Surgical news

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THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Reconstructing bronze

Fellow Christopher Edwards uses his skills on a different medium PAGE 12

The College of Surgeons of Australia and New Zealand

ON THE COVER: One of Fellow Christopher Edwards' bronze sculptures

contents

United we *stand*

What unites us as surgeons serves up hope and good will for the new year

Ian Civil
President

As the last Surgical News for 2011, I am drawn to make a few key observations from the past 12 months as I have interacted with Trainees and Fellows not only in Australia and New Zealand, but also overseas. The first is the outstanding nature of the profession of surgery and, secondly, the incredible commitment and skills of the people who spend their careers within its practice.

Aspects of surgery have been with humanity for thousands of years and the ancient Egyptian writings demonstrate part of this. Formally organised into College type structures for over 500 years, the profession of surgery gives an incredible history of mentorship, Hippocratic teaching and peer support. The importance and centrality of quality patient care is still what binds us together in this century as new technologies and systems of care provide surgical outcomes of which our predecessors would have had almost no concept.

Be the topic one of responses to disasters, surgical trauma training, systems improvement in hospitals or advanced robotic systems the application of surgeons continues to amaze. Perhaps overdriven by our internal requirement for technical excellence, surgeons are always pursuing advances and quality services with such commitment. The skills we bring to these activities are broad and highly developed. Importantly we are now ensuring that is heightened further with particular emphasis on collaboration and teamwork. The future for all of us is not only our individual excellence, but our capacity to have excellence in our teams and systems.

As I have met thousands of Fellows and Trainees over the past 12 months, it is the love and passion for our profession and the skills and commitment brought to that with such intensity that stand out. It is a privilege to be President of this College.

Within the broader surgical community, there has been much debate ▶

ELECTION OF COLLEGE COUNCILLORS 2012

Exercise your democratic prerogative!

Now, more than ever, the College needs the input of a wise and diverse group of Councillors. Those voting need to be able to express the views of the electorate by choosing from a wide-ranging group of nominees.

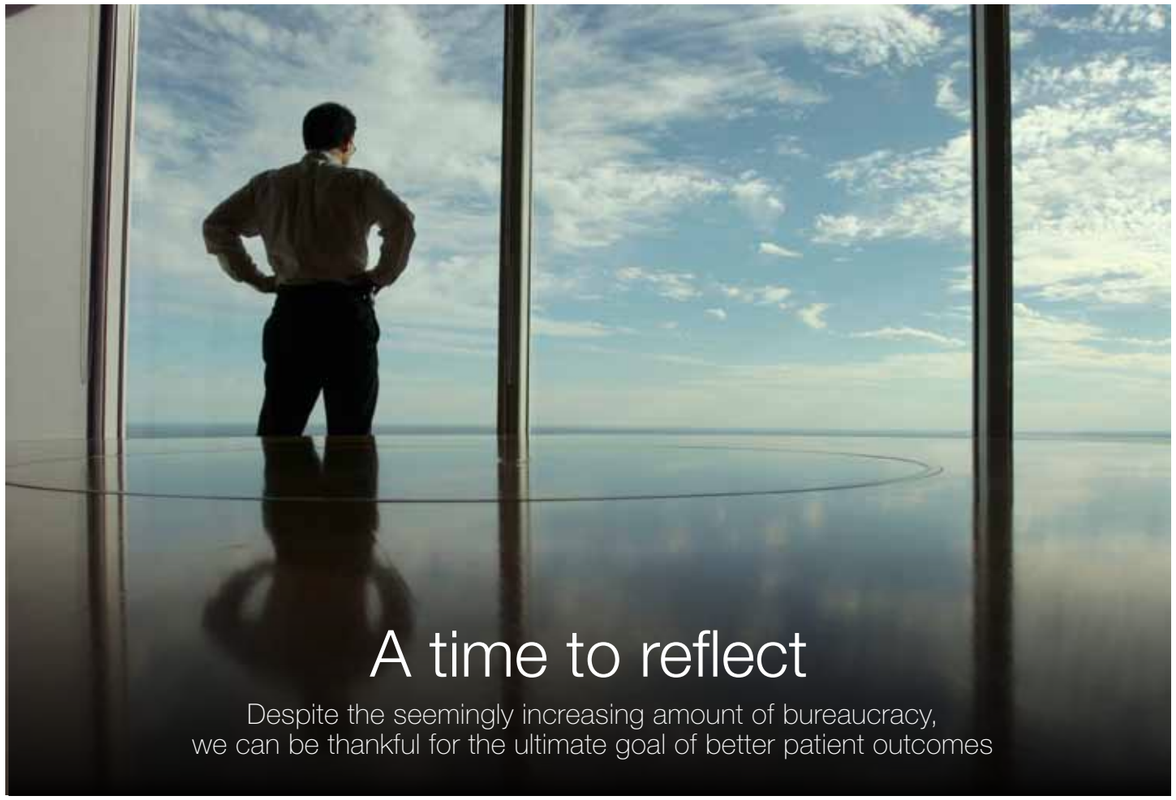
Give your colleagues the option of electing you

Consider nominating for election to College Council.

Those elected will help shape the future of surgery, and surgeons, in Australia and New Zealand.

Nomination forms will be mailed to Fellows of the College in December.

The College will be closed from 23 December and re-open on 3 January.



A time to reflect

Despite the seemingly increasing amount of bureaucracy, we can be thankful for the ultimate goal of better patient outcomes

Keith Mutimer
Vice President

From the perspective of governance and advocacy, the year drawing to a close was one of persistent effort on a number of fronts. The New Zealand National Board is to be commended on several significant achievements.

The paper it developed on "Acute Surgical Services in Regional New Zealand" was circulated to the Minister of Health, Ministry of Health and the 20 District Health Boards. It argued that New Zealand could no longer provide full acute services in every DHB and that accordingly there needs to be greater coordination among neighbouring DHBs to achieve a comprehensive, high standard service. This is a fine example of clinicians identifying ways to use existing resources more efficiently.

Health Workforce New Zealand agreed to proceed with demonstration sites for private sector training, and meetings are being arranged between interested specialties and HWNZ staff to progress this issue. The logistical challenges and expense of private sector training are considerable, but with the bulk of elective surgery being done in private hospitals we must find a way to seize the opportunity for training it presents. ▶

this year about the importance of College, the importance of unity, the importance of our collective profile to improve surgical standards, surgical services and the health of the community.

The College has had a much profiled and very important role around the prevention of road trauma. So it is both appropriate and timely that in this Surgical News we have gathered some of the advocacy stories that have been prominent in the media in 2011. The College's position on quad bikes and the requirements to make them safer will eventually be a success story of advocacy. The only question is how many preventable deaths will occur before this is achieved. At the same time the trauma of modern society with alcohol induced violence is not only a key surgical issue, but a societal one where the College has not only a role, but a powerful voice to advocate for measures that can prevent much tragedy.

Surgeons are renowned as 'time poor'. This is within a society where the required responses are often regarded as 'immediate' as well as spontaneous. One never seems to be far away from the pressures of a surgical practice, hospital commitments, or even College and Specialty Society activities. Life can indeed appear to be a juggle of competing priorities. With the pressure increasing to the end of the year with all these inherent demands, can I wish you a time of peace and rejuvenation as we enter 2012.

2011/2012 Definitive Surgical Trauma Care (DSTC) and Definitive Perioperative Trauma Nursing Care Courses

DSTC is recommended by The Royal Australasian College of Surgeons for all Consultant Surgeons and final year trainees.

The DSTC course is an invigorating and exciting opportunity to focus on:

- Surgical decision-making in complex scenarios
- Operative technique in critically ill trauma patients
- Hands on practical experience with experienced instructors (both national and international)
- Insight into difficult trauma situations with learned techniques of haemorrhage control and the ability to handle major thoracic, cardiac and abdominal injuries

The DSTC course is recommended by the Royal Australasian College of Surgeons for all consultant surgeons who participate in care of the injured and final year trainees. It is considered essential for surgeons involved in the management of major trauma and those working in remote, regional and rural areas.

This educational activity has been approved by the College's CPD programme. Fellows who participate can claim one point per hour (maximum 18 points) in Category 4: Maintenance of Clinical Knowledge and Skills towards the 2011 CPD totals.

The Definitive Perioperative Nurses Trauma Care Course (DPNTC) is held in conjunction with many DSTC courses. It is aimed at registered nurses with experience in perioperative nursing and allows them to develop these skills in a similar setting.

The Military Module is an optional third day for interested surgeons and Australian Defence Force Personnel.

DSTC Australasia in association with IATSIC (International Association for Trauma Surgery and Intensive Care) brings you courses for 2011/12.

Please register early to ensure a place!

To obtain a registration form, please contact Sonia Gagliardi on (61 2) 9828 3928 or email: sonia.gagliardi@sswahs.nsw.gov.au

2011/12 COURSES:

Melbourne: 14 – 15 November 2011
Brisbane: 12 – 14 March 2012
Sydney (Military Module): 24 July 2012
Sydney: 25 – 26 July 2012
Auckland: 30 – 31 July 1 1 August 2012
Melbourne: 19 – 20 November 2012

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The New Zealand National Board entered into a short term contract with the Ministry of Health to establish a working group to develop national Clinical Priority Access Criteria for publicly funded bariatric surgery. This has been completed and the CPAC promulgated by the Ministry.

The Medical Council of New Zealand distributed a number of documents for discussion during the year. Among these was one on Prevocational Training Requirements for doctors in New Zealand. This proposed increasing House Officer all runs from three months to four and various options to increase the number and types of compulsory rotations during the intern period. These reforms would have both extended the intern period and reduced the opportunity for House Officers to experience rotations of particular interest to them in the context of their career intentions. For those reasons, the proposals were not supported by the New Zealand National Board.

In Australia, despite years of negotiations, the promise of sweeping reform and a bewildering array of new acronyms, nothing much seems to have changed in the health sector.

Elective surgery waiting lists often expand and occasionally contract, but they remain a constant and frustrating reality for surgeons and their patients in the public health system. In October the Tasmanian government announced deep cuts to funding for elective surgery, promising, however, that these are temporary cutbacks to be endured while the government works towards major system changes aimed at improving service delivery. We can only hope this proves to be the case.

The Tasmanian cutbacks are symptoms of the relentless rise in state and territory health budgets, the unsustainability of which brought health ministers to the negotiation table in the first year of the Rudd government. Regrettably, none of these ministers has seriously addressed a key factor behind the astonishing cost of healthcare – an engorged bureaucracy which costs a fortune while not actually playing the facilitative role to which it lays claim.

Fellows will be all too familiar with the bureaucracy of the hospitals in which they work, but may not be aware of the bureaucratic entities with which the College has regularly to do business. The following is a list of regulatory entities created since 2007:

The Medical Board of Australia (MBA); Health Workforce Australia (HWA); The Australian Health Practitioners Regulation Agency (AHPRA); The Council of Australian Governments' Expert Panel; The Preventative Health Taskforce; the National Health Performance Authority (NHPA); and the Independent Hospital Pricing Authority (IHPA).

It is not suggested that these bodies add no value to the health sector, and some – refreshingly – actually have clinicians in positions of influence, but when added to the already cumbersome number of existing agencies, authorities and government departments, it is plainly apparent why people have to wait years for relatively simple and inexpensive surgical procedures.

In 2011 the College made submissions to government on issues as diverse as the plain packaging of tobacco products, the development of advanced health research centres and the four hour national access target in emergency departments. The College will continue to engage with governments to minimise any adverse impact this last reform might have.

We developed and promoted the case for the separation of elective and emergency surgical streams, and urged state and territory governments to at least consider this proven and inexpensive means of enhancing the performance of their public hospitals.

And we made a submission to, and appeared before, the federal parliamentary committee inquiring into support for Overseas Trained Doctors. The College awaits the report of the committee with interest, but no great optimism; the testimony of both the Australian Medical Council and the Australian Competition and Consumer Commission, which basically endorsed the process by which OTDs currently work towards specialist registration, was more or less dismissed by members of the committee who seemed more inclined to sympathise with those OTDs unhappy with existing arrangements.

The challenges posed by large governments and lean budgets notwithstanding, Fellows continue to bring their skills and passion to bear daily, often saving lives, almost always enhancing quality of life. We are lucky to be able to do this, and now is an appropriate time of the year to reflect on that good fortune.

I wish you all a happy festive season.

Poison'd Chalice

"We few, we happy few…"

Professor U.R. Kidding

Early in my career I was asked this question – what is it that you can't see, hear or feel, but when it is not present, you know.

The answer – leadership. This leads to a whole lot of other questions like what is leadership, how does one become a leader, etc. My entire professional life I have struggled with the abstract concept of leadership. Mind you there are plenty of other things I have struggled with – personal relationships, instruction manuals of any type, anything electronic but particularly mobile phones and computers. But these are more concrete, more definable.

However, I still have the Bard to help me in my pursuit of those leadership ideals. From Henry V to Titus Andronicus, Richard III to Anthony and Cleopatra, Hamlet to Macbeth – Shakespeare dissected and mapped the psyches of some of the most complex, dynamic, and fascinating leaders that history and literature have given us.

How often in that rugby scrum did those immortal words come to your mind, "Once more unto the breach, dear friends, once more;" (Henry V, Act 3, Scene 1) or in the pub after the match, "We few, we happy few, we band of brothers..." What examples of leadership shone out of Henry V!

Matters came to a head recently when I endured my annual appraisal with the CEO and Medical Director. The new Chairman of the Hospital Board decided to sit in. He is a well-recognised business "leader" – a company director, often in the papers, concluding some new deal or other. It occurred to me that to become a business leader, the major criteria was to make a lot of money, but maybe that is my well-renowned naivety coming to the surface.

In any case, his purpose for attending was to promote his concept of greater clinical leadership within the organisation. Great I thought – another committee! But no, he wasn't talking about my clinical leadership, but my requirement to develop other clinical leaders! Now this is an entirely different kettle of fish.

I sat there thinking, again with the words of Shakespeare whirling in my brain, "Some are born great, some achieve greatness and some have greatness thrust upon them"... (Twelfth Night, Act 11, Scene V).

I left the meeting struggling to form a plan, a way forward. After all, I have been struggling to be a clinical leader in my own right. Of course the title – Director of Surgery – is empowering, but in my experience surgeons are much more impressed by performance and results than titles. On those occasions when I have attempted by own informal 360 degree assessment, I have been left with the awkward impression that "our leader is the poor sap that has to attend innumerable meetings. Better him than me!"

Steve Waugh was regarded as a great leader of Australian cricket. Although I am a Steve Waugh fan, it is pretty easy to be a great leader if you have a great team and he did have a great team. Sporting leaders are easy to define – they lead by example – often the best player in the team, never say die attitude, fearless. Military leaders likewise – certainly historical military leaders. In my younger years, I was exposed to great surgical leaders – surgeons of stature, demanding admiration and inspiring at the same time. To a great extent, where I am now, the path I have trod, was determined by those leaders who I admired and who inspired me.

Suddenly it came to me – a flash from some unknown source. Leadership is about organisation and inspiration – the latter being the ingredient of greatness. Organisation, management, is about allowing people to be as good as they can be, but great leadership is about inspiring people to be better than they thought they could be.

How many of those Englishmen of 1415 would have thought of triumph of the fields of Agincourt. Organised and inspired by Henry V they did that and more... Now how can I do that with the surgeons of my hospital?

Quad bikes and alcohol fuelled violence

The College's Trauma Committee successfully raised the profile of key public health issues in 2011

Thanks to the efforts of the College's Trauma Committee this year, the voice of surgeons was heard on two problems of pressing importance, one endangering the lives of people in rural Australia and New Zealand, the other blighting the streets of our cities after dark.

A media release issued on 14 September called for tighter regulation of quad bikes. Citing the incidence of fatalities and the seriousness and frequency of injuries sustained by riders, Trauma Committee Chair, Associate Professor Daryl Wall, drew attention to the inherent danger of the vehicles and called on governments to tighten regulation around their use.

"The public must be made aware of their instability and the dangers they pose to children. Information on their safe use should be available and promoted at point of sale, and there should be a requirement for the training of workers who operate quad bikes to ensure competence and knowledge of safety measures," Assoc. Professor Wall said.

"There should be a restriction on their use by those under 16 years of age and the speed of all quad bikes should be limited to 55 kilometres per hour. They should be limited to use off public roads and should only be used in situations where the risk of collision with another vehicle has been removed," he said.

Assoc. Professor Wall also called for the removal from sale of three-wheel bikes or 'trikes'.

He also called for the encouragement of research into the design and development of safer bikes, and the design and development of an appropriate helmet for quad bike use.

Noting calls from workplace safety groups, endorsing many of the reforms suggested above, Assoc. Professor Wall said it was time for governments to take action which curbs the appalling rate of preventable death and injury that is occurring on farms in Australia and New Zealand.

The response to the media release was immediate, with the issue generating more than 40 mentions in the media. Not surprisingly, most interest was across rural areas, where quad bikes are commonly used and where the majority of fatalities and injuries occur. Assoc. Professor Wall, and Committee Deputy Chair, Dr John Crozier, were inundated with requests for live-to-air radio interviews and are to be congratulated for making themselves available for this important work.

