key points:

> The Budget Strategy was approved at the June 2010 meeting of Council.
> The budget would generate a modest operating surplus in order to provide both capital and recurrent funding for key educational and other initiatives including core operating and information technology applications and systems to be delivered under "Project Refresh".
> Subscriptions to be increased by 2.5% which ensures that the College can maintain staff salaries at the 25th percentile of the general market in accordance with the College remuneration policy. In addition all New Zealand based Fellows will also be subject to a fee parity adjustment which was formally adopted in 2009 for the 2010 budget onwards. Annual Subscription Fee to be set at – Australian based Fellows $2,365 (2010 – $2,310), New Zealand based Fellows $2,945 (2010 – $2,705) inclusive of GST as disclosed on the College website.
> SET, Course and Examination fees will increase by CPI of 2.5% plus fee parity adjustment for New Zealand based Trainees, where applicable, as disclosed on the College website.
> In recognition of fee parity in the College Fee Structure between Australian and New Zealand activities, all fees and charges for New Zealand based Fellows and Trainees will be increased by 4.00% (2010 – 14.45%) being based on the average currency exchange rate for the past three years less a discount to acknowledge identified New Zealand based activities which require minimal support from Australian based administrative resources.
> Cross subsidisation of activities will be minimised or made apparent.
> The subsidy for projects administered by the College will be $24k (2010 – $74k).
> New projects will not receive a "College contribution" unless strategically important.
> College investments are benchmarked for an 8% return (2010 – 12%) with an estimated return in 2010 of <10%.
> The Treasurer's contingency has been decreased to $185k (2010 – $200k).
> The Investment reserve retains all unallocated investment returns for future College initiatives including supporting the College Foundation for Surgery.
> Transfer of funds from the investment reserve and uncommitted foundation funds in order to boost the corpus in the Foundation for Surgery and enable it to independently fund education and research scholarships in the foreseeable future.

College activities by category

The activities of the College are categorised as follows:

Category 1 – College Operations and includes the operational and administrative services for the Educational, Governance and Resource activities of the College.

Category 2 – College Projects and includes externally funded Research, Audit and Aid projects managed and administered by the College.

Category 3 – Foundation and Investment Reserve and includes all activities relating to the Foundation for Surgery and the Investment Reserve.

CATEGORY 1 – In 2011 revenue for operational activities has increased by 6% to $32,693k (2010 – $30,854k) while expenditure is budgeted to increase by 7.7% to $32,670k (2010 – $29,187k). Overall this will result in a small surplus for Category 1 activities.

Expenditure on category 1 activities will include:

> Staff Payroll and On costs – increase by 5.7% to $12,346k (2010 – $11,673k) and includes an allowance for CPI increases of 2.5% ($291k), Mercer Index salary review increase of 1.2% ($140k), and net increase of 2% ($242k) due mainly to Project Refresh additional staffing requirements and new business manager position for the Research Audit and Academic Surgery division.
> Consultants' Fees – clinical – $491k (2010 – $519k) – activities for clinical/medical support and assessments, usually provided by Fellows of the College.
> Travel & Accommodation – $3,445k (2010 – $2,952k) – budgeted increase costs in relation to administration of the fellowship exam and EMST Directors workshop held every three years.
> Property expenditure and maintenance – $1,334k (2010 – $1,142k) – related to temporary relocation of Queensland office and maintenance and restoration program for College properties in 2011.
> RACS scientific visitors' program – $315k (2010 – $315k) being the final budget year of the current 2009-2011 triennium funding agreement. This is a benefit for all Fellows with many scientific visitors also attending specialty society meetings.
> College Scholarships & Fellowships – $678k (2010 – $708k) – College funded scholarship program. This expenditure is in addition to scholarships funding of $1,124k ▸

"The investment in and maintenance of these properties continues to be significant cost in 2011 especially given the heritage nature of these properties."

(2010 – $903k) from bequest funds in category 3 for 2011. Overall scholarship funding (Cat 1 & Cat 3) totals $1,802k (2010 – $1,611k) or 11.8% increase.

> A contribution for College projects of $24k (2010 – $74k) is included in expenditure for a number of projects administered by the College. This contribution represents the difference between the total indirect overheads incurred on the project and the amount which is allowed to be charged to the project in accordance with the contract. In 2011, the College contribution decreased by 67.6%.

CATEGORY 2 – Revenue for College project activities in 2011 has decreased by 7.4% to $7,695k (2010 – $8,313k) while expenditure is estimated to decrease by 5.6% to $7,789k (2010 – $8,248k). This is due to a decrease in project activity as some older projects mature. Overall this will result in a modest deficit for Category 2 activities.

Expenditure on category 2 activities will include:

> Staff Payroll and on costs – $2,697k (2010 – $1,888k) generally due to mortality audit project staff costs being budgeted for the full 12 months in 2011 compared to six months as contract extensions has not been finalised in 2010.

> Consultants' Fees – Clinical – $632k (2010 – $897k) – relates to professional services from external consultants for clinical / medical support and assessments provided to the College projects with decrease in costs generally due to scaling back of activity under the Surgical Simulation Project.

> Travel & Accommodation – $1,630k (2010 – $2,370k) – reduced level of activity expected in planned number of trips for international aid projects due to completion of contract.

CATEGORY 3 – Revenue for all activities relating to the Foundation for Surgery and the Investment Reserve has decreased to $3,090k in 2011 (2010 – $3,338k). In 2010 we anticipated a rebound in the equities markets, which has not materialised, leading to a reduced return on our investment portfolio. In 2011 we are budgeting for an overall return on our investment portfolio of 8%, which aligns closely with anticipated improvements in the equities over the next 12 months.

Balance sheet

As at 31 December 2011, it is estimated that the College Net Assets will be $53,529k (2010 forecast – $52,254k). During the period, the Investment Reserve is budgeted to increase from $6,663k to $7,711k, generated from investment returns on funds not already committed to Research Scholarships and Grants or transferred to the Foundation for Surgery.