In late September, Assoc. Professor Wall called for consideration to be given to a tightening of licensing hours, in line with the College's position paper on alcohol related trauma. The call was made in light of the failure of measures taken by the Queensland government to address the incidence of alcohol fuelled violence on the streets of cities in that state.

Once again, the reaction of media was immediate. The issue was mentioned 25 times in the media and while interest was most intense in Queensland, Assoc. Professor Wall also did media interviews on the subject in Melbourne and Sydney.

Alcohol related violence has been a focus of the Trauma Committee for several years and the College has recently worked in partnership with police forces across both countries to promote awareness of the problem.

Operation Unite is a twice yearly campaign to crack down on reckless, alcohol related behaviour. A heightened police presence on the streets is preceded by an intense public education campaign; earlier this year Dr John Crozier stood alongside New South Wales Police Commissioner Andrew Scipione and told assembled media of the shocking, and utterly preventable, nature of the alcohol related injuries surgeons have to treat.

The Trauma Committee of the Royal Australasian College of Surgeons has a proud history of advocacy on issues of public health. It has led the way on issues of road safety, championing measures that are now commonplace across the developed world. These include seat belts, blood alcohol testing of drivers and the mandatory use of bike helmets.

The work of the Trauma Committee in 2011 has continued this strong tradition of advocacy on behalf of the communities of Australia and New Zealand.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Court of Examiners for the Fellowship Examination

Applications from eligible Fellows willing to serve on the Court should be forwarded to the Department of Examinations of the College no later than **Tuesday 31 January 2011** for appointment in 2012.

Fellows are asked to note the following vacancies on the Court, in the specialty of:
– General Surgery
– Orthopaedic Surgery
– Otolaryngology – Head & Neck Surgery
– Plastic and Reconstructive Surgery
– Vascular Surgery

Should you wish to apply to be an Examiner/member of the Court of Examiners, please forward your application form with your curriculum vitae to:
examinations@surgeons.org
or post to:
Department of Examinations
Royal Australasian College of Surgeons
250 - 290 Spring Street, EAST MELBOURNE VIC 3002

> Application forms are available for downloading via the College website www.surgeons.org
> The policy in respect to Appointments to the Court of Examiners and Conduct of the Fellowship Examination can be found on the College website.
> For inquiries, please email examinations@surgeons.org

The Court of Examiners wishes to acknowledge the following Fellows and their significant contribution to the September 2011 Fellowship Examination (due to an oversight not acknowledged in Vol:12 No:9, 2011 page 34).

General Surgery,
Mr Mayank Bhandari, FRACS

Plastic & Reconstructive Surgery,
Dr Marcus Pyragius, FRACS

Where form is important

A trip to Milan helped Elamurugan Arumugam with the importance of form in reconstruction

Plastic and Reconstructive Fellow Mr Elamurugan Arumugam used the funding provided by the James Ramsay Fellowship for Provincial Surgeons to extend his knowledge and skills in immediate and delayed breast reconstruction.

Receiving the Fellowship in 2010, Mr Arumugam chose to travel to the internationally-acclaimed European Institute of Oncology in Milan.

As a provincial plastic and reconstructive surgeon working from Rockhampton and Townsville, who regularly does reconstructions after mastectomy, he said he chose to visit an international centre of excellence in breast reconstruction surgery to learn and refine his skills and also to compare Australian standards of surgical practice.

"Milan is one of the fashion capitals of the world and needless to say the public and patients are fashion and body conscious which is reflected by the type of reconstructive surgery undertaken there," Mr Arumugam said.

"Most people are slim and it reflects on the breast size and reconstruction patterns."

Mr Arumugam said there were 15 operating theatres in the Milan complex mostly running simultaneously with the Plastic Surgery Department at the Institute busy performing numerous breast reconstructions – both immediate and delayed.

"The main techniques I learned at the Institute were types of immediate reconstruction following nipple-sparing mastectomy," Mr Arumugam said.

"The European Institute was more in favour of the nipple-sparing mastectomy and immediate reconstruction using implants which seemed most suitable for the svelte and slim contour of Italian women.

"Implants played a large role in their reconstructions, although they were using autologous types of reconstruction and a combination of both.

"I also observed and learnt a lot from anciliary techniques such as nipple reconstruction and areola tattooing which was performed simultaneously in theatre. A novel sterile disposable envelope was used for their unsterile implants which were used as sizers prior to the actual implant being inserted."

> *"Implants played a large role in their reconstructions, although they were using autologous types of reconstruction and a combination of both"*

Mr Arumugam said the visit also allowed him to network with surgeons from countries such as Japan, Brazil and Korea, who were also at the Institute, to discuss breast reconstruction and surgical matters of relevance to each country.

He said that Ms Cristina Garusi, the Associate Professor of the Institute, spoke fluent English enabling him to interact well with his international colleagues.

"The James Ramsay Fellowship to Milan was a huge success professionally and personally and I was able to bring home some improved surgical techniques which could be put to use here in Australia," he said.

"I wish to thank the College and the Ramsay Foundation for supporting me with this fellowship to further my knowledge and skills for the benefit of my patients."

The James Ramsay Fellowship was established through a bequest following donations made in 1986 and 1993 by Mr James Ramsay, AO, and subsequently through the generosity of Mrs Diana Ramsay, AO.

The fellowship is only available to provincial surgeons in Australia or New Zealand and is designed to enable such surgeons to spend time developing their existing skills or acquiring new skills away from their provincial practice.

Mr Arumugam received the two-week Fellowship in September last year which carried a $5000 stipend to help support travel and accommodation costs.

With Karen Murphy

cover story

The human form

This surgeon is using his reconstructive skills on another medium

“This [drawing and modelling] course provided an enhanced appreciation of three-dimensional curves, angles and volume that is a great asset in the practice of plastic surgery

With a life-long interest in design aesthetics and visual art skills, Tasmanian Plastic and Reconstructive Surgeon Mr Christopher Edwards some years ago began using his deep knowledge of the human form to create elegant bronze sculptures. A self-taught artist who uses the ancient technique of lost wax casting, Mr Edwards' works are now held in many private collections both in Australia and overseas, with his best known collector being Oprah Winfrey.

He has exhibited at the College's ASC and at Plastic, Reconstructive and Aesthetic Surgery conferences. His current exhibition, being held at Hobart's Handmark Gallery, includes works which pay tribute to the joy of movement and the inherent beauty of the human form. Mr Edwards talks to Surgical News about his twin passions of sculpture and surgery.

When did you take up bronze sculpting? My passion for bronze figurative sculpture stemmed from attending a three-day drawing and modelling workshop run specifically for plastic surgeons by Michael Esson, Director of International Drawing Research at the College of Fine Arts of the University of NSW. This course provided an enhanced appreciation of three-dimensional curves, angles and volume that is a great asset in the practice of plastic surgery. I was impressed by all participants' ability to produce a likeness (albeit a caricature) of their colleague for the day. I decided to look into the process of casting a bonze and cast my first piece in 2003.

Why did you choose this particular art form over others? What I like about bronze, as a medium, is its durability and strength and the quality it has of maintaining its own distinctive characteristics after having undergone the necessary transformation to embody the subject.

What techniques do you use to create a sculpture? I employ the enduring ancient technique of lost wax casting. This involves creating an image, usually in clay, and then making a mould of this. This usually involves a silicon rubber layer with outer plaster-of-paris shells. Often the original sculpture is cut up before making the moulds.


Chris Edwards at his studio in Hobart.

The clay is then removed from the mould and a hollow wax poured or painted into it. This wax is then re-sculpted and a wax sprue or plumbing system is added to allow for the rapid entry of the molten bronze and the exit of gasses. This wax image plus sprue system is then filled and invested in a ceramic or plaster mix. The wax is burned out in a kiln and bronze poured into the resultant cavity. The secondary mould is broken apart to reveal the bronze.

The plumbing system has to be cut off, the various components welded together and the surface restored to the original clay form. The colour, or patina, is achieved by the application of various chemicals to the heated bronze. A layer of wax is then added to bring out the intrinsic lustre of the bronze and to seal the patina.

How long does the process take and how many have you made? It can take six months or more from start to finish. That is obviously not full-time as I do have a day job, take time away from the studio for meetings and holidays as well as waiting in the foundry queue for casting. When I add it all up, including repeats in the editions, I have cast more than 100 bronzes. No wonder I'm worn out! It surprised me to find it was that many.

Do you base your designs on models, drawings or photographs? The best way to do good figurative sculpture is to have good models. I must admit, however, that I find it ▶

hard to organise myself well enough to have set model times and thus tend to use my wife Prue and myself for the proportions, with the aid of photographs and a pinch of fantasy.

Do you have your own studio? My studio is a small, but ideally-situated upstairs room in our home. The heavy-duty fabrication work is done in what was once our two-car garage.

How do you manage your time between sculpting and operating? Time management is difficult. I am able to indulge my passions predominantly because of the help my wife Prue provides in running my practice and our home. I am now also starting to slow down in my surgical practice.

Has the close study of the human form that you have gained from your artistic work changed your approach as a plastic surgeon and if so how? My knowledge of anatomy and the ideal, beautiful normal acquired from plastic surgery training and practice is a great help with my sculpture, and the additional artistic appreciation of form gained from sculpture has significantly benefited my plastic surgery. Putting into practice the many proportional cannons described in plastic surgery literature and art, repeatedly in clay in three dimensions, is invaluable as regards learning the various angles and volumes of the many facets of the human form. Knowing the volume of clay it requires to make, for example, a cheek or a breast is a great help when planning a reconstruction.

Are your works for sale and if so who buys them? My works are for sale which is a necessity as casting bronze is very expensive and thus I need some funding to continue to indulge this passion. I have sold some to friends and colleagues and some through galleries. My most well known collector is Oprah Winfrey. So far this hobby has been self-funding and I still have a large number of pieces.

Have you enjoyed your exhibition at Hobart's Handmark Gallery? The exhibition (which ran in October) was a combination of my work and that of my friend and colleague, dermatologist Francis Watkins and is titled "Skin Deep". It appears to have been well received and we have sold some work.

What has been the highlight of your artistic life so far? The highlights have been the endorsement given to me by colleagues who have liked my work enough to buy it and the recent opening of our exhibition by Sir Guy Green, past Governor of Tasmania and patron of the arts.

What has been the highlight of your life as a surgeon? There have been many highlights in my surgical career as there are for all of us. These range from the minor technical triumphs to recognition from my peers. It may sound a bit of a cliché, but the most satisfying moments are when I feel that I have genuinely improved someone's quality of life. This may be after a major reconstructive case, a small cosmetic procedure or sometimes by simply convincing someone they do not need a particular operation. The latter gets harder the older I get. The father figure thing does not always cut it.

Have you ever wanted to devote yourself to art full-time or do you enjoy the balance between it and surgery? I sometimes fantasise about the bohemian life of an artist, but when I am in my workshop working on a repeat piece in an edition for sale at probably about 50 cents an hour I think surgery is pretty good. In reality both have their ups and downs and I think the balance is ideal.

With Karen Murphy

ROWAN NICKS FELLOWSHIP AUSTRALIA AND NEW ZEALAND

The Royal Australasian College of Surgeons invites suitable applicants who are citizens of Australia or New Zealand to apply for the 2013 Rowan Nicks Australia and New Zealand Exchange Fellowship. Rowan Nicks Scholarships and Fellowships are the most prestigious of the College's International Awards and are directed at surgeons who have the potential to be leaders in their home country.

The 2013 Rowan Nicks ANZ Fellowship is offered to a surgeon from Australia to take up the Fellowship in New Zealand or to a surgeon from New Zealand to take up the Fellowship in Australia. The Fellowship is intended to provide an opportunity for the surgeon to develop skills to enable him/her to manage a department, become competent in the teaching of others, gain experience in clinical research and the applications of modern surgical technology and obtain further advanced exposure to general or specialist surgery. The aim is to 'teach the teacher to teach others' and all scholars must come with a sense of responsibility to the needs of their home base. The Fellowship will be awarded for a period of up to twelve months.

Applicants must: (1) be under 45 years of age, (2) provide evidence they have passed the final exit exam and obtained a Fellowship of the Royal Australasian College of Surgeons at the time of selection, and (3) meet the English language requirements for registration with the Australian Medical Board or Medical Council of New Zealand. Recipients must provide evidence that they have satisfactorily completed their training program by the time they take up their Rowan Nicks Fellowship in Australia or New Zealand. *The value of the Scholarship is up to AU $75,000 (in addition to economy airfares), depending on the funding situation of the candidate and provided sufficient funds are available.*

Closing date for these Scholarships is 5pm – Monday 7 May, 2012

*Applicants will be notified of the outcome of their application by 30 October 2012. *A sponsor in the destination country is desirable (from the candidate's point of view) but is not essential and will not detract from the application.*

ROWAN NICKS INTERNATIONAL AND PACIFIC ISLANDS SCHOLARSHIPS

The Royal Australasian College of Surgeons invites suitable applicants for the 2013 Rowan Nicks International Scholarship and the 2013 Rowan Nicks Pacific Islands Scholarship. These are the most prestigious of the College's International Awards and are directed at qualified surgeons who are destined to be leaders in their home countries.

The 2013 Rowan Nicks International Scholarship is offered to qualified surgeons from Bhutan, Cambodia, Indonesia, Laos, Mongolia, Myanmar, Nepal and Vietnam. It is intended to provide an opportunity for the surgeon to develop skills to manage a department and become competent in the teaching of others in his/her home country. It is emphasised that the objectives of the Scholarship are leadership and teaching and it should not be used solely to develop surgical skill.

The 2013 Rowan Nicks Pacific Islands Scholarship is reserved for qualified surgeons and candidates who have completed the Master of Medicine examination, from the Pacific Islands in the Western Pacific rim, including Papua New Guinea. It is aimed at promoting the future development of surgery in the Pacific Islands by providing a period of selective surgical training with the specific purpose of fostering the Scholar's potential to provide surgical leadership in his/her home country. *These scholarships are usually awarded for a period of between three and 12 months and cover the scholar's travel expenses between his/her home country and Australia or New Zealand. A living allowance will be provided equivalent to AU $36,000 for up to 12 months or appropriate pro-rata for a Scholarship in Australia or New Zealand. The Scholarship does not cover any costs associated with the Scholar's family members. The Scholarship is tenable in a major hospital (or hospitals) in Australia or New Zealand, and appointees will attend the Annual Scientific Congress of the College if they are in Australia or New Zealand at the relevant time.*

Closing date for these Scholarships is 5pm Monday 4 June, 2012

Applicants will be notified of the outcome of their application by 30 October 2012.

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

The application form and submission instructions will be available for download on the College website in December 2011: **www.surgeons.org**

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

Vital skills for neighbours

A Definitive Surgical Trauma Care Course held in Auckland has given Pacific Islands surgeons vital skills

The College's AusAID-funded Pacific Islands Program (PIP) earlier this year sponsored two surgeons from Fiji and one surgeon from Tonga to travel to Auckland to participate in a Definitive Surgical Trauma Care (DSTC) Course.

One of the most highly regarded surgical trauma care courses now provided around the world, the DSTC course was developed by the International Association for Trauma Surgery and Intensive Care to provide surgeons with both the decision-making and practical skills needed to save the lives of patients within the first hours following injury.

The course held in Auckland took place in August at the University of Auckland and the Auckland City Hospital and was attended, among others, by trainee surgeons Dr Sonal Nagra and Dr Alipate Navunisaravi from Fiji and Dr Saia Piukala from Tonga.

According to College President and course instructor, Mr Ian Civil, many hundreds of surgeons from Australia, New Zealand and overseas have now taken the DSTC course in Australia or New Zealand since its introduction in 1996.

He said that in a time of increasing sub-specialisation and with studies continuing to show that up to a third of trauma deaths may be preventable or potentially preventable in areas without dedicated trauma systems, the skills transfer made possible through the DSTC course was crucial.

With growing recognition of its value, the Board in General Surgery has recently decided to make the DSTC course a mandatory requirement of general surgical training from 2013.

Mr Civil said the course had particular value given that it worked on almost a one-to-one ratio between students and instructors, was only offered to small groups of surgeons per course and included topic presentations, decision-making scenarios and practical laboratory work.

"The central issue of trauma care is that decisions often have to be made extremely quickly, yet the consequences of those decisions can be profound," he said.

"However, the chance to learn the skills needed, both practical surgical skills and decision-making skills, in a calm environment under the guidance of highly experienced senior surgeons is extremely limited.

"Trauma is relatively uncommon in peaceful countries like Australia and New Zealand so there is limited ability to learn from experience, or watch others dealing with trauma patients which is why this course is so valuable."

Mr Civil said the DSTC course differed from the EMST course in that it was designed to teach the surgical decision-making skills needed to treat patients after resuscitation or stabilisation had occurred.

He said it was of particular importance to general surgeons, but also had relevance to other specialties such as orthopaedics and neurosurgery.

"One of the scenarios we practice, for example, is what to do if a trauma patient has developed a clot on the brain," Mr Civil said.

"The life-saving technique is to do a craniotomy, or make a burr hole, to drain the clot before serious brain injury can occur.

"However, this has to be done quickly, ideally within two hours, so what does a non-neurosurgeon do if a neurosurgeon is five hours away?

"The best outcome is for there to be contact with the neurosurgeon, and after confirmation that a burr hole is appropriate, for the local surgeon to undertake this procedure as soon as possible. The local surgeon needs the confidence to be able to undertake such a procedure.

"When participants on the DSTC course do a burr hole and craniotomy in the lab, with a neurosurgeon beside them guiding them through the process, they develop confidence in their abilities to do what must be done when it must be done.

"This also goes for other time-critical surgery such as with injuries to the liver, the great blood vessels and within the chest cavity.

"Surgeons need to know what to do and how to do it given that cardiac or thoracic or hepatobiliary surgeons are not in every hospital."

Mr Civil also said that the skills and techniques taught through the course were of particular importance in an era of increasing surgical specialisation.

"In days gone by, everyone did so much of everything that there was broad experience to call on when dealing with severe trauma, yet now many surgeons sub-specialise within a few years of completing their training," he said.

"This means their experience with time-critical trauma patients can be quite limited and they greatly benefit from the teaching available in the DTSC Course.

"It is often said that there is a great deal in common between being a surgeon and a pilot. Pilots, however, train extensively for emergencies they may never have to confront. The concept that training for critical surgical emergencies is more important when the frequency is low, has not been widely appreciated in medicine.

"Time-critical surgical emergencies are uncommon events for most surgeons and the DSTC course is a valuable addition to that training."

Mr Civil said that the course was now offered in more than 20 countries around the world, with some Australian and New Zealand Fellows acting as instructors not only on local courses but, because of their experience and teaching skills, on courses in Asia and around the world.

The Director of Surgery at the Auckland City Hospital, a major trauma centre, Mr Civil said the course had long been a requirement for General Surgeons and most senior general surgery trainees completed the course during their time in Auckland.

And he said the course had particular relevance to the Fijian and Tongan surgeons given the limited options for patient transfer in those countries.

"Either these surgeons do something or the patient outcomes suffer," he said.

"There is no neurosurgeon in Fiji, there is no tertiary trauma hospital so surgeons need to know what they can do, what is reasonable to do and when to do it."

Dr Sonal Nagra from Fiji described the two-and-half-day course as excellent, not only in terms of skills learnt, but also for the chance to meet senior surgeons from Australia and New Zealand and he thanked the College for the financial support provided.

"Most of the sessions were very informative and contributed greatly to our understanding of advanced surgical care," he said.

"The most exciting part was the actual surgical labs supervised by the highly-trained faculty. As such we were given the opportunity to carry out life-saving procedures in a realistic fashion while we were also able to accumulate teaching material and presentations to share with our trainees in Fiji.

"Being exposed to high level presentations, demonstrations and activities improved our confidence level in providing definitive surgical care or undertaking damage control surgery."

Dr Alipate Navunisaravi described the course as offering fascinating access to the equipment available to New Zealand surgeons, describing the luxury of having CT scans and angiography to minimise mistakes as "amazing".

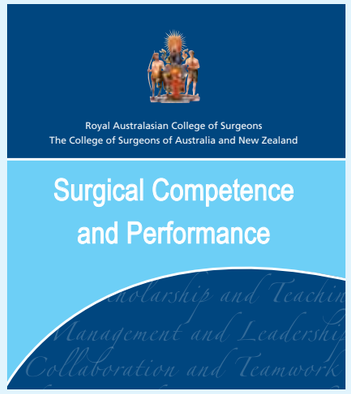
"I enjoyed the practical sessions while the course provided real life scenarios with very helpful discussions," he said.

"I enjoyed having my first feel of doing a thoracotomy, median sternotomy, pericardial window and the principles of damage control I will now master."

With Karen Murphy

How do you rate?

An opportunity to reflect on your own performance



David Watters
Chair, Performance Assessment Steering Committee

How am I performing as a surgeon? How should my performance be assessed? What tools exist that surgeons can use to stimulate performance development? To address these three questions the College developed a framework to inspire all practising surgeons to review their performance across all nine College competencies.

This work resulted in the publication of the first edition of the Surgical Competence and Performance guide in 2008. This described performance, not just across the traditionally valued competencies of clinical decision making, medical expertise and technical expertise, but also included a range of non-technical competencies relevant to surgical practice – communication, professionalism, collaboration and teamwork, health advocacy, management and leadership, scholarship and teaching.

It was always intended that this would be an aspirational guide, encouraging all surgeons to reflect on their performance as they read and re-read it. Many surgeons have found the guide helpful for this purpose. It has also been used by surgical department heads and hospital managers to identify and address underperformance. In addition, the Surgical Competence and Performance guide has received international acclaim and promoted the College as a leader in this field.

The second edition of the guide is still intended to promote reflection, learning and improvement. However, the guide also incorporates a performance assessment and feedback tool that is able to be used for self-reflection or given to colleagues and co-workers for peer review or multisource (360 degree) feedback. It is designed for all surgeons, not just those whose performance is under scrutiny.

In reviewing the first edition of the guide, we also refined the way in which several of the 'patterns of behaviour' and 'behavioural markers' were described. This was done on the basis of feedback from Fellows who had used the framework for reflection and assessment.

The guide complements the College Continuing Professional Development (recertification) program. Over the coming months, the Board of Professional Development and Standards will be considering options for integrating the assessment and feedback tool into the CPD Program from 2013. The intent is not to produce a checklist nor to promote a culture of blame or retribution, but rather to provide a tool for positive and constructive use by surgeons who wish to develop their performance across all nine surgical competencies.

I encourage all Fellows to read this guide and to share the performance assessment and feedback tool with peers and surgical colleagues as an opportunity for reflection and professional development. Your colleagues will benefit from the honest assessment and feedback that you provide, just as you will benefit from theirs.

If you have any questions or comments regarding the guide, please contact Professor David Watters, Chair Performance Assessment Steering Committee or Dr Pam Montgomery, Director Fellowship and Standards at email pam.montgomery@surgeons.org

2012 Annual Scientific Congress

Kuala Lumpur Convention Centre, Kuala Lumpur, Malaysia

Philip Truskett,
Congress Convener and Raffi Qasabian,
Congress Scientific Convener

After a gap of 20 years, the Annual Scientific Congress went off-shore to Hong Kong in 2008. Those who attended the conference, and there were 2,500 delegates, reckoned it the most exciting ASC for many years and there was great enthusiasm for another off-shore meeting. After considering the options, Kuala Lumpur and the outstanding Kuala Lumpur Convention Centre were decided upon. Opened in 2006, the Centre has won international awards being superbly situated overlooking extensive landscaped gardens and the twin Petronas Towers.

Convocation

The 2012 ASC is being convened by Sydney surgeons with 28 section programs and 35 Masterclasses. The Convocation is planned for Sunday, 6 May, at 4.30 pm to be followed by the President's Welcome Reception at 6 pm. This will be held on the Level Two foyer with outstanding views through floor to ceiling glass across the gardens to the Towers. The Syme oration will be delivered by Datuk Paul Low Seng Kuan, President of Transparency International Malaysia.

Theme of the meeting

The theme for the meeting is 'The making of a surgeon'. Each of the four plenary sessions will concentrate on one of the non-technical skills that are vital to well-rounded surgical performance: Communication, Collaboration and Professionalism. The final plenary will bring these three aspects together in a session titled 'Making the team work'. The plenary program has gone from strength to strength over the past several years and the 2012 plenaries will definitely be educational and possibly confronting.

Scientific programs

The scientific program is scheduled for Monday, 7 May, to Thursday, 10 May. An outstanding faculty of speakers from around the world have accepted invitations to participate in the 28 section programs. This has been made possible by the College's Educational Triennium Fund and with additional sponsorship from our industry partners. Again, Johnson & Johnson Medical is the platinum sponsor of the meeting. The programs range from the broad interest programs such as Surgical History and Senior Surgeons, to section programs that span the four days of the meeting, such as General surgery and Trauma surgery.

Cultural and culinary event – Monday, 7 May

For this meeting, all the section dinners will be held on Tuesday evening. This will allow a special function on Monday night – a cultural and culinary event that will bring the culture and the cuisine of Malaysia to the meeting. Malaysia is a fascinating mix of Malay, Chinese and Indian culture and cooking. One way to experience this is to venture out into the night markets, but this is difficult with 2,000 delegates so we have planned to bring this to the convention centre. The KL Convention Centre boasts Kuala Lumpur's best chefs and we have arranged a special smorgasbord of Malay, Chinese and Indian food and the best of Malaysian handicrafts and music. Make sure you pack the Hawaiian shirt or blouse, and dress to enjoy the evening with a choice of selected beverages. Outstanding artisans will demonstrate pewter work, traditional Malaysian songket weaving, dance and music.

Over the coming months we will highlight different aspects of the meeting and each of the specialty programs.

General Surgery program

Professor Michael Cox is convening the General Surgery Program and he has Acute General Surgery as the theme. The invited speakers will bring significant expertise in the organisation and delivery of emergency surgical services from around the world. Each speaker also has a specific expertise in the delivery of emergency surgical care to patients. Simon Patterson-Brown (Edinburgh, UK) has a keen interest in emergency surgery for upper gastrointestinal disease and has established a unique model of emergency general surgery in the UK. Associate Professor Phillip Carson from Darwin has immense experience in emergency surgery across a broad spectrum of disciplines in remote Australia and was pivotal in the establishment of the National Trauma Centre in Darwin. Professor Gene Moore (Denver) is a leading trauma surgeon in the US with an international reputation and in the past decade he has led the development of acute care surgery as a recognised sub-specialty in the United States.

General surgery will be running four Masterclasses addressing specific emergency presentations: acute cholecystitis, acute abdominal emergency presentations following bariatric surgery, the management of necrotising fasciitis and damage control laparotomy. Other sessions and key note addresses will cover issues such as new models of care for emergency surgery and a broad spectrum of clinically relevant sessions on a wide variety of acute general surgery presentations. As in previous years, selected research abstracts will be judged for the trainee research prize.

"A special function on Monday night – a cultural and culinary event … will bring the culture and the cuisine of Malaysia to the meeting"

Bariatric Surgery program

The Bariatric Surgery program is convened by John Jorgensen and Ken Loi. The program will extend across three days, Monday to Wednesday and will present a comprehensive summary of the latest information from research centres and the operating theatre. The program is fortunate to have three highly regarded international experts attending the meeting – Randy Seely (Fort Lauderdale), Raul Rosenthal (Cincinnati) and Wei-Jei Lee (Taiwan). The program will be a blend of presentations, a Masterclass and a video session titled 'How I do revisional surgery' with generous time for discussion.

Dr Seely is a neurobiologist who will present the latest findings from the animal laboratory. He has increasing data on weight loss surgery effects in the obese rat model in terms of weight loss, behaviour and metabolic effects. Dr Raul Rosenthal is a very experienced bariatric surgeon from Florida. He will present one of the Masterclasses (held in association with General Surgery) on bariatric emergencies as they present to the emergency department. He will also contribute in the general program, particularly with reference to re-operative surgery. Professor Lee has participated in numerous prospective randomised studies on the surgical procedures available for weight loss and he will guide the discussions on tailoring the appropriate choice of operation. He will also focus on the metabolic effects of surgery and will lecture on surgery for type 2 diabetes, itself the subject of a dedicated session. There will an emphasis on interactive sessions as well as the video session and research papers. Research abstracts presented by Trainees will be selected for presentation for the Trainee Research Prize. All in all, a very full and exciting program.

Salamat datang ke Malaysia
– Welcome to Malaysia

Ongoing recovery

Christchurch has undoubtedly changed forever, but the community is moving forward

In an extraordinary testimony to the resilience and dedication of staff and the successful roll-out of crisis management plans, the Canterbury District Health Board achieved 97 per cent of its expected workload in the financial year to the end of June.

With the September and February major earthquakes and management of the consequent casualties, on-going aftershocks, damage to a major ward building and other hospital facilities, the Christchurch Hospital lost an estimated 10 to 12 per cent of its elective operating capacity, according to the Chief of Surgery, Mr Gregory Robertson.

Mr Robertson described the past year as "challenging" and said the September earthquake, where there were no fatalities, acted almost as an exercise to help prepare staff for the major catastrophe of February in which more than 180 people died.

"I'm very proud of what we have achieved this year given the issues affecting our staff and the facilities that they work in," he said.

Central to these outcomes were coordinated local and national health system responses.

"Local staff showed phenomenal strength and resilience in working through those first hours, in particular, when many did not know if their families were safe or their homes intact," Mr Robertson said.

"They were working in buildings which they had concerns about the stability of and were seeing and treating patients with injuries we do not often have to confront.

"The emergency physicians showed exceptional skills in how they managed the initial triaging systems and patient flow.

"And then it seemed that all of New Zealand and Australia came to our aid, with surgeons from across the countries offering their assistance either to come to Christchurch or by treating our patients elsewhere.

"The human spirit can be amazing when things need to be done."

Mr Robertson said there have been around 8,300 Accident Compensation claims related to the February earthquake, with many of the injured being treated at community triage centres or other non-acute hospitals.

There were 171 admissions to Christchurch Hospital with the predominant injury type being orthopaedic and crush injuries. The local orthopaedic surgeons dealt with the initial influx, then received assistance from their colleagues from Wellington and Auckland. A staffed Australian field hospital was also mobilised to help in Christchurch.

Complex patients already being treated in the hospital and those in the Intensive Care Unit (ICU) were transported to other centres during the first days following the disaster, while patients requiring planned, non-deferrable surgery (such as cancer patients) were transferred out of Christchurch to be treated by surgeons around New Zealand.

"We were very grateful for this, appreciating our colleagues already had full operating schedules, so it was not easy for them to find the time or theatre space," he said.

Mr Robertson said all the hospital buildings had been damaged to a variable extent by the earthquakes, however, the partial closure to inpatients of the Riverside block – a late 1970s-era building which housed the hospital's main ward block of 350 beds – had a major effect on the delivery of secondary care.

He said infrastructural and water damage as well as difficulties evacuating patients from the top two floors of the building after the elevators lost power resulted in a decision to close the fourth and fifth floors of the Riverside Block to overnight general medical patients. These wards have temporarily moved to The Princess Margaret Hospital in Cashmere.

Process changes to improve patient flow (such as the provision of more acute orthopaedic operating time) and the altered use of hospital spaces for other functions (such as the creation of a 23-hour ward in the day surgery centre) were used to augment the available beds.

The Princess Margaret Hospital, mainly a rehabilitation and elderly health care facility, had office space reconverted into acute general medical wards.

Mr Robertson said while Christchurch Hospital had already been earmarked for replacement in a new facilities plan developed before the September earthquake, government approval was still pending.

"The Riverside block appears to be stronger than we originally thought, but it is likely considerable strengthening work will still be needed," he said.

"However, as an older building it does not provide for the best of contemporary care and because it would require considerable financial input to make the necessary improvements, discussions are still underway as to whether this is the best way forward.

"The financial implications of the widespread earthquake damage to Christchurch and the present global economic climate have created difficulties to say the least."

Mr Robertson said there have been a number of resignations of some medical, nursing, radiology, allied health and surgical staff at Christchurch Hospital since the February disaster was managed – an outcome to be expected given the on-going aftershocks, the destruction of the city and effects on people's lives.

"With the central city still cordoned and major demolition work continuing, the city is going to take a long time to rebuild and people will always consider their options when other opportunities arise," he said.

"While we have had some difficulty in attracting junior registrars, we have been allocated the normal quota of advanced surgical trainees.

"We are also extending opportunities to surgical trainees from the Pacific Islands, which is a good outcome as we all benefit. We are advertising extensively and have been attracting quality new staff of all levels to Christchurch."

Mr Robertson said that despite approximately 8000 aftershocks since September last year and predictions reducing seismic activity would likely continue for another year or more, there was still guarded optimism within the Christchurch community.

"New buildings are going up despite the on-going difficulties with insurance and people are getting on with their lives so there is an air of normality returning to the city," he said.

"It's been an interesting 12 months in Christchurch and we have shared what we have learned with our colleagues in other parts of the country, given that there are other areas in New Zealand I had always thought were more of an earthquake risk than Christchurch."