College properties

The College owns properties in Adelaide, Brisbane, Melbourne and Sydney in Australia as well as Wellington in New Zealand. In Canberra, Hobart and Perth accommodation is leased for College offices

The investment in and maintenance of these properties continues to be significant cost in 2011 especially given the heritage nature of these properties. Overall expenditure for 2011 will be $3,052k, made up of $1,334k maintenance costs such as day to day repairs, management fees and insurance (2010 – $1,142k) capital expenditure of $1,718k including repair of the facade of the south wing of the College in Melbourne and development of the Queensland Surgical Education Centre (2010 – $3,180k).

At its meeting in February 2008, Council approved the development of the Queensland Surgical Education Centre (QSEC) on the Queensland property with a total overall project cost of $7.5 million. The Development Application for QSEC has been adversely impacted by a protracted application period with current legal action being progressed by objecting parties opposing the decision by the Brisbane City Council to grant a building permit for the QSEC development. The budget is based on a timeline that construction will commence in late 2011 subject to the outcome of the legal action.

The College was bequeathed a property in the suburb of Paddington, Sydney by the late Mrs Elisabeth Unsworth with the proceeds from sale realised in April, 2010. The proceeds from the sale of the property has been added to the John Mitchell Crouch Research Fellowship fund, which has enabled an increase for 2011 in awarded research scholarships of $150k (2010 – $75k) to individuals who have made an outstanding contribution to the advancement of surgery or to fundamental scientific research in the field.

In closing

As the year draws to a close the College continues to make significant progress in completing the key activities outlined in the Strategic Plan. The proposed initiatives, and challenges, for 2011, which I have outlined in my report, will ensure that the College continues to meet these challenges and progress in 2011.

I would like to thank my Deputy Treasurer, Dr Sam Baker, for his continued support during 2010 and his oversight of property matters and especially the demands of the QSEC project in Queensland.

I would also like extend my warm thanks to the Honorary Advisers of the College, Mr Brian Randall, Mr Michael Randall, Mr Anthony Lewis, Mr Stuart Gooley, Mr Reg Hobbs and Mr John Craven for their ongoing advice and support. Also the advice, excellent service and support from Mr Graham Hope, Investment Adviser, of J B Were have continued to benefit the College enormously.

The support provided by our Honorary Financial Advisers over many years has been invaluable to the College and its Fellows.

Also I would like to thank the Resources staff and the Director, Mr Ian T Burke, for their commitment, support and hard work in assisting me in my role as Treasurer.

Despite the pressure on College resources and demanding times on all of us, the financial position of the College continues on a solid base and is in sound shape for the coming year.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
SUMMARY OF SUBSCRIPTIONS, EDUCATION & TRAINING AND OTHER FEES FOR 2011

		2011 AUST Fees AUD (Inc. GST)	2011 NZ Fees NZD (Inc. GST)
SUBSCRIPTIONS & ENTRANCE FEES			
#Annual Subscription - 2011 payable on 1 January 2011		$2,365	$2,945
Fellowship Entrance Fee payable in full (10% discount applies) or over 5 years - no CPI increase		$6,105	$7,595
EDUCATION & TRAINING			
Surgical Training			
Administration Fee - exam pending, interruption and deferral (SET)		$740	$920
Selection Processing Fee - (Note 6)		$630	$785
Selection Registration Fee		$430	$530
# SET Training Fee	*	$5,330	$7,285
Examinations			
Clinical Examination Fee	*	$1,745	$2,380
Fellowship Examination Fee	*	$6,335	$8,665
Generic Surgical Science Examination Fee	*	$3,050	$4,170
Orthopaedic Principles & Basic Science Examination Fee	*	$1,525	$2,090
Paediatric Anatomy and Embryology Examination Fee	*	$1,900	$2,270
Paediatric Pathophysiology Examination Fee	*	$765	$1,045
Plastic and Reconstructive Surgical Science & Principles Examination Fee	*	$1,525	$2,090
Speciality Surgical Science Examination Fee	*	$1,525	$2,090
Skills Courses - refer to note 4			
ASSET Course		$3,035	$3,765
CCrISP Course		$2,535	$3,155
CLEAR Course		$1,235	$1,530
STATS Course	7	$1,235	–
EMST Course - Provider		$2,535	$3,155
EMST Course - Refresher		$1,620	$2,015
Course Accreditation			
Course Accreditation Fee		$1,100	$1,360
PROFESSIONAL DEVELOPMENT WORKSHOPS & COURSES			
Beating Burnout	7	$260	–
Expert Witness	7	$945	–
Mastering Difficult Clinical Interactions		$770	$960
From the Flight Deck	7	$985	–
Making Meetings More Effective	7	$515	–
Polishing Presentation Skills	7	$470	–
Practice Management for Practice Managers	7	$550	–
Surgical Teachers Course (STC)		$280	$365
Writing Reports for Court	7	$865	–
Leadership in a Climate of Change	7	$2,035	–
Strategic Direction	7	$1,815	–
AMA Level 4/5: Difficult Cases	7	$85	–
Building Towards Retirement - Fellow	7	$220	–
Building Towards Retirement - Fellow & Partner	7	$325	–
Getting Px Back to Work	7	$80	–
Risk Management: Drafting a Consent	7	$205	–
Sustaining Your Business	7	$2,090	–
Understanding Your Px	7	$265	–
Working Together: Surgeons and Administrators	7	$210	–
Process Communication Model	7	$1,195	–
OTHER FEES			
Training Post Accreditation Fees		$3,385	$4,205
Peripheral Endovascular Therapy - Assessment Fee	7	$340	–
Re-assessment Fee	7	$110	–
Appeals Lodgement Fee	7	$5,980	–
Distance Learning (Exam Preparation) Fee	7	$575	–
International Medical Graduates			
Paper Based Assessment Fee	7	$4,785	–
Paper Based Assessment & Interview	7	$7,240	–
Supervision / Oversight Fee- onsite	7	$5,865	–
Supervision / Oversight Fee - remote	7	$16,745	–
Document Assessment Fee - AoN subsequent to specialist assessment	7	$1,150	–
Document Assessment Fee - College endorsement for AoN (Area of Need)	7	$1,150	–
Assessment Fee - Reconsideration for Exceptional Performance	7	$2,300	–
Short Term Specified Training Position Application Fee	7	$920	–
Post Fellowship Education and Training			
Program Assessment Fee		$565	$700
Annual Administration Fee		$115	$140
MOPS - Maintenance of Professional Standards			
Australia & New Zealand		$2,515	$3,130