With Karen Murphy

New edition of ‘Preparation for Practice’

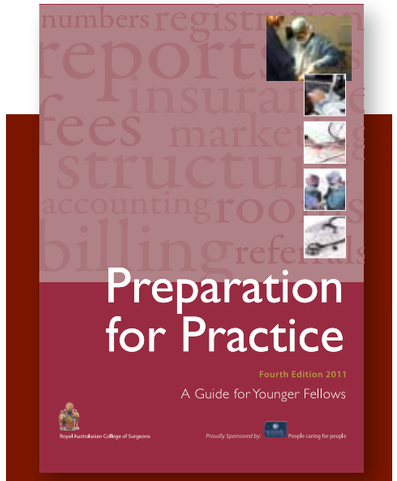
How you will practice is one of the hardest decisions

Steve Leibman
Chair, Younger Fellows Committee

Anyone who has gone into private practice will tell you that it is a huge undertaking; there are so many issues to consider and big decisions to make. However, there is good news! A new edition of the College’s publication Preparation for Practice: A Guide for Younger Fellows is now available. It provides Fellows with useful information to deal with some of the complexities of setting up a practice. The College would like to thank Ramsay Health Care who has again provided a generous educational grant to support the production of this edition.

This resource was first produced in 2004 in response to requests from Younger Fellows and is based on a similar guide produced by the Urological Society of Australasia. There is information about one of the first and hardest decisions you have to make – What type of practice are you considering? There is a range of private practice options to choose from including a solo or group practice, a partnership, a company or an associateship as well as undertaking contract work with an established practice.

The latest edition also includes a range of information sources to help you make a myriad of other decisions about issues such as registration and insurance, provider and prescriber numbers, medical referrals, surgical billing, hospital credentialing and dealing with complaints. There is a section devoted to setting up consultation rooms in which you can find tips about staffing arrangements, IT requirements, appointment systems plus the required forms and stationery. Even for the IT savvy surgeon, setting up the office IT system is not a DIY activity. System security and reliability is critical and you will need experienced and professional support. Don’t forget that at www.surgeons.org you will find information about the FRACS logo for Fellows to use on letterhead and signage.



All new Fellows receive this resource in their welcome pack and an electronic copy is available on the College website. If you would like a hard copy, please contact the Younger Fellows Secretariat at Younger.Fellows@surgeons.org or on +61 3 9249 1122.

Professional Development WORKSHOPS

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

>Non-Technical Skills for Surgeons (NOTSS) *NEW*

Please see website for 2012 dates

This new workshop focuses on the non- technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve your performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/ teamwork. Each of these categories is broken down into elements or behavioural markers that can be used to identify a superior or substandard performance. Through a series of interactive exercises you will better understand how these markers can be used to reflect on your own performance and that of the surgeons you work with. Target group - Fellows, International Medical Graduates and senior SET trainees.

>Keeping Trainees on Track (KToT)

16 February, Auckland NZ; 28 February, Brisbane; 27 March, Melbourne

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

>Process Communication Model (PCM) *NEW*

8-10 March, Wellington NZ

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.

>Practice Made Perfect; successful principles in practice management

9 March, Perth

This whole day workshop focuses on the challenges of running a practice. Learn more about the six principles of managing a small business. Practice managers, practice staff and Fellows are encouraged to join these workshops for a valuable learning experience.

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.

KL

7 May, Keeping Trainees on Track (KToT) , (ASC)
7 May, SAT SET Course, (ASC)
4-6 May, Younger Fellows Forum (YFF), (ASC)
TBA, Non-Technical Skills for Surgeons (NOTSS), (ASC)

2012 DATES:
JANUARY - MAY

ACT

7 March, Canberra / SAT SET Course

NSW

30 March, Sydney / Occupational Medicine
Non-Technical Skills for Surgeons (NOTSS)
2 April, Sydney
Keeping Trainees on Track (KToT)

NZ

16 February, Auckland
Keeping Trainees on Track (KToT)
8 – 10 March, Wellington
Process Communication Model

QLD

28 Feb, Brisbane / Keeping Trainees on Track (KToT)
21 March, Brisbane / Polishing Presentation Skills
29 May, Brisbane / SAT SET Course
26 – 28 April, Brisbane
Process Communication Model
TBA, Brisbane
Non-Technical Skills for Surgeons (NOTSS)

SA

27 February, Adelaide / SAT SET Course
TBA, Adelaide
Non-Technical Skills for Surgeons (NOTSS)

TAS

21 April, Launceston / Keeping Trainees on Track (KToT)

VIC

10 March, Melbourne
Communication Skills for Cancer Clinicians
22 – 24 March, Melbourne
Surgical Teachers Course (STC)
27 March, Melbourne, Keeping Trainees on Track (KToT)
27 April, Melbourne / Occupational Medicine
30 April, Melbourne / SAT SET Course
TBA, Melbourne
Non-Technical Skills for Surgeons (NOTSS)

WA

9 March, Perth / Practice Made Perfect

Planning for the future of surgeon skills

Are patients happy for us to showcase our teaching skills in live presentations?

Helen E. O'Connell
College Councillor and Chair Skills and Education Centre Oversight Committee

The public do not expect junior pilots to practice their fledgling skills in passenger aircraft. Though databases about surgical simulation are relatively under-developed, training by simulation to some extent is expected of us as we teach or learn to become firstly surgeons, then expert surgeons.

The complex operation performed by a star surgeon, beamed from the operating 'theatre' to an adjacent auditorium is now very familiar to all of us. But would we be eager to put ourselves forward as the patient participant in such a theatrical exercise albeit with the best educational intent? This is regarded as less than ideal by patient advocates.

Skills and Education Centre at RACS Headquarters

Skills laboratories and associated educational facilities – lecture and meeting rooms and their associated IT capability – can be put to the purpose of upskilling the least trained individuals, e.g. teaching suturing to medical students. GPs can be taught procedural work such as excision of skin lesions, surgical trainees can learn laparoscopic, endoscopic and open skills where the appropriate and costly equipment is housed and where there are willing and skilled staff available to provide the supervision.

Of course Fellows of the College can benefit from both teaching and learning in this environment and many have benefited from the opportunities afforded by our College facility and other surgical simulation environments in either Australia or New Zealand. The Skills and Education Centre at the College has the IT capability to showcase simulated procedures to anywhere in the world. Such facilities can also be utilised for advanced surgical training or "master classes" where sophisticated procedures are taught to sub-specialty groups including training of local and international highly experienced surgeons in new or complex procedures.

Examples of this include the cochlear implant course, which has been held several times each year, and a course developed in NeuroUrology to teach procedures associated with a high complication rate such as continent urinary diversion. Potentially any procedure in any specialty could be simulated in part or total for education in a skills facility. Surgical champions are the other key ingredient to develop the simulated models and the resources to bring the surgeons and trainees to the facility which must be well-stocked with state of the art equipment.

History of Surgical Skills and Education Centre

Since the establishment of the College Skills and Education Centre in 2004, thousands of Trainees, Surgeons, other medical practitioners and medical students have benefited from world-class teaching across a wide array of skills. During that time, workshops have ranged from fundamental surgical skills courses to cadaveric workshops, attracting participants from all around Australia and many from overseas.

There is a rich history to the Skills laboratory site which could be provided to an interested Fellow or trainee. The Centre's Medical Director and surgical innovator Dr Donald Murphy and the laboratory staff, manager Dr David Lawrence and Ms Arwen Tudor, have provided ingredients for excellent training courses.

Strategic planning to drive skills training

A strategic planning workshop was recently held by the Oversight Committee of the Skills Centre supported by a group of interested Fellows and management staff, and an external facilitator John Viljoen PhD. A strategic plan has been drafted to be refined in coming months.

Taken from the draft report still to be ratified at Education Boards and College Council and without specifying the precise words at this stage, the ideas put forward at the workshop suggested a vision incorporating:

1. To be the Centre of choice for surgical specialties, supported by appropriate non-surgical skills training.
2. To be a sustainable, ethical, state-of-the-art surgical laboratory.
3. To promote and support the surgical skills of Fellows, Trainees and other health professionals locally, nationally and internationally.

It is preferable that the vision refers to the product of the facility rather than the facility itself. This favours Option 3, and Options 1 and 2 become means to achieving Options 3.

Re-stating the vision for the Centre is no trivial matter and should be fully considered by the Oversight Committee and the College before any final decision is made.

The pro bono model of surgical teaching has underpinned our College training boards and much of the teaching we undertake, particularly teaching in technical skills. Some training in hospitals is now funded supporting the idea that not all training of juniors by surgeons should be pro bono. Some recent data has demonstrated that technical skills, particularly for junior trainees, can be undertaken by non-surgeons at least as (possibly even more) effectively than by surgeons.

The future of skills training

Surgery is underpinned by cognitive activity of the highest order. We need to have the patients' best interests at heart as we perform technical procedures in front of a group of skilled health professionals, sometimes in settings where the financial and emotional stakes are very high.

We undertake a multitude of decisions as we perform what appear superficially to be routine procedures. Much of this cognitive activity has been subliminal, and we learn it by modelling of surgeons we admire. A more systematic approach may be effective and that is part of our challenge in creating surgical skills training and resources for the future.

"Surgical champions are the other key ingredient to develop the simulated models and the resources to bring the surgeons and trainees to the facility"

Useful research is being done in this non-technical intellectual space to drive an excellent future for us as surgeons and trainees, but also of course for the communities we serve. The Skills and Education Centre at College headquarters is an outstanding resource for the development of technical and non-technical competencies.

The development of skills and what resources are best used to develop them for Trainees and Fellows is the focus of many aspects of College strategy. It involves CPD, our Education Boards, the growing Academy of Surgical Educators and our research capability. Our future skills capability requires planning as an integrated effort involving the Specialty Societies and the College. To be the surgical professionals we aspire to be is not just about us, but what is expected of us.

A brave new web world

Embrace the new services available with the revamped College website

Cathy Ferguson
Chair, Fellowship Services Committee

The 2010 Fellowship survey reveals strong levels of satisfaction with the College website. The survey identified that 76 per cent of Fellows are very satisfied or satisfied with the website. Similar results were reported when comparing active and retired Fellows. Which begs the question why try to improve it?

Since the web was first provided as a resource a lot has happened and new opportunities to provide service to Fellows, Trainees and IMGs (members) are available.

LinkedIn, the National Broadband Network, iPads, E-Health, Android – it's a dynamic and connected world we live in. In developed countries we are close to a time when more mobile devices are connected to the internet than computers. Industry analysts International Data Corporation predict that this will happen in the US by 2015.

It's time for a major makeover of the website. We have strong feedback from the work of the Communications Working Party, Fellows, Trainees and IMGs at both the Annual Scientific Congress and our participation at various specialty society events with which to design a new web facility. In November of 2010 we took the first step by upgrading the web technology platform.

What will we see in the new website? The focus will be on the needs of members who after log in will each have their own personalised page. This page will have information relevant to that member, including CPD or Pathway to Fellowship progress, key content, quick links and more. Members will be able to define a personal profile of the information they receive from their own "news feed". You will be able to book and pay for conferences, courses and other College offerings online. This service focus will also extend to key stakeholder groups who access information on the home page.

There will be new opportunities to build and share information with other members. Discussion forums, blogs and professional networking facilities will be readily available and we encourage members to use these facilities. If you are interested in blogging, forming a professional network or commencing a discussion forum please contact andrew.mclorinan@surgeons.org for more information or assistance.

The website is already significantly accessed via mobile devices. We expect that to explode in the future with Apple and Android based platforms reaching new levels of affordability and functionality. Accordingly the new website will be mobile optimised to allow greater access to key content like the online library.

There will be a focus on better online content. The library is by far the most accessed section of the College website, with more than 40,000 visits to the login page since July. In its new form the web will provide "RACS Knowledge" to members with e-learning, library, multimedia and social media elements.

This undertaking is not without its challenges, but it is an exciting new facility I hope you will embrace.

Out of sight – *out of mind*

Severe problems at our nation's heart need more attention

Dr Jacob Ollapallil
Director of Surgery, Alice Springs Hospital

The title of this article evokes the principle: 'that which is not seen is easily forgotten or dismissed, and is therefore unimportant'. The Alice Springs Hospital (ASH) may fall into this category.

One hundred and seventy-one medical officers are employed at ASH (71 per cent are International Medical Graduates (IMGs)). There are 35 specialists (83 per cent are IMGs). All clinicians in the area of surgery and renal medicine are IMGs.

There is a very heavy workload at ASH and the disease burden in the Alice Springs population is extremely high. There are significant cultural challenges to be faced daily and the work is extremely difficult in such an isolated area. It is a long way from nowhere.

Little wonder that remote hospitals such as ASH cannot attract young surgeons, except when locum agencies lure them with significant sums of money. The sales pitch may as well read: "Sexy locum job seeks smart consultant who does not want a long-term relationship" or "Slim, low-maintenance locum job seeks available doctor for regular get-togethers".

Despite advertising repeatedly for the vacant position of consultant General Surgeon in Alice Springs, there has been no applicant from Australia, but many offers from young surgeons to do locum work for periods varying from three to six months. This may reflect a trend in young surgeons' mindset; perhaps many are opting for short-term, well-paid locum jobs to fill a gap before taking an overseas posting or something in the city.

Locum surgeons are appreciated but, by definition, they lack long-term commitment. They also impose an enormous cost on the health department. The cost of one locum surgeon equates to approximately $1 million, a very large percentage of the total budget of ASH. Furthermore, most locums do not have the necessary skill set that is needed for such a surgical practice and serious complications may arise as a consequence. The skill set required in Alice Springs is quite different from that needed in metropolitan practice, and in many ways is different from that needed in other parts of regional Australia.

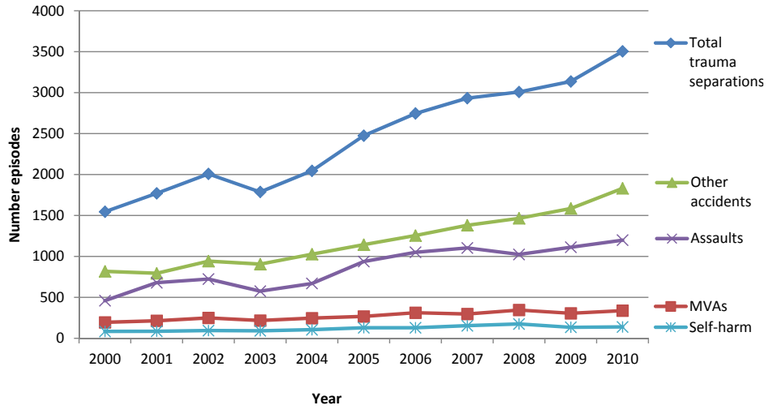


Figure 1: Alice Springs Hospital trauma episodes 2000–2010

Trauma

ASH has substantially more trauma separations – specifically motor vehicle accidents (MVAs), other accidents (burns and falls), assault and self-harm – than almost every other hospital in Australia. This is depicted in Figure 1. ASH maintains a database of all hospital admissions (ICD-10 classification) and trauma admissions are corroborated with surgical and orthopaedic weekly audit data.

Assault

Assault figures are also very high, as indicated below (Figure 2). All published studies on assault usually report young males as the most common victims of assault. However, ASH statistics confirm that Northern Territory is one of the worst places in the world in terms of volume of violence and assault against women.

Ear disease

Ear disease in Indigenous communities is another huge problem. Recent data show that otitis media affects 91 per cent of Indigenous children, and that 31 per cent of all Indigenous children have bilateral otitis media with an effusion (Morrie et al BMC Pediatr 2005 Jul). Chronic suppurative otitis media is present in 15 per cent, and tympanic membrane perforation affects 40 per cent of children in the first 18 months of their life (Morrie et al BMC Pediatr 2005 Jul).

These are astounding data considering that those affected are children. The situation may be even worse, as World Health Organization (WHO) data suggest that seven per cent of Indigenous children have only one normal tympanic membrane (Lasisi et al 2008). This amounts to a public health disaster in the Northern Territory. (The WHO states that if >4% of a population has otitis media, then that population has a health crisis.)

Consequently, a yawning education gap has opened up. High levels of hearing impairment after ear infection leave children unable to attend school or unable to make the most of the learning process. Poor general hygiene, overcrowding, poor diet, high levels of bottle feeding of infants, feeding infants while supine, having a sibling with otitis media and living with people who smoke in the home are all predisposing factors to ear disease.

Our dream in Central Australia is to have an ENT Institute in Alice Springs, a centre of excellence in ear, nose and throat health. I urge the College to support this area of surgical enterprise by whatever means it can.

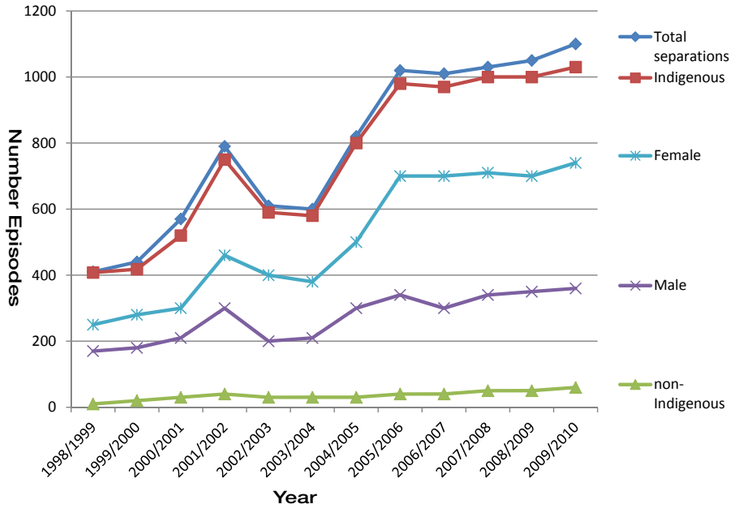


Figure 2: Alice Springs Hospital assault episodes 1998–2010

"Mother Teresa summed it up well: "It is easy to love the people far away; it is not always easy to love the people who live right next to us"

Conclusion

Many decades of neglect, compounded by poor education and a heavy burden of disease, have led to a reduction in life-expectancy and increases in renal disease, diabetes, heart disease, skin disease and pelvic inflammatory disease. There is almost universal ear infection and a high rate of acute alcoholic pancreatitis. ASH has the largest single standing dialysis unit in the southern hemisphere. Two hundred and fifteen patients currently attend the unit, and this number is expected to double in the next four years.

Amid this nightmare of disease, injury and trauma are often overlooked as part of the overall legacy of inequity and neglect. What then can we do to address these problems?

College support for innovative means of increasing surgical supply would – and must – improve health outcomes in the Alice Springs region. The College could consider initiating a locum register or even a recruitment business. Any such arrangements would need to be on a 'one in four on-call' basis and could, in theory, attract world-class surgeons to meet a pressing local need.

Guidelines for locum work should be distributed via College media rather than by professional recruitment marketing. Locum periods in ASH should be carefully constructed, advertised and monitored to maximise service delivery and avoid burnout of both local surgeons and locums.

The College must meet the challenge to both prevent and treat Indigenous health problems and particularly to reduce the problem of Indigenous trauma-related injury. Our College and its Fellows have a longstanding and highly beneficial interest in surgical service delivery all over the world, including the South Pacific and Africa, but pay little attention to the Northern Territory.

Mother Teresa summed it up well: "It is easy to love the people far away; it is not always easy to love the people who live right next to us".

This article is based on a presentation given by Dr Jacob Ollapallil, Director of Surgery, ASH, and member of the Northern Territory Audit of Surgical Mortality Management Committee. (The RACS presentation was at the NT, WA & SA combined 2011 Annual Scientific Meeting held at Voyages Resort, Ayers Rock, Northern Territory on 11-13 August, 2011.)

References
Morrie et al BMC Pediatr 2005 Jul
World Health Organisation http://www.who.int/en/ (Lasisi et al 2008)

Doctors to the rescue!
Planes, trains and automobiles

What are your responsibilities and liabilities in an emergency?

Michael Gorton
College solicitor

I have recently been asked on a number of occasions about the liability of doctors who attend emergencies or "come to the rescue". With the increased risk and fear of litigation and willingness of patients to initiate proceedings, doctors are becoming more worried about their legal liability in situations where they are asked to act in an emergency – in road accidents, on plane flights and other emergency situations.

A case some time ago in Queensland highlighted the situation where a doctor assisted in an acute asthma attack, having to resuscitate a patient 20 times in the course of travel to hospital. The doctor was painted as a 'Good Samaritan' and the patient survived. However, it was subsequently revealed that the doctor may have been impaired by alcohol after being charged with a drink driving offence relating to the same evening.

On the lighter side, an airline reported a case where a patient suffered an attack en route and the pilot enquired over the loudspeaker whether a doctor was available. Over 20 cardiologists on board returning from an international convention immediately volunteered. (The outcome for the patient was not revealed.)

Two questions arise:-

1 Must doctors render assistance at the scene of an emergency?

2 If a doctor attends an emergency, what is his or her liability?

Must doctors render assistance?

There is no general requirement at law for anyone to provide assistance in an emergency or accident, even where it may be clear or foreseeable that the failure to act may result in death or injury. The liability of a rescuer in such circumstances is much reduced from the ordinary liability for negligence. The duty in such cases is simply to ensure that the conduct of the rescuer does not increase the risk or peril of the person in danger.

There is a general duty for a person coming to the rescue to act reasonably, but this is interpreted at a reduced level, given the context of the emergency situation.

Additionally, at law, there is no legal obligation for doctors to give assistance at the scene of an accident or emergency. However, a positive duty to act does exist where the doctor is in a particular role or part of a system, part of which is to deal with accidents or emergency situations. For example, a doctor in an emergency department clearly has a role to play in dealing with emergencies as they arise. However, even in these cases, even where a doctor is in a casualty department, the English Courts have found that there was not a general obligation to examine all patients who came to the department. The doctor need not see every patient who calls at the department. The overriding determination by the Courts, is whether a doctor has acted reasonably in all of the circumstances.

The Courts also recognise the ability of doctors to carry out procedures, without informed consent if necessary, where treatment is reasonably necessary in the particular emergency situation. Clearly where treatment is necessary in an emergency to save life or prevent serious injury, a doctor is entitled to act.

Apart from the law, the doctors might have a responsibility to attend an accident or emergency under ethical or professional obligations. General profession "moral" obligations certainly recognise the requirement for doctors to render assistance where they are available to do so and such assistance is within their competence.

It may amount to "professional misconduct" if a doctor refuses or fails, without reasonable cause, to attend within a reasonable time after being requested to do so to render professional services, in any case where the doctor has reasonable cause to believe that the patient is in need of urgent attention by a doctor.

The decision in New South Wales of Lowns v Woods in 1996 confirmed that, if a doctor fails to respond to an emergency request for help, even if the victim is not an existing patient, the doctor would have responsibility if:-

> the request for assistance is made in a professional context;
> the doctor and the patient are in close physical proximity (such that the doctor could attend):
> the doctor is aware of the need for emergency treatment or attention for a serious medical case;
> the doctor is appropriately qualified to provide the treatment, has the equipment which may be necessary and is not otherwise at physical risk.

Obviously, any requirement to attend will depend on a range of circumstances:-

> is the doctor able to attend?
> are there other patients requiring his attention?
> are ambulance or other medical services readily available?
> are the doctor's skills sufficient to deal with this situation?
> is he/she competent in the area of treatment or procedure that may be required?
> what is the nature of the illness or remedy required?
> is it a real emergency or merely perceived by those around to be an emergency?
> what are the circumstances of the emergency – is it a road accident in the bush? Is it a heart attack of a visitor in a hospital? What are the resources available?
> these principles obviously apply differently to other professionals such as nurses, paramedics, teachers, etc.

What is the liability of doctors who render assistance?

As noted previously, the law recognises a lesser onus or duty on doctors who render assistance in an accident or emergency situation. The law merely requires that a rescuer, particularly a doctor, acts reasonably, depending on the circumstances. Those circumstances include the fact that the usual medical equipment and supplies may not be available and that doctor is acting under extreme, stressful situations. The law will only require a doctor to conduct procedures that are reasonably necessary in the emergency situation. Of course, the doctor may be liable where his or her own actions contribute to or acerbate injuries.

The position at law in all States has been modified by legislation to specifically protect doctors acting as "Good Samaritans".

For example, in Queensland section 26 of the Civil Liability Act 2003 provides that:-

"(1) Civil liability does not attach to a person in relation to an act done or omitted in the course of rendering first aid or other aid or assistance to a person in distress if:-

(a) the first aid or other aid or assistance is given by the person while performing duties to enhance public safety for an entity prescribed under a regulation that provides services to enhance public safety; and

(b) the first aid or other aid or assistance is given in circumstances of emergency; and

(c) the act is done or omitted in good faith and without reckless disregard for the safety of the person in distress or someone else."

To take advantage of this provision, the doctor must act without gross negligence, which goes beyond simple negligence or misadventure. The doctor would have to be so reckless or incompetent that it warranted the description of "gross negligence".

The doctor must also be acting in good faith. Clearly if the doctor was acting under the influence of alcohol, it is arguable whether the doctor is acting in good faith. If the doctor is clearly under the influence of alcohol and acts incompetently, it may also be that the doctor is grossly negligent. This raises interesting situations where doctors are at social functions, where clearly they have had a few drinks, but may be asked to act in an emergency situation. On the one hand, society would want doctors to intervene and exercise the skills and specialist knowledge that they obviously possess. On the other hand, an impaired doctor may not be of assistance and may in fact exacerbate the situation.

Most medical defence organisations now also provide insurance cover for doctors acting in emergency situations. The Medical Board of Australia has also confirmed that doctors registered as "non-practising" may act in emergencies, without fear of a charge of breaching medical registration limits. (But non-practising doctors should check their insurance cover.)

Small is good, but can be a problem

Help from other states has revealed more for the South Australian audit

Glenn McCulloch
Clinical Director, SAAPM

Small can be good. There are many aphorisms with which we are all familiar: 'good things come in small packages', 'mighty oaks from little acorns grow', 'that's one small step for a man and a giant leap for mankind'. (Before someone picks me up on the last quote that is actually what Neil Armstrong said, but an electronic burp made it sound like "one small step for man".)

However, in audits of surgical mortality, 'small' may be a problem. One of the basic principles of the audit is that the first or second line assessor will be a surgeon who is not involved in the care of the patient, does not work at the same hospital and is not a practice partner. Naturally it must be an appropriate person from the same specialty. It is clear that a urologist cannot assess a patient with a ruptured aortic aneurysm, but it is less obvious that a general adult urologist may not be the best person to assess a paediatric urology case. The word 'appropriate' is important here.

There are many examples of 'small' specialities. Cardio-thoracic, paediatric surgery and neurosurgery are obvious 'small' specialties. In the smaller states, there may be only one unit in a particular specialty and so the question arises: how do we do a first or second line assessment that satisfies the principle of independence? In some sub-specialty areas it may be difficult to get an assessment at all, as the surgeon in the sub-specialty may be the only one (or one of two) in the state doing that sort of surgery – areas such as paediatric cardio-thoracic surgery, transplant surgery and endovascular surgery come to mind.

The South Australian Audit of Perioperative Mortality (SAAPM) has been fortunate in that we have had cooperation from other states to assist us with this issue. In return, South Australian surgeons are helping these states with some cases that may be best assessed outside that state. An example would be where there has been media publicity about a particular case, or where there have been multiple consultations and all surgeons in that specialty in the state are in some way connected with the case.

There are, however, some issues relating to the interstate transfer of surgical report forms and case notes. The confidentiality requirements and regulations vary from state to state, and some of these requirements render the interstate transfer of notes difficult, if not impossible. The smaller states may have more need for outside assistance and the larger states may feel as if they are being unduly imposed upon.

Already we have seen the publication of an Australian and New Zealand Audit of Surgical Mortality national case note review booklet and annual report. With all states now involved in the audits, I would hope that the audits of surgical mortality will become truly national.

Literature Searches – RACS Library

More resources to help you

Cathy Ferguson
Chair, Fellowship Services Committee

Need to know the most recent treatments for metastatic clear cell renal carcinoma? Writing a chapter on decision-making in re-operative surgery for ulcerative colitis? Preparing a presentation on the role of helmet therapy to treat positional plagiocephaly? Need information on the surgical techniques used for hilar cholangiocarcinoma?

The College Library offers all Fellows and Trainees a free Medline literature search service. Complete the Literature Search form (available from the Online Library), with details of the topic you would like searched and we will search Medline, Cochrane and various other online sources for articles and/or details of guidelines or policy documents and email or post the results back to you within two to five working days. Full-text of any article can then be requested via the Online Journal Article Request Form.

You will receive a list of article references along with abstracts. We will also have a look through our book collection to see if there are any relevant pages that can be forwarded to you.

Each Medline search will show the search strategy used so that you can see how the search was carried out.

If you would like to carry out your own searches, Medline via OVID is available online through the Online Library. In addition, if you decide to visit the library, you will be able to access Medline on the OVID platform while you are here.

The Cochrane library is also available free through the Online Library.

If you decide to do your own searches, Medline is the best starting point. Updated daily, Medline on Ovid offers you seamless and up-to-the-minute access to the latest bibliographic citations and author abstracts from more than 5,500 biomedicine and life sciences journals in nearly 40 languages. English abstracts are included in more than 80 per cent of the records.

Some tips are listed below to assist you in obtaining the most appropriate results from your Medline search:

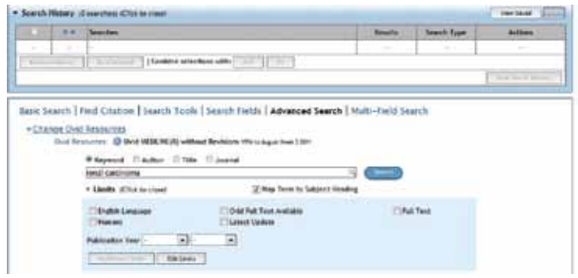
Know what you are looking for!

Medline via OVID includes millions of citations, and not all of them will be relevant to your needs. Think carefully about your topic and be specific about the search concepts. Break your topic into individual concepts, such as the problem or subject group, intervention, outcome, and/or type of study. Search for each concept separately and then combine them. This will allow you to easily modify your strategy and reuse sets in different combinations.

Search with subject headings whenever possible

Medline is a database indexed by subject experts who read the articles and assign specific terminology to describe the content of the articles.

Medline via Ovid offers a list of possible headings – be sure that "Map Term to Subject Heading" is checked. Start the search using your own keywords, and then select the appropriate heading on the next screen.



When appropriate, consider using the "explode" function to broaden your retrieval

"Explode" allows you to include more specific subject headings relevant to your search by combining a broad heading and all the narrower, more specific terms indented under it within the hierarchical arrangement of subject headings (often referred to as the tree structure).

Check the Explode box on the subject heading Tree display page.

When appropriate, consider using 'subheadings' to narrow your search retrieval

Subheadings are qualifying terms that can narrow a search to specific aspects of a topic, such as prevention, therapies, diagnosis, epidemiology, etc. Subheadings vary according to the subject heading used. If none are selected, the default is to include everything in the search. (Example: For articles on the adverse effects of the drug methotrexate, use the subject heading methotrexate with the subheadings adverse effects, contraindications, poisoning, and toxicity.)

After selecting the MeSH term, choose appropriate subheadings from the Subheadings page.

Combine search sets

The main combining terms (Boolean operators) are "and" and "or." "And" will include all the concepts/terms in the same reference. "Or" will include either concept/term in the reference; it is used to combine terms similar in meaning.

Select search sets from the Search History, and then click on the AND or OR buttons to combine. Ex: 1 and 2.

"We will search Medline, Cochrane and various other online sources for articles/and/or details of guidelines or policy documents and email or post the results back to you within two to five working days"

Consider using both subject headings and textwords (keywords)

To increase retrieval, try searching for the concept using both subject headings and textwords. Textwords (or keywords) include words used by the author in the title or abstract –this does not guarantee that the article will be focus on the topic. Textwords can be useful when retrieving a concept for which there is no good subject heading.

1. Palliative Care/ or exp Terminal Care/ [MeSH terms]
2. end of life care.mp. [keyword]
3. 1 or 2

Consider using "truncation" with textwords (keywords)

Truncating textwords allows you to search for a word root with various endings.

For example, diagnos$.tw. in the main search box retrieves diagnosis, diagnostic, etc. [Note: This will not map to subject headings.]

Use appropriate "limit" features

Narrow your final set to the most appropriate articles. Examples of common limits are English language, age groups, publication types, and journal subsets. (Note: The "full-text" limit does not reflect all of RACS holdings.) Select from the common limits shown under the search box, or use the Additional Limits button.

Search by author, words in the article title, volume number, first page number, etc.

This can help you go directly to a specific reference or verify the citation for an article you are having trouble finding.

Use the Find Citation link located above the main search box.

Basic search and advanced search demonstrations can be viewed via the Online Library in the "Database" section.

Why search Medline via OVID? What's the difference between Summon & Medline?

Summon searches the Library's full text content only, with a fast reliable response, however, it is not as comprehensive as Medline. Medline is independent of the Library, and results may or may not have links to full text. Medline can give you more opportunity to combine various keywords for the purpose of complex research.

If you have any questions, regarding the literature search service, or carrying out literature searches, please contact the College Library on college.library@surgeons.org or +61 3 9249 1271, and we will be happy to guide you through your search.