1. All fees are payable in either Australian or New Zealand Dollars as invoiced.
2. All New Zealand fees, including Examinations undertaken in NZ, are subject to the Goods & Services tax of 15%.
3. All Australian Fees will be subject to GST of 10% except approved Education courses.
4. Examination & training fees for Australian based activities have been approved by the Australian Taxation Office as GST free for all courses relating to the awarding of the RACS Fellowship.
5. Subscriptions and Fees marked (#) may be paid to the College by 4 equal instalments during the year by AMEX, Diners, Visa or MasterCard credit cards only. Further details will be made available when fees are raised.
6. Specialty programs may charge their own selection processing fees, these fees will be published by the respective Specialty Society.
7. Workshops and courses are only provided in Australia and other College fees are only payable in Australian Dollars.
**All Australian Fees marked with an asterisk (*) are not subject to Australian GST of 10%*

Surgical news

Index/Volume 11/2010

INDEX

Academic Surgery
An encore for Academic Surgery Pg 40 No. 2
Another home run for Academic surgery Pg 18 No. 6

Annual Scientific Congress
All is ready Pg 10 No. 3
Heading west for the congress Pg 14 No. 1
Photos Pg 24-28 No. 5
The 2010 Hamilton Russell Memorial lecture Pg 30 No. 8
"In Praise of Surgery" The 2010 Hamilton Russell Memorial lecture Pg 20 No. 9
"In Praise of Surgery" continued. The 2010 Perth Annual Scientific Congress Pg 10 No. 2
The May Congress covered a wide range of topics Pg 22 No. 5
80th Annual Scientific Congress Pg 22 No. 9
2010 ASC Evaluation Pg 14 No. 8
80th Annual Scientific Congress Page 22, No. 10

ASERNIP-S
Consumer information Pg 18 No. 8

Atkinson, Rob Pg 12 No. 9
Barraclough, Bruce Pg 10 No. 1

Beating Addiction
Solving the world's addiction problems Pg 35 No. 5

Beasley, Spencer Pg 14 No. 5
Beasley, Spencer Pg 8 No. 8
Beasley, Spencer Pg 15 No. 9
Behan, Felix (Surgeons of the First Fleet) Pg 40 No. 1
Behan, Felix (Vieux de Paris) Pg 46 No. 5
Behan, Felix (Wine is poetry in a bottle – R.L. Stevenson) Pg 40 No. 9
Berry, Neil Pg 22 No. 4

Book review
Against the Odds: Albert Coates, a historic life Pg 35 No. 2
Reviewed by Scotty Macleish

Burke, Peter Pg 36 No. 1
Campbell, Graeme Pg 14 No. 6
Campbell, Graeme Pg 21 No. 8
Chuen, Jason Pg 24 No. 2
Civil, Ian Pg 24 No. 6

Cochlear Implants
The 2009 Graham Coupland Lecture Pg 20 No. 1
The 2009 Graham Coupland Lecture continued. Pg 20 No. 2

College Awards
Allsop, Christine Pg 35 No. 9
Bridger Associate Professor Patrick Pg 24 No. 1
Peters, Matthew Pg 35 No. 9
Storey, Professor David Pg 24 No. 1
Stitz, Russell Pg 38 No. 6
Storey, David Pg 38 No. 6
Thal, Erwin Pg 32 No. 7
Cheng, Terence Pg 32 No.1
Cho, Carolyn Pg 32 No. 2
Connelly, Damien (Life after retirement) Pg 30 No. 5

College Budget 2011
The College finances and budget for 2011 Pg 40, No. 10

Commentary
Pre-anaesthesia consultations Pg 27 No. 9

Costa, Robert Pg 40 No. 5

Dean of Education
The College has a new Dean of Education Pg 10 No. 1

Drummond, Kate Pg 26 No. 4

EDSA
Code of Conduct breaches Pg 16 No. 7
Preventing another Patel incident Pg 8 No. 7
What is acceptable behaviour? Pg 33 No. 5

Education
A new resource for learning anatomy Pg 19 No. 7
Fellowship examination workshop Pg 8 No. 8
Fellows respond without fault Pg 30, No. 10
The virtues of examiners Pg 15 No. 9

Education and Training
Recognition of prior learning Pg 10 No. 6
Selection into Surgical Education and Training Pg 12 No. 5
Specialist Training Program Pg 12 No. 7

Education Development and Assessment
Has SET changed how we examine? Pg 14 No. 5

Edwards, Mark Pg 14 No. 5
Edwards, Mark Pg 19 No. 7

Employment & Life Balance
Medicine in Australia: Balancing Employment and Life Pg 32 No. 1 (MABEL)

Faulkner, Kingsley Pg 45 No. 8

Fellowship Services
Canberra meets College in E Health Workshop Pg 28 No. 4
Fellowship survey 2010 Pg 21 No. 8
Promoting surgery as a career to Indigenous communities Pg 38 No. 5
Your communication needs Pg 14 No. 6

Fellows in the News
Brown, Matthew (Deadly Ears Program) Pg 22 No. 7
Clark, Professor Graeme Pg 14 No. 9
Hughes, Cliff (Passionate for promoting change) Pg 26 No. 3
Jurisevic, Craig (A Surgeon at war) Pg 22 No. 6
Keene, Greg (Racing cars as a hobby) Pg 22 No. 3
Lusby, Robert (Life of experience) Pg 46 No. 8
Maoate, Kiki (Surgeon optimistic about future) Pg 12 No. 9
McClellend, Steve (Working in the Military) Pg 18 No. 4
Nicks, Rowan (Order of Australia) Pg 39 No. 7
Emeritus Professor Tim Reeve AC, CBE, Pg 26 No. 2
Australian Cancer Network Renaut, Andrew (Brisbane surgeon wins international award) Pg 47 No. 6
Saies, Andrew (The sailing surgeon) Pg 26 No. 1
Scott, Allen (Home is where the heart is) Pg 24 No. 4
Is creativity worth fostering? Pg 35, No. 10