2012 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

Professor Marcus Stoodley – NSW
Professor Marcus Stoodley is a leading Vascular Neurosurgeon based at the Australian School of Advanced Medicine at Macquarie University. Funds from the John Mitchell Crouch Fellowship will be used by Professor Stoodley and his team to investigate the pathogenesis of the serious neurological condition of syringomyelia, as well as to develop new treatments for brain arteriovenous malformations.
Fellowship Value – $150,000

Eric Bishop Scholarship*

Dr Lawrence Lau – Vic
Specialty: General
Scholarship Value – $60,000
Topic: PET: A non-invasive tool to access biology and tailor treatment in colorectal liver metastases
Supervisor: Mr Vijayaragavan Muralidharan

Raelene Boyle Scholarship – – Sponsored by Sporting Chance Cancer Foundation*

Dr Adam Frankel – Qld
Specialty: General
Scholarship Value – $60,000
Topic: Genome–wide analyses of OAC for the identification of prognostic biomarkers
Supervisor: Associate Professor Andrew Barbour

Paul Mackay Bolton Scholarship for Cancer Research*

Dr Joanne Dale – Qld
Specialty: General
Scholarship Value – $60,000
Topic: Pathology to polypectomy: Serrated colorectal carcinogenesis
Supervisor: Professor Barbara Leggett

WG Norman Research Fellowship*

Dr Alexander Cameron – SA
Specialty: Plastic and Reconstructive
Scholarship Value – $60,000
Topic: The role of Flightless 1 in human scar formation
Supervisor: Associate Professor Peter Anderson

Sir Roy McCaughey Surgical Research Fellowship*

Dr Justin Gundara – NSW
Specialty: General
Fellowship Value – $60,000
Topic: Micro-RNA profiling of medullary thyroid cancer: Identification of novel prognostic and therapeutic markers of disease
Supervisor: Associate Professor Stan Sidhu

Francis & Phyllis Thornell Shore Fellowship*

Dr Loretta Wigg – NZ
Specialty: General
Fellowship Value – $60,000
Topic: In vivo and in vitro models for the effects of calcium supplements on vascular calcification
Supervisor: Professor Ian Reid

Foundation for Surgery Reg Worcester Research Fellowship*

Dr Simon Liubinas – Vic
Specialty: Neurosurgery
Fellowship Value – $60,000
Topic: Radiological and molecular features correlating with seizures in patients with supratentorial gliomas
Supervisor: Professor Terrence O'Brien

Foundation for Surgery Catherine Marie Enright Kelly Scholarship*

Dr Ajay Iyengar – Vic
Specialty: Cardiothoracic
Scholarship Value – $60,000
Topic: Detection and treatment of failure of the Fontan circulation
Supervisor: Associate Professor Yves d'Udekem

Foundation for Surgery New Zealand Research Fellowship*

Dr Ryash Vather – NZ
Specialty: General
Scholarship Value – $60,000
Topic: The management of postoperative ileus
Supervisor: Associate Professor Ian Bissett

Foundation for Surgery Scholarship in Surgical Ethics*

Dr Joseph Smith – SA
Scholarship Value – $60,000
Topic: Surgical Ethics, Law and Mandatory Reporting
Supervisor: Professor Guy Maddern

Foundation for Surgery ANZ Journal of Surgery Scholarship*

Dr Christopher Delaney – SA
Specialty: General
Scholarship Value – $60,000
Topic: Exercise and the clinical, systematic and local biological response in claudicants

Foundation for Surgery Research Scholarship*

Scholarship Value each – $60,000
Dr Richard Ross – Vic
Specialty: General
Topic: Characterisation of angiosome subunits of the head and neck superficial tissues
Supervisor: Associate Professor Mark Ashton

Dr Lisa Brown – NZ
Specialty: General
Topic: Accelerating liquefaction of pancreatic necrosis using exogenous maggot-driven enzymes
Supervisor: Mr Richard Flint

Dr Anannya Chakrabarti – Vic
Specialty: General
Topic: Pharmacological induction of dormancy in metastatic breast cancer and its correlation to the tumour suppressor gene ARHi.
Supervisor: Associate Professor Robin Anderson

Dr Regent Lee – NSW
Specialty: Vascular
Topic: Plaque imaging and biomarker study
Supervisor: Professor Keith Channon

Dr Benjamin Dixon – Vic
Specialty: Otolaryngology
Topic: The introduction of next-generation image guidance for endoscopic skull base surgery
Supervisor: Professor Peter Choong

Dr David Westwood – Vic
Specialty: General
Topic: Role of pro–gastrin derived peptides on colorectal cancer development
Supervisor: Professor Graham Baldwin

Dr Alice Guidera – NZ
Specialty: Otolaryngology
Topic: The parapharyngeal space: Advancing surgical practise through anatomical study
Supervisor: Associate Professor Patrick Dawes

Foundation for Surgery Research Fellowship*

Dr Cherry Koh – NSW
Specialty: General
Scholarship Value – $60,000
Topic: ERAS – Cost effectiveness and clinical benefit in rectal surgery
Supervisor: Professor Michael Solomon

Travel Scholarship, Fellowship and Grant Recipients

Margorie Hooper Scholarship

Dr Theodore Athanasiadis – SA
Specialty: Otorhinolaryngology
Scholarship Value – $65,000

Stuart Morson Scholarship

Dr Noojan Kazemi – NSW
Specialty: Neurosurgery
Scholarship Value – $30,000

Murray and Unity Pheils Travel Fellowship

Mr Sameer Memon – Vic
Specialty: General
Fellowship Value – $10,000

Morgan Travelling Scholarship

Dr Eugene Ek – Vic
Specialty: Orthopaedic
Scholarship Value – $10,000

Hugh Johnston Travel Grants

Dr Ardalan Ebrahimi – Vic
Specialty: General
Grant Value – $10,000

Dr Arul Bala – Vic
Specialty: Neurosurgery
Grant Value – $10,000

Hugh Johnston ANZ Chapter American College of Surgeons Travelling Fellowship

Dr John Beer – Vic
Specialty: Plastic & Reconstructive
Grant Value – $8,000

Ian and Ruth Gough Surgical Scholarship

Dr Darren Katz – Vic
Specialty: Urology
Grant Value: $10,000

John Buckingham Travelling Scholarship – 2011

Dr Justin Gundara – NSW
Specialty: General
Grant Value: $3,000

James Ramsay Fellowships for Provincial Surgeons – 2011

Mr Elamurugan Arumugam – Qld
Fellowship Value – $5,000
Specialty: Plastic and Reconstructive

Dr Stephen Tobin – Vic
Fellowship Value – $2,500
Specialty: Plastic and Reconstructive

Dr Sally Meade – Qld
Fellowship Value – $5,000
Specialty: General

Dr Vinny Mamo – NSW
Fellowship Value – $7,500
Specialty: Orthopaedic

Other Scholarships

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

Edwards Lifesciences Travelling Scholarship

Dr Justin Chan – Vic
Funding to visit America for various meetings, tours and visits through AATS
Specialty: Cardiothoracic
Vascutek Terumo Young

Achievers Award

Dr Michael Byrom – NSW
Gross value of award – $2,000
Specialty: Cardiothoracic

St Jude Educational Grant

Dr Sean Galvin – NZ
Gross value of award – $5,000
Specialty: Cardiothoracic

The Cure for Life Foundation Scholarship

Dr Iwan Bennett – Vic
Gross value of award – $50,000
Specialty – Neurosurgery
Project title – Vascular biomarkers in malignant glioma

Neurosurgical Research Foundation (SA) Scholarship

Dr Adam Wells – SA
Gross value of award – $50,000
Specialty – Neurosurgery
Project title – Establishing a surgical model of middle cerebral artery occlusive stroke in the sheep

Synthes–NSA Research Scholarship

Dr David Oehme – Vic
Gross value of award – $35,000
Specialty – Neurosurgery
Project title – Novel approaches to the repair of degenerate and prolapsed lumbar intervertebral discs

Lifehealthcare – NSA Research Scholarship

Dr Wayne Ng – Vic
Gross value of award – $35,000
Specialty – Neurosurgery
Project title – Investigation of PI3k/Akt pathway inhibitors using a mouse gliomas stem cell bioluminescent

Synthes – NSA Research Grant

Dr Stephen Byrne – NZ
Gross value of award – $35,000
Specialty – Neurosurgery
Project title – Viral pathogenesis in glioblastoma and its impact on virus-specific cellular immunity

Preliminary Notice: Applications for 2013 scholarships will open in March 2012

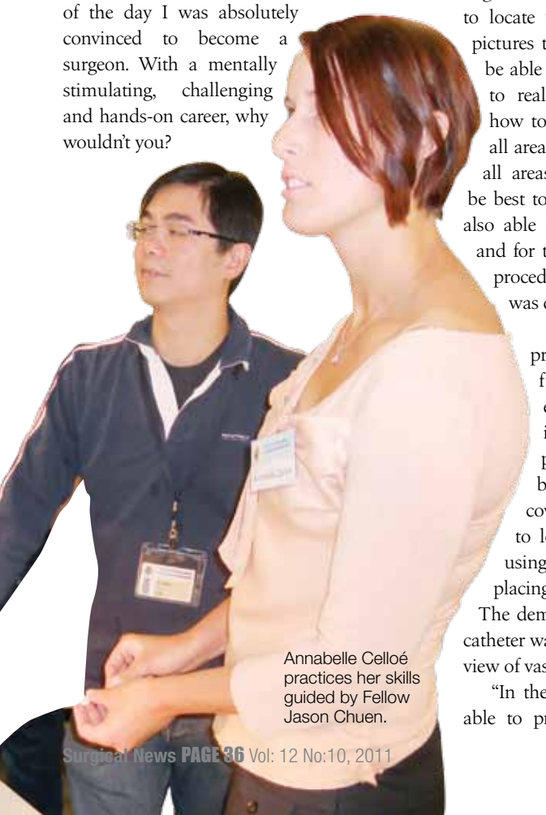
Promoting surgery as a career

The sponsorship of an Indigenous medical student at a recent College workshop was an encouraging success

Kelvin Kong
Chair, Indigenous Health Committee

In August this year, the Indigenous Health Committee (IHC) was very pleased to sponsor Aboriginal medical student Annabelle Celloé, to participate in a surgical workshop organised by the Victorian Regional Office at the College's training facilities in Melbourne. Annabelle is in her second year of medicine at the University of Sydney and is also enrolled in the first year of a Masters of Indigenous Health at the University of Wollongong.

The one-day workshop provided Annabelle with the opportunity to learn about the Surgical Education and Training (SET) program and have hands-on experience in surgical techniques. She describes her experience positively, concluding, "By the end of the day I was absolutely convinced to become a surgeon. With a mentally stimulating, challenging and hands-on career, why wouldn't you?



Annabelle Celloé practices her skills guided by Fellow Jason Chuen.

"The skills learnt were engaging, practical and helped to form an idea of the common procedures, instruments, tools and encouragement to be a surgeon through tasks that I found to be thoroughly enjoyable and engaging. All of the registrars and consultants were passionate about what they did and were willing to share with us their experiences.

"Rotations included urology, vascular, orthopaedics and fundamental laparoscopic techniques that lasted for 30 minutes each. I am sure all of us participating wished the rotations were longer especially those we favoured. The hands-on experience with professional guidance were a great change from university study and brought a new outlook on a medical career, one that is exciting and challenging.

"Urology was set up to include practise of laparoscopic surgery using different camera angles inside a model bladder where we tried to locate various objects made fun by the pictures that we could see. It was useful to be able to manipulate the scopes ourselves to really understand the differences in how to angle the scope to be able to see all areas, how to create a pattern to ensure all areas are visualised and when would be best to use which angled scope. We were also able to practice urinary catheterisation and for those already comfortable with the procedure, a supra-pubic catheterisation was demonstrated.

"Vascular allowed us to practice suturing teaching all the fundamentals from the naming of equipment, how to correctly hold instruments and how to suture with precision. This I thoroughly enjoyed because of the level of detail we covered. We also had the opportunity to learn how to place a cannula and using a model x-ray machine, practice placing the cannula into different vessels. The demonstration of the aortic bifurcated catheter was impressive and shaped a rounded view of vascular surgery.

"In the general surgery rotation we were able to practise manipulating the different instruments through a range of skill sets that reminded me somewhat of skill testers in game arcades. Understanding and practising these basic skills, however, I felt were essential in being able to learn and manipulate a variety of instruments.

"Walking into orthopaedics, I was reminded of what our garage looked like, with tools such as hammers, braces, chisels and saws, all of which were familiar. As we were stepped through the procedure of a knee replacement, it seemed to be a very quick fix and with an ageing society would become more important and common for quality of life.

"After a spectacular lunch (from a student perspective!), we were presented with information about entry into the SET program, what was expected and where to find up-to-date information on the changing programs and variations between the different specialities. Again we were also informed about the sort of lifestyle would could expect as a surgeon."

Annabelle is one of 28 Indigenous medical students and doctors participating in the College program to promote surgery as a career. The program is being developed in partnership with the Australian Indigenous Doctors' Association and the Maori Medical Practitioners Association Te Ora. In December members of the IHC will host a surgical career workshop for Maori medical students and doctors at the Advanced Skills Centre in Auckland. This builds on the College's sponsorship of Te Ora's scientific symposium in September where over 100 students and doctors heard local Indigenous surgeon Jonathan Koea and local Indigenous trainee Maxine Ronald speak on their experiences and answer questions on preparation for surgical training.

Providing Indigenous students with opportunities to engage with Fellows and Trainees is one of the aims of our program. We hope this will successfully deliver many more Indigenous doctors in to surgical training and therefore improve the representation of Aboriginal, Torres Strait and Maori people in the surgical workforce.

Congratulations on your achievements

Professor John Bartlett Blennerhassett FRCPA
Award of the Heslop Medal

The Heslop Medal is awarded to a person who has made a long-term and outstanding contribution to the Board of Surgical Training and its committees. The recipient must be a member of the Board or one of its committees for at least five years and for the recipient to have made regular and substantial contributions to the activities of the Board and its committees during that period.

Professor Blennerhassett is a most distinguished and outstanding medical educator and leader.

John was born in Auckland and, following school matriculation and graduation in medicine, worked and trained in Wellington for six years before travelling overseas to North America to further his studies and experience. He was appointed Teaching Fellow at Harvard University for four years before becoming an Assistant Professor in Pathology at that same prestigious institution in Boston after a sojourn of four years at McGill University in Montreal. At the Royal Victoria Hospital in Montreal he was Associate Pathologist and, on his return to Boston, was appointed Head of Surgical Pathology at the Massachusetts General Hospital. In 1966, he was awarded a Diploma of the American Board of Pathology.

New Zealand was indeed fortunate to have had John return home in 1971 when he accepted the Chair in Pathology at Otago University in Dunedin. He remained the incumbent until his official retirement in 1996 when his contributions were recognised by his being awarded an emeritus professorial title. In the two years prior to his official retirement, John was also Provost of Otago University of Otago. He was also a recipient of FRCPA and FRACP diplomas from the Royal Colleges of Pathology and Medicine for New Zealand and Australia.

Although during his short period in North America, John was a co-author on three published manuscripts in the prestigious New England Journal of Medicine, it was his outstanding ability as a medical teacher that was his greater achievement and for which he remains renowned internationally. The College has been fortunate indeed that John has given his expertise and time unstintingly since the 1980s, in addition to running courses in Pathology for the first part RACS examination in Dunedin, Melbourne and elsewhere by invitation. John has been one of the longest, if not the longest serving member of the Pathology Subcommittee, latterly as chairman. His calm and sensible approach to resolving issues brought stability following a prolonged period of uncertainty and change. His endearing qualities of leading by example and never shirking mundane and tedious chores endeared him to his contemporaries. Through his standing, new members were attracted to the committee and valued other members induced to remain.

Neither the magnitude nor the extent of John's contributions would have been possible were it not for the unwavering support of his wife Jill who maintained the home front and nurtured their six children during their important formative years. It was always good latterly when Jill was able to accompany John to College meetings in Melbourne which they would sometimes use as a staging post for short sojourns to other parts of Australia for well deserved recreation leave.

The Heslop Medal was struck to "award a person who has made a long-term and outstanding contribution to the Board of Basic Surgical Training and its committees". Professor John Blennerhassett's contribution to the College in the field of education most certainly has been outstanding. Indeed, I cannot think of anyone worthier as the recipient of this most highly regarded award.

Citation kindly provided by RA ('Frank') Gardiner
Chairman, Pathology Sub-committee, Royal Australasian College of Surgeons

Professor Andrea Van Rij
Award of the Colin McCrae Medal

Approved by Council in 2001, the Colin McRae Medal commemorates the life and work of the late Colin Ulrich McRae. It recognises and promotes the art and science of surgery and surgical leadership in New Zealand and honours those who have made outstanding contributions in this way. The Colin McRae Medal is awarded by Council on the recommendation of the New Zealand National Board.

Professor Andre van Rij is an outstanding general and vascular surgeon.

Andre was born in Holland moving to New Zealand with his family at the age of five, first to Auckland then Hamilton where he attended Hamilton Boys' High School. He undertook his basic medical training at the Otago University Medical School, the inclusion of a Bachelor of Medical Science degree hinting at the future and a career which would contribute significantly to surgical research. Andre quickly developed an interest in general surgery and was admitted to Fellowship of the Royal Australasian College of Surgeons in 1978. Valuable experience was gained in the surgery departments of the East Carolina University in USA and St Mary's Hospital, University of London before his return to New Zealand in 1981. He commenced as Senior lecturer in the Department of Surgery of the Otago University and just four years later was appointed the Ralph Barnett Professor of Surgery, a position he continues to hold. He completed an MD with distinction the same year.

Throughout his career Andre has been a dedicated, hard-working and competent surgeon who at an early stage acquired an interest and skills in vascular surgery – long before this became a separate specialty. In the 1980's he and Stephen Packer made up one of three general surgical teams in Dunedin and did all of the vascular surgery as well. With his increasing commitment to vascular surgery so too came a shift in his research interests. From the outset Andre has been a leader and promoter of surgical audit. He has contributed to more than ten books and in excess of 150 journal publications. In addition to his personal achievements Andre has been a strong advocate for surgical research in Dunedin supporting the research projects of numerous trainees and other junior and senior medical colleagues and he is currently the Associate Dean of Research. His significant contribution to surgical research was recognised in the awarding of the Louis Barnett medal in 2006.

Andre has contributed significantly to surgical education. In his role as the Ralph Barnett Professor of Surgery at the Otago Medical School he has lectured at both undergraduate and postgraduate levels and has been a role model for a significant number of young doctors seeking a career in surgery. Andre has had an important role in surgical training, accepting the responsibility of Trainer and Supervisor in general surgery in Dunedin and subsequently serving as New Zealand Censor to the College. He has also been an examiner in General Surgery, Chair of the New Zealand Subcommittee of the Board in General Surgery and has also served the College as a member and chair of the Academic Surgeons Committee.

As a surgeon, Andre has never shied away from hard work or from the most difficult of cases. He has always been the colleague that young surgeons and old would turn to when the challenge of a very difficult case seemed too much to handle alone. He has been his own hardest task master, and has always taken an intense interest in every aspect of the care of his patients. Woe betide the registrar or house officer who did not call him about a problem with one of his patients, whatever the day, whatever the hour. He has lived by the dictum "the doctor must always come" and he has always expected the same of all those on his team. His reputation for fierceness arose from a demanding expectation of the highest standards of patient care, one that some see as old-fashioned and somewhat out of step with the expectations of doctors of the Generations X and Y. This has not always been easy on his wife, Anita, and their five children, but they have been as supportive and proud of his care and dedication to his life's work as any family could be. Although they sometimes had to wait, he is a man who clearly values them dearly, and the obvious pleasure of family holidays or weekend outings biking or walking were plain to see. This delight in his family has extended to his eight grandchildren.

I present Professor Andre van Rij as an outstanding clinician and surgeon who has demonstrated leadership in surgical education and research for more than 20 years. He is a very worthy recipient of the Colin McRae medal.

Citation kindly provided by Allan Panting
Executive Director of Surgical Affairs, Royal Australasian College of Surgeons

In Memoriam

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

> HL Eaton, WA General surgeon
> John W. Everingham, Qld Plastic and Reconstructive surgeon
> Kevin Hinrichsen, Vic General surgeon
> Kerry Edgar Clark, NZ General surgeon
> Jeffory George Mander, Vic Orthopaedic surgeon
> Lena McEwan, Plastic & Reconstructive surgeon
> John R. Solomon, Vic Paediatric surgeon
> John Utley, NZ General surgeon
> James Wright, NZ O&G surgeon

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

Informing the College

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

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

Travel broadens the mind

A trip to Paris to make presentations at a surgical congress allowed time for some cultural reflections

Felix Behan
Victorian Fellow

Opus XX

This early 20th century English proverb on travel (the heading of this article) came to mind following my recent Paris presentations at the 4th Annual Mega Hand and Aesthetic Meeting.

I arrived on that autumn Thursday afternoon in late September to find Paris in Autumn basking in an Indian summer, approaching 29°. When I passed Fauchon at the Madeleine, that exclusive food store in which the cakes and chocolates on display are an image of artistic elegance and even the chocolates are embellished with edible gold leaf, I was concerned to see a glistening surface on the chocolate display. It would be a tragedy if they ever melted, I thought, as each one costs €2 to buy and a box of 250 is not cheap.

The following day I arrived at the Palais de Congres with my USB in my holster to install my two presentations – on Dupuytren's disease and the Perforator Flaps on the Upper Limb. These French meetings have a particular emphasis on aesthetic outcomes as well as function. I appreciate why John Hueston had this focus on reconstructive hand surgery. In his 1993 obituary by John Varian, John Hueston was quoted as saying that "if you do not have a high level of excellence in hand surgery, the patient will certainly remind you of this need". Professor Illouz of lipoinjection fame began injecting decanted fat into burn scars, radiation changes, even the ageing hands since the mid-eighties. He presented his 30-year experience in the use of this mesenchymal stem cell source, which is far superior to bone marrow.

When chairing the Dupuytren's session, it was certainly rewarding to hear the names of two Melbourne luminaries – the anatomist Wood Jones and John Hueston – commonly referenced. It brings to mind that famous quote from Twelfth Night: "Some are born great, some achieve greatness and some have greatness thrust upon them". John's innovative article of using a fire-break technique is still being widely quoted. Principally it was a technique to minimise recurrence and optimise function to bypass the McCash technique. With its Jacobson variation for a Type IV Dupuytren's for a little finger, it is still preferable today as any recurrence merely reflects the incomplete removal initially.

In yet another new technique for Dupuytren's, Roger Khoury from Miami uses a scything method to do an aponeurotomy (up to 30 inserts) with a bent 14-gauge needle and fills the created space with decanted fat. As Don Marshall said to me: "What an interesting way to ruin a great operation." The Collagenase technique did not even feature at this meeting.

Pierre Fournier (no relation to Fournier's Gangrene), the other expert in lipoinjections, and I spent quite some time together. He liked the flyer for the new textbook on the Keystone Perforator Island Flap and told me: "Felix, you have found the key".

Pierre Fournier trained in London at the Hammersmith in the 1960's after graduating in Paris. He knew Gillies and represents the hybrid of English tradition peppered with the French élan. He mentioned his mentor, Faulkner, at the Hammersmith, where he trained. His two superb maxims are worth quoting – "Prepare and prevent whereas some repair and repent." And the other one – "Think before you ink". Incidentally he gave me his two published works on the Aesthetics.

He stressed to me the importance of the injections technique of the decanted fat using the syringe with the plunger in the middle of the hand, gently injecting and not to use

Assoc. Professor Felix Behan, Professor Jeong Tae Kim from Korea and Professor Niri Niranjan from Essex

The chocolate at Fauchon.

a tripod grip with any hydro-dissection which may damage the fat cells. With the mesenchymal stem cells from decanted fat regenerating into multiple cell types, I will have my own potentially arthritic knees so injected in the near future. As my registrar Michael Lo said: "Fat is magic".

My singular social activity in this four-day Paris excursion was attending a concert at the Madeleine on the Sunday, in which Massenet's opera Mary Magdalene was performed with a 60-voice choir Ensemble Josquin des Prés de Poitiers with a 70-piece orchestra. This once in a lifetime experience was free, and we appreciate how the French cultivate the arts.

My final day was spent in the area of Notre Dame before crossing to St Michel on the Left Bank. Once again I went again to see how Dupuytren from Hotel-Dieu was portrayed this time, following his most recent redecoration by the current cohort of junior medical staff. Now it is sky-blue. The colour blue features prominently in French artistic development. I recall the story of Manet, a pivotal figure in the development of French Impressionism, who one day was painting with a group of colleagues plein-air in the countryside. They ran out of black paint (the tonal substance of colour intensity), used blue and Impressionism was born.

This story directs my mind to the tale about Gershwin and Rhapsody in Blue and the French link. Its initial performance was at the Aeolian Hall (where Percy Grainger also performed) in New York in 1924. His musical origins began in Tin Pan Alley. He went to Paris to meet Maurice Ravel, who was regarded as the father of musical Impressionism (Bolero), to get lessons in compositional theories. Ravel's response to this request is noteworthy – "How would you listen to a second-rate Ravel when you can listen to a first-rate Gershwin?" Sadly both died in the same year (1937). Ravel was a chain smoker and died of neuronal degeneration – Pick's disease. Gershwin died a week after his craniotomy for a brain tumour. Interesting.

French inspiration

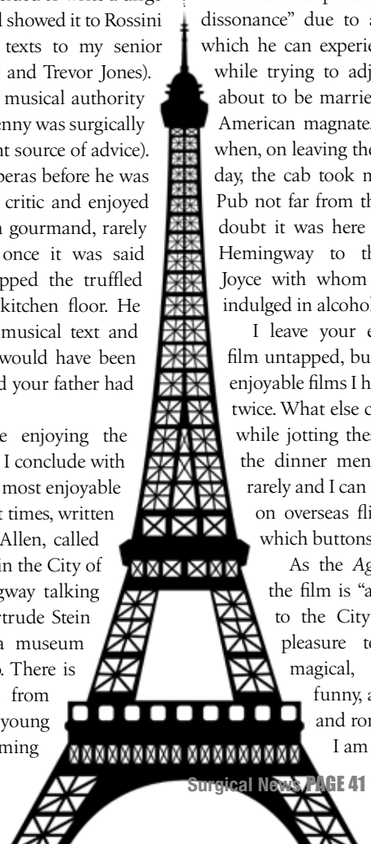
As usual, I went scavenging along the Left Bank and quite fortuitously found the original text of the concert piece I had heard the evening before – Massenet's Mary Magdalene – which I bought. What a coincidence.

This association with Massenet brings to my mind another story about the composer. When he died, his son decided to write a dirge for his father's funeral and showed it to Rossini (as I often show these texts to my senior colleagues Don Marshall and Trevor Jones). Rossini was the supreme musical authority in Paris of the day (like Benny was surgically in Melbourne – a constant source of advice). Rossini had written 40 operas before he was 40 and was the ultimate critic and enjoyed such privileges. He was a gourmand, rarely showing emotions, but once it was said he cried. Why? He dropped the truffled roasted chicken on the kitchen floor. He eventually reviewed the musical text and told Massenet's son: "It would have been better if you had died and your father had written it".

On the flight home enjoying the surging power of the 380, I conclude with a little story of one of the most enjoyable films I have seen in recent times, written and directed by Woody Allen, called *Midnight in Paris* located in the City of Lights. We meet Hemingway talking in a night club with Gertrude Stein and Pablo - Give me a museum and I will fill it - Picasso. There is a memorable comment from Hemingway to this young author about his forthcoming book. Hemingway said abruptly, "Any story based on truth is a good story. But I will hate your book". When asked why, he simply said: "If it is badly written I will hate it and if it is better than what I can do, I will also hate it." The next phase of this nostalgic tour reverts back, in time, where we meet Salvador Dali and Scott Fitzgerald drinking in some Latin quarter before we go to the Moulin Rouge to hear Offenbach's Gaite Parisienne and see Toulouse Lautrec sketching at one of the tables in keeping with historical accuracy. The actor describes these phases as part of his "cognitive dissonance" due to a brain abnormality in which he can experience times of yesteryear while trying to adjust his life as a writer about to be married to the daughter of an American magnate. I had a similar feeling when, on leaving the Palais de Congress one day, the cab took me past the James Joyce Pub not far from the Arc de Triomphe. No doubt it was here Ezra Pound introduced Hemingway to the Irish writer James Joyce with whom Hemingway frequently indulged in alcoholic divergences.

I leave your expectations about this film untapped, but it was one of the most enjoyable films I have seen and I watched it twice. What else can you do over 16 hours while jotting these notes on the back of the dinner menu? I get to the movies rarely and I can only manage to see them on overseas flights (when I work out which buttons to press).

As the *Age* described it recently; the film is "an exhilarating valentine to the City of Light and a sheer pleasure to watch – beguiling, magical, thoughtful and very funny, and a paean to dreamers and romantics everywhere". Yes, I am a romantic.



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The College finances and budget 2012

A report from the Treasurer

Mike Hollands
Treasurer

The College Budget for 2012 was approved at the October meeting of Council. As fellows subscriptions and trainee fees account for a significant share of the College's annual income I thought it would be helpful to explain how these monies will be expended in the forthcoming year.

When trying to understand the way the College finances work it is best to consider the College as 3 separate "businesses" or Categories. First, in Category 1, there are the finances associated with core College business, namely education and training as well as professional development and standards, i.e. matters immediately relevant to Fellows and trainees. This part of College activity is funded by subscriptions and trainee fees. The second "business", Category 2, is College projects. This includes participation in audit such as the different State audit programs, rural training programs, and international aid programs funded through organisations such as AusAID. All these activities are funded through the associated project grants (not fees and subscriptions). The College aims to make a small surplus to cover costs. The third "business", Category 3, revolves around the Foundation which provides scholarships for research and funds for international aid. These activities are funded through donations to the Foundation and bequests, and from income earned from the College's investment portfolio.

The Budget process started in June with the integration of key budget parameters and strategic initiatives for 2012. Within this governance framework the budget is built up to fund day to day College activity and identify new initiatives such as enhancements to the library or educational programs.

Before outlining the key components of the budget I would like to briefly identify some areas of College activity during the current year which has benefitted Fellows and trainees.

College Activities in 2011

Value for money initiatives for Fellows and Trainees being progressed:

> Further development and expansion of online library and information services including 12 month trial of the AAOS Orthopaedic Knowledge Online.
> Secured significant funding under the Specialist Training Program for trainee salary and rural payment loading payments to hospitals.
> Advocacy initiatives including submissions on issues concerning advanced health research centres in Australia, separation of elective and emergency surgery, registration processes and support for overseas-trained doctors and the national health workforce innovation and reform strategic framework.
> Continued expansion of benefits offered to Fellows and Trainees under the Member Advantage program.
> Introduction of "Fax Mentis" a weekly e-newsletter that contains information deemed of interest to Fellows and Trainees and up-to-date news on College activities.
> New accredited courses in rural health and training and assessment as part of the CPD program aimed to support surgeons in their professional life and development growth in surgical competencies.
> RACS Web redevelopment to provide an improved personal experience and value for Fellows, Trainees and Staff with enhanced online technology.
> RACS Portal to Surgical Knowledge incorporating eLearning modules for Fellows and Trainees.
> Increased utilisation of Online Web conference or Webinars and greater opportunities for information sharing.
> Single email address for Fellows and Trainees for life of relationship with the College.

2012 Budget

The College continues to maintain a strong financial position and has budgeted for a modest surplus of $1,341k or 1.7%. The 2012 Budget ensures ongoing investment in Fellows' services and educational activities while ensuring an overall organisational structure and facilities appropriate for our professional organisation.

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

> Achieve a modest surplus return from operations.
> Ensure appropriate staffing resources to deliver objectives in line with the Strategic Plan 2011-2015 and maintain salary levels to the general market in accordance with the remuneration policy.
> Project related activity must be fully self-funded unless Council deems that the engagement in the project is considered to be of value to our strategic interests.
> An allocation of 50% of surpluses on completed projects should be placed in the Foundation for Surgery for ongoing funding commitment to International Projects and Surgical Research.
> New key initiatives proposed will be assessed on the basis of adding value to Fellows and Trainees and should be cost neutral by either generating additional income streams or achieving identifiable savings from existing expenditure.
> Subscription fees to be increased by CPI to ensure the College operational activities achieve the agreed operating surplus.
> Review of all NZD denominated fees to be charged at AUD equivalent to consider parity in fee structure between the jurisdictions.
> Trainee related activities – aim is to ensure that all educational expenditure is fully funded from trainee's fees.
> Fellow related activities – aim to ensure all expenditure is fully funded from annual subscriptions.

Total College Budget – 2012 (2011 Budget Comparison)

	Budget 2012 $000s	Budget 2011 $000s	Increase / (Decrease) %
Revenue	52,690	43,479	21.2% ↑
Expenditure	51,349	42,204	21.7% ↑
Total Surplus	1,341	1,275	5.2% ↑

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 – Bequest funded scholarships and research grants, Foundation and Investments.

CATEGORY 1 – In 2012 revenue from operational activities is budgeted to increase by 6.5% to $34,823k (2011 - $32,693k) while expenditure is budgeted to increase by 4.9% to $34,257k (2011 - $32,670k). Overall this will result in a modest surplus of $566k being closing aligned to the strategic surplus target of 2% of revenue.

Specific items of expenditure on category 1 activities include:

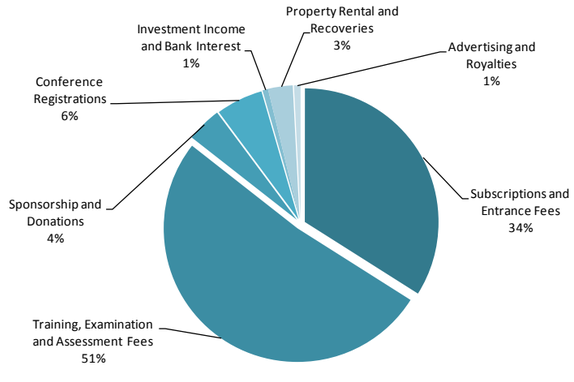
> Staff Payroll and On costs – increased by 3.3% to $12,720k (2011 – $12,346k) and provides for salary increases in line with the general market and new staffing resources to support the delivery of new initiatives and growing business need.
> Consultants Fees – Clinical – $419k (2011 – $491k) – activities for clinical/medical support and assessments, usually provided by Fellows of the College.
> Printing and Office Supplies – $1,356k (2011 – $1,456k) primarily related to the production of the *ANZ Journal of Surgery*, *Surgical News* and brochures for the Annual Scientific Congress.
> Travel & Accommodation – $3,736k (2011 – $3,445k) – predominately relates to governance activities, and travel co-ordination for examinations and skills courses.
> RACS scientific visitors program – $355k (2011 – $315k) being the first year of the new 2012-2014 triennium funding period to benefit the Fellowship with many scientific visitors also attending specialty society meetings.
> Specialty Society funding – $3,720k (2011 – $3,361k) provided for from Surgical Education Training (SET) fees in accordance with the training program agreement.