Fellowship Survey 2010
Have you had your say yet? Pg 23, No. 10

Fellowship Services
Online Library Resources Pg 18 No. 2

Foundation for Surgery
Bike ride in the scenic Boonah Valley Pg 8 No. 5
Douglas Stephens honoured by family, friends and colleagues Pg 24, No. 10
Medics and markets Gala Event Pg 39 No. 8
Troy, Chester Alan Pg 45 No. 8

General Surgeons Australia
Emergency surgery: the cutting edge Pg 14 No. 4
Gibson, William Pg 20 No. 1
Gibson, William Pg 20 No. 2
Grigg, Michael Pg 28 No. 1
Grigg, Michael Pg 14 No. 3
Grigg, Michael Pg 20 No. 3
Hanney, Richard Pg 40 No. 2
Hamdorf, Jeff Pg 15 No. 6
Hanney, Richard Pg 36 No. 3
Hanney, Richard Pg 18 No. 6
Harvey, Greg Pg 30 No. 3

Heritage Report
Memorabilia of Sir Sydney Sunderland Pg 44 No. 7
Mummies, motorbikes and manatees Pg 46 No. 3 (Professor Archibald Watson)Neurosurgical instrument collection Pg 45 No. 5
Obras medico-chirurgicas de Madama Fouquet Pg 44 No. 2
Old School Gates Pg 42 No.1
Osler and Cowlishaw Pg 40 No. 8
The enigmatic Dr Brown Pg 44 No. 6

Hip replacement
Williams, Randal (Surgeons as patients) Pg 40 No. 6

Hollands, Mike Pg 30 No. 2
Hollands, Mike Pg 45 No. 5
Hollands, Mike Pg 44 No. 6
Hollands, Mike Pg 44 No. 7
Hollands, Mike Pg 40 No. 8

Indigenous Health
Surgery as a career Pg 30 No. 7
Success for surgery careers among Indigenous medical students Pg 25, No. 10

International Development
Davidson, Fergus Pg 20 No. 5
East Timor Eye Program Pg 22 No. 2
Giving the gift of sight Pg 20 No. 5
Hargrave, John Pg 24 No. 3
Healing Timor Pg 24 No. 3
Healing the blind in East Timor Pg 30 No. 6
Paediatric team works in PNG Pg 8 No. 9
Prepared for trauma Pg 47 No 7
President visits PNG for Symposium Pg 19, No. 10
Project China Pg 32 No. 4
Project China Rotary Award Pg 40 No. 3
Teaching and treating in West Timor Pg 20 No. 4
The beginning of an eye program in Samoa Pg 40 No. 7
Training and teaching in the Pacific Islands Pg 22 No. 1
Sillar, Bob Pg 20 No. 4
Upadhyay, Vipul Pg 22 No. 1
Verma, Nitin Pg 22 No. 2
Verma, Nitin Pg 30 No. 6
Verma, Nitin Pg 40 No. 7
Building anaesthetic services in Timor-Leste Pg 12, No. 10

Interplast Australia & New Zealand
Donahoe, Simon Pg 36 No. 2
Interplast in Papua New Guinea Pg 36 No. 2

Inventors Corner
Catchpole, Bernard Pg 46 No. 9
Grafting in the 1950s Pg 46 No. 9
Miller, Brian Pg 34 No. 6
The Miller's Visceral Retainer Pg 34 No. 6

Knife Injuries
Australia's growing knife culture Pg 22 No. 8
Kollias, James Pg 18 No. 1
Kong, Kelvin Pg 30 No. 7
Kyngdon, John Pg 16 No. 9
Lai, Christine Pg 18 No. 5

Law Commentary
Assessment of International Medical Graduates Pg 10 No. 8
Court determines surgeons' legal duties Pg 8 No. 4
Employers' Rights to Employees' Inventions Pg 8 No. 2
Mandatory reporting Pg 10 No. 7
Privacy laws Pg 11 No. 6
Protection of College intellectual property Pg 20 No. 7
Referral to public waiting lists Pg 28 No. 2
Shareholder agreements Pg 8 No. 3
Leibman, Steven Pg 12 No. 4
Leibman, Steven Pg 18 No. 7
Levitt, Michael Pg 14 No. 1
Levitt, Michael Pg 10 No. 3

Letters to the Editor
Behan, Felix Pg 32 No. 5
Behan, Felix Pg 34 No. 8
Fernandes, Sylvester Pg 34 No. 4
Holland, Andrew Pg 38 No. 7
Holland, Andrew response Pg 39 No. 7
Horne, Geoffrey Pg 32 No. 5
Johnston, Craig Pg 35 No. 4
Johnston, Craig response Pg 35 No. 4
Keene, Greg Pg 48, No. 10
Giele, Henk Pg 48, No. 10
Low, Gordon Pg 34 No. 4
Miles, Campbell Pg 34 No. 8
Orr, Kevin Pg 35 No. 4
Orr, Kevin response Pg 35 No. 4
Turner, RWL Pg 44 No. 9
Turner, RWL response Pg 44 No. 9
Walker, John Pg 35 No. 2
Walker, John response Pg 35 No. 2
Walker, John Pg 36 No. 6
Yin, Jessica Pg 32 No. 5
Li, Ran Pg 26 No. 4
Low, Gordon and Rosie Pg 40 No. 3
Low, Gordon Pg 32 No. 4
Maddern, Guy Pg 12 No. 6
Maddern, Guy Pg 26 No. 7
Maddern, Guy Pg 18 No. 8
Maddern, Guy Pg 28 No. 9
Martin, Jenepher Pg 24 No. 8
Martin, Richard Pg 20 No. 6
McAuliffe, Michael Pg 8 No. 5
McClelland, Brett Pg 8 No. 6
McClelland, Steve Pg 18 No. 4