Ongoing investment in education and other initiatives embarked upon in 2011 will be further consolidated in the forthcoming year. Some of the key areas of focus to add further value to Fellows and Trainees are:

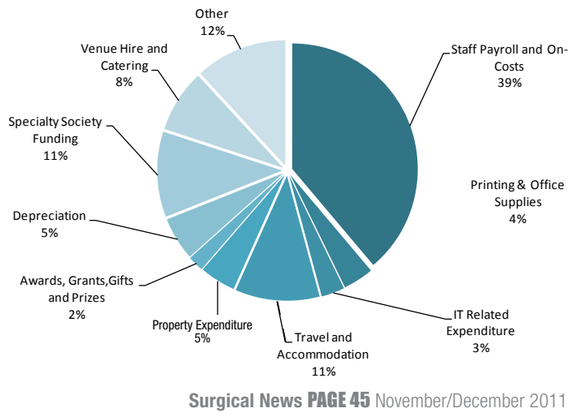
> Enhancement to the "Find a Surgeon" web-based facility in order to provide the best possible surgical consumer advisory service and create interest in other sections of the website from the community.
> Increased resourcing for the College's e-Learning services to ensure high quality delivery of web based learning opportunities.
> Upgrade of RACS CPD system to enhance Fellows online experience.
> Ongoing consultation with Specialty representatives to assist in the planned expansion and purchase of new products for the Online Library.
> Continued funding program for College representation at specialty society events in order to further engage with the Fellowship and promote professional development.
> Active advocacy initiatives with high level representations via College submissions on critical issues of public health policy, standards and protocols. ▶

Main sources of revenue and expenditure are represented in the chart display below:

Category 1 - Breakdown of Revenue - $34,823k



Category 1- Breakdown of Expenditure - $34,257k



“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 2012, which I have outlined in my report, will ensure that the College continues to meet these challenges and progress in 2012.”

CATEGORY 2 – Revenue for College project activities in 2012 has increased by 86% to $14,309k (2011 – $7,695k) while expenditure is forecasted to increase by 87% to $14,616k (2011 – $7,789k). The overall result is a projected deficit of $307k which is mainly due to funding business development and support initiatives within the Research Audit and Academic Surgery division.

This deficit result is partially offset by the College overhead charge levied on projects which for 2012 has increased 28% to $920k (2011 – $720k) having a direct nexus with increased levels a project activity.

The significant increase in project activity is predominantly due to the Specialist Training Program (STP) contract which provides for trainee salary support and rural loading payments to hospitals for specialist training posts.

Specific items of expenditure on category 2 activities include:

> Staff Payroll and on costs – $3,479k (2011 – $2,697k) primarily due to new project contracts.

> Consultants Fees – Management and Clinical – $868k (2010 – $1,067k) – 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 extended Surgical Simulation Project.

> Grants – $5,910k (2011 – $92k) with projected increase related to the new STP contract.

CATEGORY 3 – Category 3 – Revenue for all activities relating to the Foundation and Investments is budgeted to increase 15% to $3,557k in 2012 (2011 – $3,090k) and mainly relates to investment income. The College's investment portfolio has faced challenging market conditions for the current year due to international influences and therefore the budgeted return will remain at 8% down from the general setting of prior years of 10%. The main factors for the budgeted increase in investment income are the significant anticipated contribution of $3,600k from the Rowan Nicks Estate and the creation of the RACS Scholarship corpus which has increased the pool of fund holdings.

Balance Sheet

As at 31 December 2012, it is estimated that the College Net Assets will be $52,596k (2011 forecast – $51,255k). During the period, the Investment Reserve is budgeted to increase from $3,288k to $4,307k, 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 College is planning to sell the Sydney property later this year and relocate to leased premises which at present is still subject to negotiation. The new premises will provide NSW Fellows and Trainees with facilities that better meet their contemporary needs.

Maintenance and repair of these properties is budgeted at $422k compared to $384k in 2011 and is largely accounted for restoration work of the façade of the south wing of the Melbourne property.

Proceeds from the Rowan Nicks Estate, an estimated $3,600k, will be transferred to the Rowan Nicks Scholarship Fund. Rowan Nicks, OBE, FRACS, AO established a scholarship program in 1987. Between 1991 and 2010, 48 international scholars from 20 countries have been awarded the Rowan Nicks Scholarship to undertake training attachments in one or more Australia, New Zealand and Indian hospitals.

The College was successful in defending the building permit issued by the Brisbane City Council for its proposed Queensland Surgical Education Centre (QSEC) development. Council is now considering its options in consultation with the Queensland State Committee. As an interim measure the office will be relocated to leased premises due to the poor condition of the Brisbane property.

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 2012, which I have outlined in my report, will ensure that the College continues to meet these challenges and progress in 2012.

I would like to thank my Deputy Treasurer, Dr Sam Baker, for his continued support during 2011 and his oversight of property matters and especially the demands of the QSEC project in Queensland.

I would also like to 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, Mr John Craven and Mr Chesley Taylor 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 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 2012

		2012 AUST Fees AUD (Inc. GST)	2012 NZ Fees NZD (Inc. GST)
SUBSCRIPTIONS & ENTRANCE FEES			
#Annual Subscription - 2012 payable on 1 January 2012		$2,431	$3,220
Fellowship Entrance Fee payable in full (10% discount applies) or over 5 years - no CPI increase		$6,105	$7,590
EDUCATION & TRAINING			
Surgical Training			
Administration Fee - exam pending, interruption and deferral (SET)		$759	$1,000.50
Selection Processing Fee - (Note 6)		$649	$862.50
Selection Registration Fee		$440	$575
# SET Training Fee	*	$5,490	$7,958
Examinations			
Clinical Examination Fee	*	$1,800	$2,599
Fellowship Examination Fee	*	$6,525	$9,464.50
Generic Surgical Science Examination Fee	*	$3,140	$4,554
Orthopaedic Principles & Basic Science Examination Fee	*	$2,355	$3,415.50
Paediatric Anatomy and Embryology Examination Fee	*	$2,975	N/A
Paediatric Pathophysiology Examination Fee	*	$1,180	$1,713
Plastic and Reconstructive Surgical Science & Principles Examination Fee	*	$2,355	$3,415.50
Speciality Surgical Science Examination Fee	*	$1,570	$2,282.75
Skills Courses - refer to note 4			
ASSET Course		$3,124	$4,117
CCrISP Course		$2,607	$3,450
CLEAR Course		$1,276	$1,667.50
STATS Course		$1,276	N/A
EMST Course - Provider		$2,607	$3,450
EMST Course - Refresher		$1,672	$2,196.50
Course Transfer Fee		$176	$230
Course Accreditation			
Course Accreditation Fee		$1,133	$1,483.50
PROFESSIONAL DEVELOPMENT WORKSHOPS & COURSES			
Polishing Presentation Skills		$484	N/A
Practice Management for Practice Managers		$572	N/A
Surgical Teachers Course (STC)		$286	N/A
Writing Reports for Court		$891	N/A
Leadership in a Climate of Change		$2,101	N/A
Strategic Direction		$1,870	N/A
AMA Level 4/5: Difficult Cases		$88	N/A
Building Towards Retirement - Fellow		$231	$300
Building Towards Retirement - Fellow & Partner		$330	$430
Sustaining Your Business		$2,156	N/A
Working Together: Surgeons and Administrators		$220	N/A
Process Communication Model		$1,221	$1,592.75
Occupational Medicine		$77	N/A
AMA Impairment		$88.	N/A
Finance for Surgeons		$528	N/A
Strategy and Risk for Surgeons		$528	N/A
Acute Neurotrauma		$110	N/A
OTHER FEES			
Training Post Accreditation Fees		$3,487	$4,588.50
Peripheral Endovascular Therapy - Application Fee		$352	N/A
Re-Assessment Fee		$115	N/A
Appeals Lodgement Fee		$6,160	N/A
Distance Learning (Exam Preparation) Fee		$594	N/A
International Medical Graduates			
Paper Based Assessment Fee		$4,928	N/A
Paper Based Assessment & Interview		$7,458	N/A
Supervision / Oversight Fee- onsite		$6,039	N/A
Supervision / Oversight Fee - remote		$17,248	N/A
Document Assessment Fee - AoN subsequent to specialist assessment		$1,188	N/A
Document Assessment Fee - College endorsement for AoN (Area of Need)		$1,188	N/A
Assessment Fee - Reconsideration for Exceptional Performance		$2,365	N/A
Short Term Specified Training Position Application Fee		$946	N/A
Post Fellowship Education and Training			
Program Assessment Fee		$583	$770
Annual Administration Fee		$121	$149.50
MOPS - Maintenance of Professional Standards			
Australia & New Zealand		$2,585	$3,415.50

1. All fees are payable in either Australian or New Zealand Dollars as invoiced.
2. All New Zealand fees, including Examinations undertaken in New Zealand, are subject to the Goods & Services tax of 15.0%.
3. All Australian Fees will be subject to GST of 10% except those approved Education courses marked with an asterisk (*) which are not subject to Australian GST.
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.

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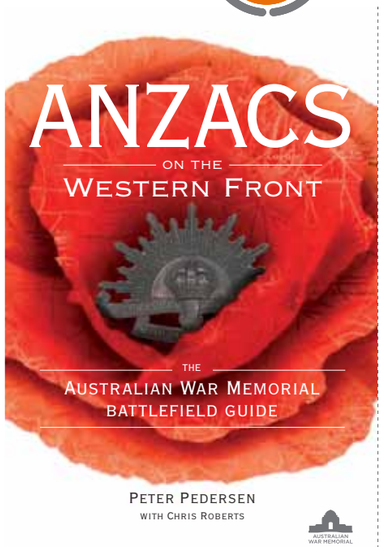

ANZACS on the Western Front: The Australian War Memorial Battlefield Guide

Dr Peter Pedersen
9781742169811 | Pbk | 600 pages | November 2011
~~AU$49.95~~ | **AU$37.46**
Member Price

ANZACS on the Western Front: The Australian War Memorial Battlefield Guide is the definitive guide to the Western Front battlefields.

Meticulously researched and written by the Head of Research at the Australian War Memorial, Dr Peter Pedersen, this landmark publication guides readers chronologically through the battles in which Australians and New Zealanders fought on the Western Front

from 1916–1918. Lavishly illustrated in vibrant colour, with fascinating images from the Australian War Memorial archive as well as new panoramic location shots to provide an in situ perspective for the reader, each chapter covers the important tactical milestones passed along the way and explains how the Australian Imperial Force and the New Zealand Expeditionary Force evolved to meet the war's changing demands.

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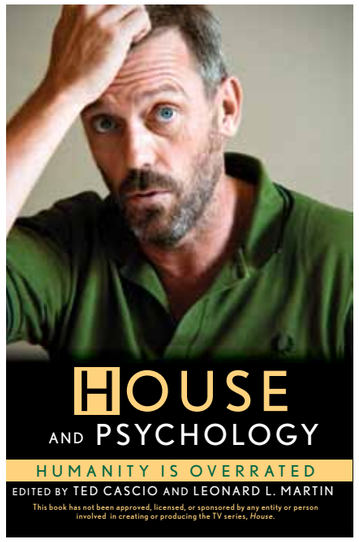

House and Psychology: Humanity Is Overrated

Ted Cascio and Leonard L. Martin
9780470945551 | Pbk | 336 pages | September 2011
~~AU$22.95~~ | **AU$17.21**
Member Price

An irresistible look within the mind and behind the hit TV drama, House While House is a smart medical drama and Gregory House faces countless ethical quandaries as a doctor, what makes the show unique is that it's much more deeply rooted in psychology than in medicine. At its core, House is a show about the mind and human behavior. Gregory House is a medical genius and a Sherlock Holmesian figure, but he's also a deeply troubled misanthrope. What's going on inside the brain of this beloved, arrogant, cane-waving curmudgeon that is so appealing? House and Psychology tackles this question and explores the latest findings in brain science research, defines addiction in its many forms, and diagnoses dysfunctional relationships, all using test cases at Princeton-Plainsboro Hospital. House and Psychology will help you discover the extraordinary mental universe of your favorite brilliant, bombastic, bile-belching doctor of medicine.

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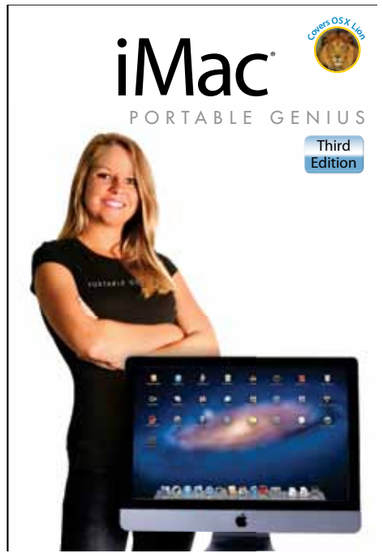

iMac Portable Genius, 3rd Edition

Guy Hart-Davis
9781118147580 | Pbk | 416 pages | Sep 2011
~~AU$32.95~~ | **AU$24.71**
Member Price

Tips, tools, and shortcuts on the latest features of the iMac Completely updated to cover the latest features and capabilities of the iMac, this handy guide is packed with useful tips, full-color screenshots, and savvy advice to show you how to get the most out of your iMac. You'll find cool information on iMacs as well as the new iLife '11 suite (Garageband, iMovie, and iPhoto) and the exciting OS X Lion operating system. Veteran author Guy Hart-Davis shows you how to set up and customize your iMac so that it will work best for you, plus he shows you how to get more from your iMac, whether you're switching from an older Mac or migrating from Windows.

- Explores the best ways to maximize the amazing speed and impressive graphics of the new iMac
- Highlights all the bells and whistles of the new iMac, including the new Magic Mouse, iLife applications, and the new OS
- Provides you with the most up-to-date, accessible, useful information on the most used features of the iMac

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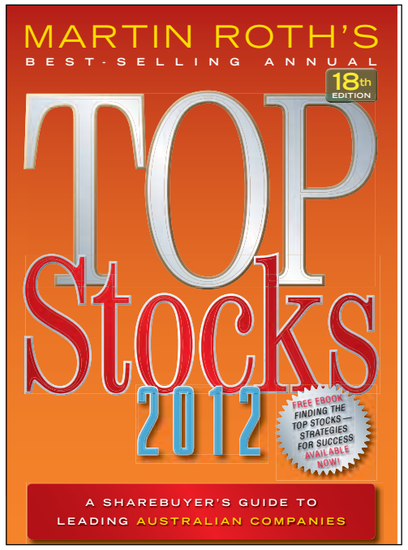

Stocks 2012: A Sharebuyer's Guide to Leading Australian Companies, 18th Edition

Martin Roth
9780730377276 | Pbk | 192 pages | October 2011
~~AU$29.95~~ | **AU$00.00**
Member Price

Amid a weak economy, slowing corporate profitability, a limping share market and growing investor caution, the 18th edition of Australia's most trusted and sought after share market reference, Top Stocks, returns. Despite the current financial climate, a surprisingly large number of Australian companies continue to race ahead with surging profits, Top Stocks 2012 guides investors with the lasted information on the companies that will help them build a successful portfolio.

Respected financial journalist Martin Roth puts his rigorous, independent selection criteria to work on the top 500 Australian companies, once more delivering detailed and crucial analysis on Australia's best public companies. In Top Stocks 2012 you will discover which firms pose the lowest risk and the greatest long-term investment value. Inside, you'll find:

- Individual, unbiased analysis of the latest results from 102 top Australian companies
- Comparative sales and profits data, and in-depth ratio analysis

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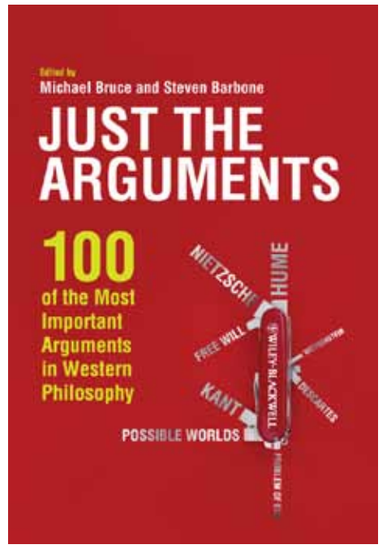

Just the Arguments: 100 of the Most Important Arguments in Western Philosophy

Michael Bruce and Steven Barbone
9781444336382 | Pbk | 424 pages | September 20111
~~AU$29.95~~ | **AU$22.46**
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Surgical news

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Australia Patent No. 703926 and New Zealand Patent No. 556353. AU and worldwide patents pending.