Medical Technology
The new compliance framework Pg 44 No. 3

Medico Legal
Medico Legal Newsletter Pg 30 No. 1
Medico Legal Newsletter Pg 22 No. 4

Merchant, Nipun (Forming ties with USA) Pg 38 No. 9
Miles, Campbell Pg 10 No. 9
Miles, Campbell Pg 14 No. 8
Miles, Campbell Pg 22 No. 9

Military Surgery
Working in the Military (Steve McClellend) Pg 18 No. 4

Mulcahy, Andrew Pg 27 No. 9
Mutimer, Keith Pg 42 No. 1
Mutimer, Keith Pg 44 No. 2
Mutimer, Keith Pg 46 No. 3
Mutimer, Keith Pg 37 No. 7

New to Council
All will be revealed Pg 10 No. 9
Covering the costs to run the College Pg 7 No. 6
Doctors need Doctors Pg 7 No. 2
Long service to the College Pg 7 No. 7
Policies and more policies Pg 7 No. 5
Rural surgery Pg 7 No. 8
Sweeping changes Pg 7 No. 3
We all need emotional and physical hugs Pg 7 No. 4
When should surgeons retire from active surgery? Pg 7 No. 1
Oliver, David Pg 14 No. 1
Oliver, David Pg 10 No. 3
O'Grady, Greg Pg 14 No. 7
O'Grady, Greg Pg 34 No. 7
O'Neil, George (Solving the world's addiction problems) Pg 34 No. 5
Otto, Greg Pg 28 No. 8
Page, Richard Pg 8 No. 1
Panting, Allan Pg 33 No. 5
Peters, Matthews Pg 28 No. 3
Here I am Pg 10, No. 10

President's Corner
Clock do tick Pg 24 No. 6

President's Perspective
Advocacy and the role of the College Pg 3 No. 3
Challenges for the College Pg 3 No. 4
Health workforce self sufficiency Pg 3 No. 6
Post fellowship training Pg 3 No. 6
Professionalism and surgery Pg 3 No. 5
"Surgeon" – is the title protected? Pg 3 No. 2
The crisis in Emergency Surgery Pg 3 No. 1
Times are changing Pg 3 No. 8
Workforce planning – always at sea Pg 3 No. 9
This is the last Surgical News for 2010 Pg 3, No. 10

Professional Development
Advance Diploma of Management Pg 10 No. 4
ASC Surgeons as Educators Pg 24 No. 8
Ear disease in Far North Queensland Pg 18 No. 3
Happy third birthday Pg 15 No. 6
Occupational Medicine (Bridging) Course Pg 33 No. 9
Process Communication Model Course Pg 19 No. 8
Professional Development Activities 2010 Pg 12 No.1

Professional Standards
Code of Conduct Breaches Policy Pg 20 No. 3
Continuing Professional Development (CPD) Pg 28 No. 1
Digital Diagnostic Imaging Guidelines Pg 17 No. 3

Prostate Cancer
Prostate cancer is a silent disease Pg 32 No. 4

Provincial Surgeons
Work Life Balance Pg 28 No. 6
Quinn, John Pg 12 No. 3
Quinn, John Pg 8 No. 7
Quinn, John Pg 16 No. 7
Rao, Sudhakar Pg 44 No. 8
Rashid, Prem Pg 32 No. 3

Regional News
ACT Pg 32 No. 2
New South Wales Pg 40 No. 5
New Zealand Pg 30 No. 4
New Zealand Pg 16 No. 9
Queensland Pg 26 No. 6
South Australia Pg 28 No. 8
Tasmania Pg 31 No. 3
Victoria Pg 36 No. 1
Western Australia Pg 28 No. 7

Relationships & Advocacy
Planning the 2011 census Pg 5 No. 8
Politicians face the hard questions Pg 5 No. 7
Skills and education centre Pg 5 No. 6
Surgical Leaders Forum – May 2010 Pg 32 No. 6
The need for a new College Constitution Pg 5 No. 2
The Surgical Leaders Forum Pg 5 No. 3
The 2009 Census Findings … enclosed Pg 5 No. 5
Threat of litigation – an avoidable stress? Pg 5 No. 4
Welcome to 2010 Pg 5 No. 1
We live in interesting times Pg 5 No 9
Young American leader visit the College Pg 37 No. 7
Life-saving workshops not only for surgeons Pg 5, No. 10

Research, Audit & Academic Surgery
ASERNIP-S Review Pg 34 No. 1
ASERNIP-S Review Pg 12 No. 6
Audit of Surgical Mortality Pg 26 No. 7
Findings from the VASM audit Pg 19 No. 2
Missing data equals missed opportunity Pg 37, No. 10
Surgical mortality Pg 46 No. 6
Scholarship and grant recipients for 2010 Pg 38, No. 10
The Mobile Surgical Stimulation Unit Pg 38 No. 3
The National Breast Cancer Audit Pg 18 No. 1
Rice, Michael ('Test their limits' at Jamboree) Pg 46 No. 2

Retired Fellows
Connelly, Damien (Life after retirement) Pg 30 No. 5
Russell, Colin Pg 19 No. 2
Schutz, Edward M. Pg 34 No. 7
Schutz, Edward M. Pg 33 No. 9
Selvey, Hilton M. Page 32, No. 10

Scouting Surgeons
'Test their limits' at Jamboree (Michael Rice) Pg 46 No. 2

Skirving, Allan Pg 30 No. 8
Skirving, Allan Pg 20 No. 9

Successful Scholar
Bala, Arul Pg 16 No. 6
Burgess, Adele Pg 34, No. 10
Fowler, Adam Pg 26 No 8
Hirst, Jodi Pg 41 No. 3
Hooi Ooi, Eng Pg 36 No. 6
Itinteang, Tinte Pg 34 No. 9
O'Leary, Stephen Pg 34 No. 2
Sammour, Tarik Pg 16 No. 4
Wu, Michael Pg 35 No. 1
Watson, Alasdair Pg 16 No. 5
Scott, Anthony Pg 32 No. 1
Smith, Julian Pg 34 No. 1
Smith, Julian Pg 38 No. 3
Smith, Julian Pg 28 No. 4
Smith, Julian Pg 46 No. 6
Stevens, Maurice Pg 26 No. 6

Surgical Affairs
International English Language Testing System Pg 12 No. 3
The National Broadband Network and you Pg 16, No. 10

Surgical Services
Chalice poison'd Pg 16 No. 1
Chalice poison'd Pg 16 No. 2
Chalice poison'd Pg 14 No. 3
Chalice poison'd Pg 13 No. 4
Poison'd chalice Pg 10 No. 5
Poison'd chalice Pg 13 No. 6
Poison'd chalice Pg 13 No. 7
Poison'd chalice Pg 16 No. 8
Poison'd chalice Pg 7 No. 9
Poison'd Chalice Pg 7, No. 10

Surgical Students
Surgical Training Pg 21 No. 6
The Surgical Students Society of Melbourne Pg 26 No. 4

Surgical Training
Excessive working hours and fatigue Pg 12 No. 8
Let's do the Time warp Pg 18, No. 10
Mind, Body and Soul Pg 24 No 7
Selection for surgical education and training Pg 20, No. 10
Short-term specified training Pg 36 No. 9
Snakes and Ladders Pg 18 No. 9
Theis, Jean-Claude Pg 30 No. 4
Theophilus, Mary Pg 28 No. 3
Thompson, Andrew Pg 28 No. 6

Trainees Association
A Trainee voice on College Council Pg 14 No. 7
Extended format for Occupational Medicine Course Pg 34 No. 7
Nominations for the John Corby Medal Pg 34 No. 7
Report card on Surgical Education Pg 8 No. 6
What's on for Trainees at the 2010 Perth ASC Pg 28 No. 3

Trauma Committee
Malaysia joins the ATLS Family Pg 30 No. 2
Time to act on rising violence in EDs Pg 8, No. 10

Trauma Services
Alcohol and Injury Pg 32 No. 8
Trauma inspection in Perth Pg 44 No. 8

Trimmer, Anne Pg 44 No. 3
Truskett, Philip Pg 14 No. 4
Turner, Richard Pg 18 No. 3
Vonau, Marianne Pg 10 No. 4
Vonau, Marianne Pg 14 No. 8
Vonau, Marianne Pg 19 No. 8
Wall, Daryl Pg 32 No. 8
Waxman, Bruce Pg 15 No. 6
Williams, Randal (Surgeons as patients) Pg 40 No. 6
Williams, Simon Pg 12 No. 5
Williams, Simon Pg 10 No. 6
Williams, Simon Pg 12 No. 7
Williams, Simon Pg 36 No. 9
Windsor, John Pg 40 No. 2
Yin, Jessica Pg 28 No. 7

Younger Fellows
An opportunity at academia Pg 36 No. 3
A year in review and the year ahead Pg 8 No. 1
Covidien Travelling Fellowship Grant Pg 38 No. 8
Leadership Exchange Program Pg 18 No. 5
Preparation for Practice – Help is at Hand Pg 24 No. 2
Preparation for Practice workshop Pg 31, No. 10
Porter, Mark Pg 38 No. 8
The 2010 Younger Fellows Forum Pg 20 No. 6
Topics for Younger Fellows Pg 12 No. 4
Wang, Frank (Covidien Travelling Fellowship Grant) Pg 30 No. 9
2011 Professional Development Opportunities Pg 18 No. 7

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.

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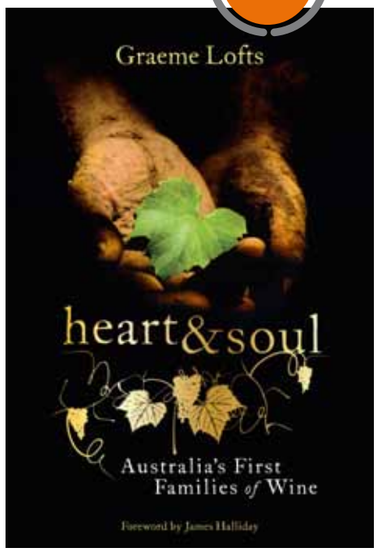

Heart & Soul: Australia's First Families of Wine

Graeme Lofts, (Foreword by) James Halliday
9781742469249 | Pbk | 360 pages | October 2010

~~AU$39.95~~ / AU$31.96

Detailing the history of the families who pioneered the Australian wine industry over generations, *Heart & Soul* is a beautifully packaged premium paperback covering trials and tribulations on the land, their ascent within the industry, the inspiration behind their signature wines and, of course, the passion that goes into every vat. Scattered throughout the pages are exclusive photographs for the family' archives, wine labels, letters, maps of the regions and sidebars filled with tips and secrets from the experts. You'll discover the essence of Australian wine, from grape growing to the dinner table, with all the characters and stories in between. Written with passion by Graeme Lofts and with a foreword by Australia's most well-known wine commentator James Halliday, *Heart & Soul* will provide inspiration for wine lovers and historians alike.

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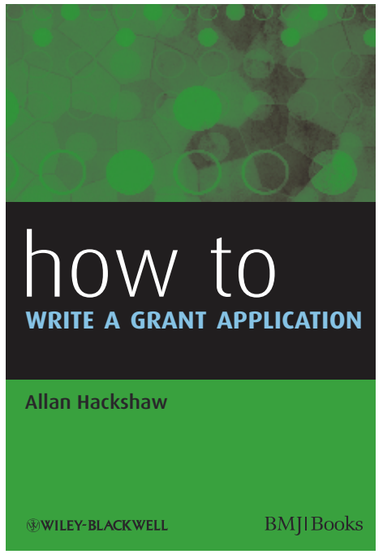

How to Write a Grant Application

Allan Hackshaw
9781405197557 | Pbk | 144 pages | December 2010

~~AU$37.95~~ / AU$32.26

This concise guide covers the important angles of your grant application, whether for a health research project or personal training program, and will help you be among the successful applicants. The book takes you through the grant application process, explaining how to:

- Present the justification for the project
- Describe the study design clearly
- Estimate the financial costs
- Understand a typical review process, and how this can influence the contents of the grant application

The author provides practical advice on a range of project types (observational studies, clinical trials, laboratory experiments, and systematic reviews) to increase the chance that your application will be successful. There are also tips on what to avoid throughout the application. With generic information about application requirements, *How to Write a Grant Application* is ideal for healthcare professionals seeking a health services or scientific grant.

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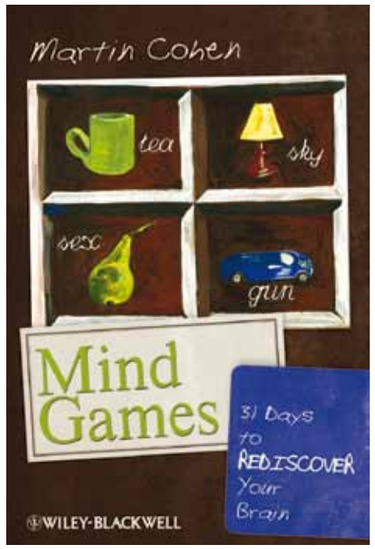

Mind Games: 31 Days to Rediscover Your Brain

Martin Cohen
9781444337099 | Pbk | 168 pages | September 2010

~~AU$19.95~~ / AU$16.96

This original and innovative book is an exploration of one of the key mysteries of the mind, the question of consciousness. Conducted through a one month course of both practical and entertaining 'thought experiments', these stimulating mind-games are used as a vehicle for investigating the complexities of the way the mind works.

- By turns, fun, eye-opening and intriguing approach to thinking about thinking, which contains inventive and engaging 'thought experiments' for the general reader
- Includes specially drawn illustrations by the French avant-garde artist, Judit
- Reunites the social science disciplines of psychology, sociology and political theory with the traditional concerns of philosophy

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iPad Fully Loaded

Andy Ihnatko, Alan Hess
9780470878248 | Pbk | 272 pages |October 2010

~~AU$27.95~~ / AU$23.76

'A one-of-a-kind reference, *iPad Fully Loaded* will show iPad users how to download almost anything onto their new iPad' – from old LPs, radio/television shows and movies, to spreadsheets, presentations and PC rescue files. Going beyond just downloads, the book will enable users to modify their iPad to their own specifications and teach them unknown tricks to truly get the most out of this highly anticipated new device. Written by wildly popular technology expert and Chicago Sun Times columnist Andy Ihnatko, this book will be updated with the latest iPad technology developments. Appropriate for both for both Mac OS X and Windows users, iPad Fully Loaded will teach readers more iPad tips and tricks than any other book on the market. Full-colour throughout, this book will walk readers step-by-step through both common and uncommon tasks to get the most out of their iPad.

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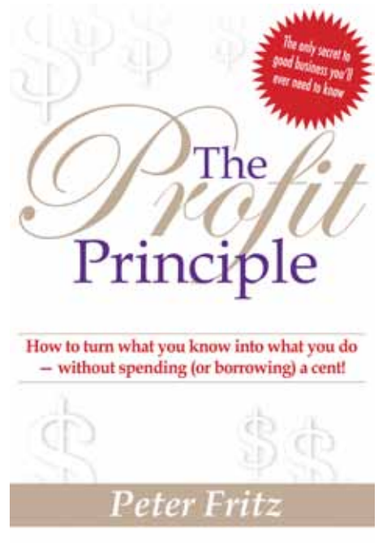

The Profit Principle: Turn What You Know Into What You Do – Without Borrowing a Cent!

Peter Fritz
9781742468310 | Pbk | 208 pages | September 2010

~~AU$24.95~~ / AU$21.21

Peter Fritz, one of the country's most successful serial entrepreneurs, debunks the myths that surround starting and growing a business. He shares his unique approach and the lessons he has learnt from four decades of turning good skills and ideas into profitable businesses. *The Profit Principle* shows you how to turn what you know into what you do and how to launch a successful, sustainable venture without spending (or borrowing) a cent. It's a process that's simpler than you think and already within reach. If you want to run your own business and don't already, stop and ask yourself: 'Why not?' *The Profit Principle* is a modern classic that will flip your thinking on what it takes to succeed and inspire you to get started.

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Directors and the new order of Local Hospital Boards

This letter originally appeared in Volume 26, Issue 8 September of *Company Director,* the official publication from the Australian Institute of Company Directors.

Dr Greg Keene
MB, BS, FRACS, FASMF, FAICD
Senior Surgeon & Director
SPORTSMED.SA, South Australia

I agree largely with the opinions expressed and with the included comments by some of the leading Australian health advisors, executives and directors (Leeder, Mountford, Williams, Geyer, O'Grady & Bowden).

As a director and a user surgeon at one of the nation's leading private orthopaedic "hospitals" I wanted to add to the debate with my thoughts based on a long experience with delivery of high quality healthcare in the private sector coupled with my experience and knowledge of public hospital systems globally.

One of the striking contrasts between Australia's public and private hospitals is the dramatic difference in surgical productivity. For example, 50 per cent of the numbers of hip and knee arthroplasties that are performed collectively across the entire SA public hospital system annually are performed in the 49 bed SPORTSMED.SA hospital. This is despite massive government expenditure in public hospital infrastructure and funding aimed directly at improving productivity. To put it bluntly, the public system is woefully inefficient despite the best intent of many of the dedicated staff.

Surprisingly our private hospital has a board comprising five user surgeons, three of whom have done the AICD Directors course and one external non-executive director who is also an FAICD.

What clinicians bring to the boardroom in the hospital sector is an intimate knowledge of the functional operation of the facility and usually a passionate desire to improve efficiency and the quality of patient care and outcomes; all of which should be strategic ambitions of the new order of community based public hospital boards. Properly trained in corporate governance they can quickly cut across the competing self-interest of various hospital departments who often convince non-medical hospital executives that their needs are critical when they are not. In particular, those needs sometimes bear little or no relationship to the core function of the hospital to provide quality medical care, but this may not be appreciated by the board. It is, of course, important that clinician directors can properly wear a director's hat and not bring their own self-interest to the board as pointed out by Stephen Leeder.

September issue of *Company Director*

In the past 30 years, the private hospitals of Australia have gone from a collection of small independent hospitals often community owned, to much larger networks of linked and commercially run hospitals, surviving on efficiency and productivity and in general providing a highly sought-after level of care to their customers. These differences between private and public are, in my experience with visiting overseas hospitals and discussions with colleagues from many other countries, almost uniform globally.

There are many reasons for this and some of them are not open to easy alteration due to the intrinsic differences between public and private. However, most surgeons who have experience in both sectors lament the inefficiencies and believe that we should be aiming to and can change them in order to deliver a higher level of care to Australians by dramatically reducing the surgery waiting lists and the 'hidden waiting lists' (the wait for an outpatient appointment).

Most doctors feel that the public hospitals of this country do a pretty good job despite these inefficiencies, but that should not prevent us from attempting to do better with the same number of dollars and to attempt to match the productivity of the private hospitals. Unfortunately state and federal governments assume these problems can be fixed with money and happily take the politically popular route of throwing more dollars at the issue.

The new direction of the Labor Party to hand management of public hospitals to community-based boards could be a welcome change in strategy and a step in the right direction to dramatically improve productivity using some of the experienced and skilled people from the private sector to tackle the basic problem of inefficiency.

As suggested by John O'Grady "as custodians of public funds, directors (of hospital community-based boards) will face the special challenge of demonstrating effective and prudent use of those funds to deliver optimal clinical outcomes for the benefit of the local community", it will be essential for boards to fully understand their role and responsibilities.

A lot will depend on the makeup of these boards and their terms of reference with possible limitations on strategic and infrastructure decision making as noted by Philip Williams and Bill Mountford in their articles in *Company Director*.

It is hard to know exactly what is meant by 'community-based board' and one hopes this will not allow totally unqualified persons appointed politically rather than the rigorous selection of well qualified and experienced directors. Any attempt to appoint the first mentioned type of director will result in abject failure of the government's proposals and should be strongly opposed by board chairpersons. In addition, modern corporate governance demands that boards adhere to the AICD and corporate law principles.

I agree with Stephen Leeder that clinicians could have a conflict of interest as board members, but they are at the healthcare 'coal face' and properly selected and trained (AICD), they can make a very positive input to a board attempting the complex task of putting the patient first despite all the conflicting interests. There are increasingly many doctors in Australia who have done the AICD directors course leaving them in no doubt as to their legally obligated fiduciary duty as a board director. It could be that a clinician with the right experience and qualifications, but from outside the hospital(s) covered by that local hospital network, could serve very positively on that board.

As noted by John Merco, existing hospitals can have weak organisational structures at executive level resulting in "governance challenge" and future boards "will require directors who are able to effect real improvements in the complex organisational environments that are hospitals". It should be mandated that at least half, if not all, board members have AICD qualifications or significant board experience to allow board to operate effectively and deliver the outcomes expected by government and the public. This is a position taken by many publically listed national companies and endorsed by strong board chairpersons.

It is my view that this proposed revamp of our nation's public hospitals provides an opportunity for experienced executives/directors (and maybe even clinicians!) from the private system to provide very positive input and help improve the efficiencies and productivity of our public hospitals for the improved health benefit of all Australians.

About the author

Dr Greg Keene is a specialised knee surgeon having trained in Australia, Switzerland and Canada. He is a founding principal of SPORTSMED.SA and a member of the current Board of Directors. Dr Keene has an interest in surgical equipment development and has been on several international prosthesis/instrument development panels. He has also lectured on knee surgery in 28 different countries and is heavily involved in teaching young surgeons from other countries. Dr Keene has been on the board of SGIC Hospitals in SA and previously been Managing Director at SPORTSMED.SA. In 2009 he did the AICD directors course and in 2010 the Mastering the Boardroom course.

About SPORTSMED.SA

SPORTSMED.SA began in 1989 and is now the largest multidisciplinary sports medicine clinic/day surgery/hospital in the southern hemisphere. There are seven sports doctors, 16 physiotherapists and 12 orthopaedic surgeons and more than 300 staff with four peripheral branches in metro Adelaide. The day surgery/hospital performs nearly 8,000 operations per year about half which are arthroplasties. More than 100,000 patient consultations are performed per year. In 2009 the hospital was voted the best private hospital in SA and the third best in Australia by a comprehensive national patient satisfaction survey by Medibank Private.

In 2010, the same survey rated SPORTSMED. SA as the no 1 private hospital in Australia. Even more interesting is that of the top four private hospitals in Australia in the 2010 survey, three of them are either owned or run largely by doctors. This is a significant statistic for those around the world who seek to bar doctors from hospital ownership, and would suggest that the time has come for carefully regulated physician ownership of private hospitals and a massive increase in board representation of public hospitals.

Letter to the Editor ...

Oxford Radcliffe Hospitals NHS
Department of Plastic and Reconstructive Surgery
Level LG1, West Wing
John Radcliffe Hospital
Headington, Oxford, OX3 9DU

Dear Editor,

Regarding Jessica Yin's article on the four hour emergency department rule in Western Australia (*Surgical News*, Volume 11, no 7, August 2010). She states that the four hour rule has recently been scrapped in the UK. This is not the case (as at 6 Sept) and the four hour rule remains in process.

The new Health Secretary did make a statement that he wished to scrap the four hour waiting target, but as yet has not done so. We await to see whether such a decision will really be made. I can confirm that it has significantly changed behaviour and not necessarily for the better. In many ways, it has made the Accident and Emergency Department a triage centre rather than a treatment unit.

Yours sincerely,
Mr Henk Giele FRACS
Consultant Plastic, Reconstructive and Hand Surgeon

In Memoriam

Information about deceased Fellows

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

Sam Robinson,
SA Otolaryngology surgeon.
Allan George, QLD 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
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